PROPOSED REGULATION OF THE COMMISSIONER OF INSURANCE

LCB File No. R049-14

March 20, 2014

EXPLANATION – Matter in *italics* is new; matter in brackets [~~omitted material~~] is material to be omitted.

AUTHORITY: NRS 679B.130 and 687B.490

Section 1. NAC 687B is hereby amended by adding thereto the provisions set forth as sections 2 through 13, inclusive, of this regulation.

Sec. 2. ***1. A carrier applying to the Commissioner for the issuance of a network plan must establish that the network plan has an adequate number of providers in each category of health care necessary to serve its members in each geographic service area to which the network plan will be applicable.***

2. The categories of health care necessary to serve members are:

(a) Cardiology;

(b) Dermatology;

(c) Emergency medicine;

(d) Gastroenterology;

(e) Hematology and oncology;

(f) Internal medicine, general practice and family practice;

(g) Mental health;

(h) Nephrology;

(i) Obstetrics and gynecology;

(j) Ophthalmology;

(k) Orthopedics, including general, hand and neurosurgery;

(l) Otolaryngology;

(m) Pediatrics, not including pediatric dentistry;

(n) Pediatric dentistry;

(o) Pulmonology;

(p) Substance abuse;

(q) Surgery, including general, cardiovascular, cardiothoracic, vascular and colorectal;

(r) Urgent care; and

(s) Urology.

3. A network plan which does not offer pediatric dental coverage pursuant to 42 U.S.C. § 18022(b)(4)(F) shall not be required to establish that the network plan has an adequate number of providers of pediatric dentistry under paragraph (n) of subsection 2 of this section.

Sec. 3. ***1. A carrier applying to the Commissioner for the issuance of a network plan must establish that the providers of health care with whom the organization has contracted to provide services within the network plan are located so that the members may obtain health care without unreasonable travel.***

2. On or before April 1 of each year the Commissioner shall make available a list of the minimum number of providers and maximum travel distance or time, by county, for each category of health care necessary to serve members within network plans. The list will be applicable to health benefit plans issued or renewed on or after January 1 in the calendar year after the list is issued.
3. The carrier shall ensure that nonemergency services are available and accessible during normal business hours and emergency services are available at any time.

Sec. 4. *1. A carrier applying to the Commissioner for the issuance of a network plan must have a sufficient number and geographic distribution of essential community providers, where available, within the network plan to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the network plan's geographic service area or areas.*
2. A network plan that includes at least 20 percent of the available essential community providers in the network plan's geographic service area or areas shall be deemed sufficient pursuant to subsection 1.
3. As used in this section, "essential community provider" has the meaning ascribed in 45 C.F.R. § 156.235(c).

Sec. 5. *1. A carrier applying to the Commissioner for the issuance of a network plan shall use best efforts to maintain arrangements that ensure that American Indians and Native Alaskans who are covered persons within the network plan have access to insurance health care services and facilities that are part of the Indian Health Care System.*
2. Such covered persons may obtain covered services from the Indian Health Care System at no greater cost to the covered person than if the service were obtained from network providers and facilities.
3. Nothing in this section prohibits a health benefit plan from limiting coverage to those health care services that meet the standards for medical necessity, care management, and claim administration, or from limiting payment to that amount payable if the health care service were obtained from a network provider or facility.

Sec. 6. *For a network plan issued to a health maintenance organization the health maintenance organization shall ensure that:*
1. Members have access to their primary care physician through on-call procedures after normal business hours;
2. The providers of health care with whom the health maintenance organization has contracted provide services to maintain records of health care of its members which are accessible to other professionals within the organization;
3. It provides a health care professional who is primarily responsible for coordinating the overall health care services offered to members; and
4. It has established a quality assurance program required pursuant to NAC 695C.400.

Sec. 7. *A carrier applying to the Commissioner for the issuance of a network plan shall establish a system to collect data related to the health care services provided to members.*

Sec. 8. ***1. A carrier applying to the Commissioner for the issuance of a network plan that meets all of the requirements of sections 2 through 7 of this regulation shall be deemed to have an adequate network.***

2. A network plan which has not been deemed to be adequate may apply to the Commissioner for a determination of an adequate network. In determining whether a network plan is adequate the Commissioner may consider:

(a) The relative availability of health care providers or facilities in the geographic service area or areas to be covered by the network plan;

(b) The willingness of providers or facilities in the geographic service are or areas to be covered by the network plan to contract with the carrier under reasonable terms and conditions;

(c) The delivery system of care to be furnished by the providers or facilities in the geographic service area or areas to be covered by the network plan; and

(d) The clinical safety of the providers or facilities in the geographic service area or areas to be covered by the network plan.

3. A network plan which is determined to be insufficient for failing to meet the requirements of sections 4 or 5 of this regulation shall not be approved by the Commissioner.

4. A network plan which is determined to be insufficient for failing to meet the requirements of sections 2 or 3 of this regulation may be approved by the Commissioner. If such a network plan is approved, the Commissioner shall notify the carrier of the specific requirements which have been deemed sufficient and those which have been deemed deficient.

5. For requirements which have been deemed deficient pursuant to subsection 4, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains covered services from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers or facilities, or shall make other arrangements acceptable to the Commissioner.

Sec. 9. ***A carrier with an approved network plan shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health care services to covered persons.***

Sec. 10. ***1. A carrier with an approved network plan shall update its provider directory no less frequently than every 30 days.***

2. The provider directory and all updates shall be posted to the carrier's Internet web site and filed with the Division by means of the System for Electronic Rate and Form Filing within 24 hours.

Sec. 11. ***1. Each carrier with an approved network plan shall attest that its network or networks will meet the requirements of this regulation:***

(a) For a health benefit plan for individuals available for sale during the open enrollment period described in NRS 686B.080, by January 1 of the calendar year in which the coverage is to be effective.

(b) For a health benefit plan for individuals not available for sale during the open enrollment period described in NRS 686B.080, 30 days prior to the health benefit plan being made available for purchase by any individual.

(c) For a health benefit plan for small employers, 30 days prior to the health benefit plan being made available for purchase by any small employer.

2. The attestation shall be renewed on or before January 1 of each subsequent calendar year.

3. The attestation shall be on a form prescribed by the Commissioner and must be signed by an officer of the carrier issuing the health benefit plan.

4. Each attestation shall be accompanied by a Network Access Plan Cover Sheet Template and filed through the System for Electronic Rate and Form Filing.

Sec. 12. *1. A carrier with an approved network plan shall notify the Commissioner within 30 days of any significant change to its network.*

2. If a significant change in network results in a deficiency in the network the notification must include a corrective action plan to resolve the deficiency within 60 days.

3. If a significant change in network results in a deficiency in the network with respect to any category of provider or facility, the carrier shall, during the period the corrective action plan is being implemented and with respect to that category of provider or facility:

(a) Ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than id the service were obtained from network providers or facilities; or

(b) Make other arrangements acceptable to the Commissioner.

4. If at the end of the corrective action plan time period the network is still deficient then:

(a) For health benefit plans made available for purchase through the Silver State Health Insurance Exchange, the health benefit plan will be declared deficient pursuant to 45 U.S.C. § 18031(c)(1) and decertified pursuant to 42 C.F.R. § 156.290.

(b) For all other health benefit plans, the health benefit plan shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

Sec. 13. *1. A carrier with an approved network plan may, upon the approval of the Commissioner, make health benefit plans using that network plan available to individuals outside of the approved service area.*

2. A health benefit plan made available outside of the approved service area pursuant to subsection 1 shall:

(a) Include a disclaimer, the content and placement of which shall be approved by the Commissioner, notifying potential enrollees located outside of the approved service area that the network plan may not provide contracted physicians or facilities within the enrollee's service area; and

(b) Be subject to all relevant state and federal laws regarding guaranteed availability of coverage.