REVISED PROPOSED REGULATION
OF THE COMMISSIONER OF INSURANCE

LCB File No. R049-14

October 19, 2015 **(Updated by DOI 2 March 2016)**

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

AUTHORITY: §§1-29, NRS 679B.130 and 687B.490; §30, NRS 679B.130, 695C.130 and 695C.275.

A REGULATION relating to insurance; establishing certain requirements relating to the adequacy of a network plan issued by a carrier; establishing provisions relating to the determination by the Commissioner of Insurance of whether a network plan is adequate; requiring a carrier to notify the Commissioner of any material change to its network and take certain actions to correct any deficiency that results; providing for the availability of a network plan to persons outside of the approved service area in certain circumstances; ***creating a Network Adequacy Advisory Council***; and providing other matters properly relating thereto.

Legislative Counsel's Digest

Existing law authorizes the Commissioner of Insurance to adopt reasonable regulations for the administration of the Nevada Insurance Code and as required to ensure compliance with federal law relating to insurance. (NRS 679B.130) Existing law also requires: (1) a carrier who offers coverage in the group or individual market to demonstrate the capacity to deliver services adequately before making any network plan available for sale; and (2) the Commissioner to promulgate regulations concerning the organizational arrangements of the network plan and the procedure established for the network plan to develop, compile, evaluate and report certain statistics relating to its services. (NRS 687B.490)

This regulation establishes certain requirements for a carrier who applies to the Commissioner for the issuance of a network plan. **Section 17** of this regulation requires a carrier who applies for the issuance of a network plan to establish that the carrier has contracted with an adequate number and geographic distribution of providers of health care. **Section 18** of this regulation requires the Commissioner to make a preliminary and a final list of the minimum number of providers of health care and the maximum travel distance or time, by county, which is presumed to be reasonable for certain specialties and categories of health care. **Section 19** of this regulation requires a carrier to gather and present sufficient data to establish the adequacy of its network plan to the Commissioner in conjunction with its annual rate and form filing. **Section 20** of this regulation requires a carrier who applies for the issuance of a network plan to establish that the carrier has a sufficient number and geographic distribution of essential community providers. **Section 21** of this regulation requires a carrier who offers a network plan on the Silver State Health Insurance Exchange to use its best efforts to ensure that American Indians and Alaskan Natives who are members of the network plan have access to health care services and facilities that are part of the Indian Health Service. Section 22 of this regulation establishes criteria the

Commissioner may use to determine whether a network plan is adequate. **Section 23** of this regulation requires a carrier to monitor the ability and clinical capacity of its providers of health care. **Section 24** of this regulation requires a carrier to update its provider directory at least once a month and to post each update on its Internet website. If a material change to a network plan occurs, **section 24** requires a carrier to update its directory within 3 business days and notify all covered persons affected by the material change. **Section 25** of this regulation requires a carrier to notify the Commissioner of any material change to its network plan within 3 business days.

Section 26 of this regulation requires a carrier to take certain actions to correct any deficiency in its network plan that results from such a material change. **Section 27** of this regulation allows the Commissioner to declare a network plan inadequate pursuant to existing law if it remains deficient at the end of the time period allowed for corrective action. **Section 28** of this regulation excludes a network plan issued by certain smaller carriers from the provisions **sections 20-22, 26 and 27** of this regulation and deems such a network plan to satisfy the requirements of existing law. **Section 29** of this regulation excludes certain other plans from the provisions of this regulation.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 28, inclusive, of this regulation.

Sec. 2. ***As used in sections 2 to 28, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in sections 3 to 16, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. 3. "***Access plan" means a plan submitted by a carrier which describes how access to health care will be provided when a network plan fails to meet a specific standard including, but not limited to, any relevant established patterns of care.***

Sec. 4. ***"Carrier" means an insurer who makes a network plan available for sale in this State pursuant to NRS 687B.490.***

Sec. 5. ***"Centers for Medicare and Medicaid Services" means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.***

Sec. 6. ***"Covered person" means a policyholder, subscriber, enrollee or other person participating in a network plan.***

Sec. 7. *"Essential community provider" has the meaning ascribed to it in 45 C.F.R. § 156.235(c).*

Sec. 8. *"Geographic service area" means a network plan's geographic area as approved annually by the Commissioner.*

Sec. 9. *"Material change" means any change to a network plan that results in the failure of a network plan to meet the requirements issued by the Commissioner pursuant to Sections 19 and 20.*

Sec. 10. *"Medically necessary emergency services" has the meaning ascribed to it in subsection 3 of NRS 695G.170.*

Sec. 11. *"Network Adequacy Advisory Council" means the council established by the Commissioner pursuant to Section 17.*

Sec. 12. *"Network plan" has the meaning ascribed to it in subsection 2 of NRS 689B.570.*

Sec. 13. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 14. *"Provider of health care directory" means a list of doctors, hospitals, and other professionals and organizations that provide health care services as part of a network plan, to include telehealth providers. The provider of health care directory is reviewed by the Division for purposes of monitoring a network plan's adequacy pursuant to NRS 687B.490.*

Sec. 15. *"Qualified health plan" has the meaning ascribed to it in NRS 695I.080.*

Sec. 16. *"Standard" means a quantifiable metric commonly used in the health care industry to measure network adequacy pursuant to 80 Fed. Reg. 75,488, 75,549 (Dec. 2, 2015).*

Sec. 17. *1. The Network Adequacy Advisory Council is hereby created pursuant to NRS 679B.160. The purpose of the Council is to develop and submit a recommendation to the*

Commissioner each year, pursuant to Section 19, as to the network adequacy requirements for the relevant network plan year.

2. The Council shall consist of nine persons. The members of the Council shall be appointed by the Commissioner and shall serve at the discretion of the Commissioner. Vacancies on the Council shall be filled in the same manner as initial appointments. The Council shall consist of representatives of carriers, health care providers, and consumers.

Sec. 18. *Meetings and Notice. The Council shall conduct at least three meetings each year. The first meeting of the Council shall occur no later than June 15th of each year. The final meeting of the Council shall contain an action item to adopt a recommendation pursuant to Section 19 to submit to the Commissioner no later than September 15th of each year. Notice of each meeting will be posted:*

1. At least five business days prior to the date of the meeting, not counting the day of the meeting;

2. At a minimum, at the offices of the Division of Insurance, the Legislative Building, the Grant Sawyer State Office Building, and on the State's and Division of Insurance's websites; and

3. Interested parties may also contact the Division of Insurance to be added to its notification list.

Sec. 19. *Recommendation of the Council; Failure to Make Recommendation.*

1. The recommendation of the Council shall include the minimum requirements set forth in Section 20.

2. The Council may include in the recommendation:

(a) Other provider types, and

(b) A number of essential community providers greater than the minimum percentage required by the Centers for Medicare and Medicaid Services for qualified health plans.

3. Failure of the Council to make a recommendation does not prevent the Commissioner from issuing final requirements in his or her discretion.

4. The Commissioner shall decide what action to take on the recommendations by October 15th of each year.

Sec. 20. *A network plan must contain the following:*

(a) The specialties and categories of health care which appear on the Network Adequacy Template issued annually by the Centers for Medicare and Medicaid Services pursuant to 80 Fed. Reg. 75,488, 75,549 (Dec. 2, 2015), and available through its website https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html;

(b) Provider types mandated under NRS 689A.0435, NRS 689C.1655, NRS 695C.1717, NRS 695G.1645, and other Nevada law; and

(c) Standards that meet the minimum established in the Letter to Issuers published annually as subregulatory guidance by the Centers for Medicare and Medicaid Services for qualified health plans, and posted to its website https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html, which are acceptable to the Centers for Medicare and Medicaid Services.

Sec. 21. *A carrier who applies to the Commissioner for the issuance of a network plan shall, in conjunction with its annual rate filing, submit in a format determined by the Commissioner, sufficient data and documentation to establish that its proposed network plan meets the requirements.*

Sec. 22. *1. A carrier shall update its provider of health care directory at least once each month. Each update to the directory shall indicate each provider of health care which has left the network plan or is no longer accepting new patients. A carrier is deemed to have complied with this subsection if it fails to update its directory as a result of the failure of a provider of health care to provide information to the carrier which the provider of health care is contractually obligated to provide.*

2. If a material change to its network plan occurs, a carrier shall update its provider of health care directory within 3 business days after the effective date of the material change and provide a description of the material change.

3. The provider of health care directory and each update thereto must be:

(a) Posted to a publicly available website maintained by the carrier within 3 business days after the update which allows a person who is not enrolled in any plan offered by the carrier to view the directory; and

(b) Made available in a printed format upon request.

Sec. 23. *A carrier shall, within 3 business days after the effective date of a material change in its network plan, notify the Commissioner of the material change. Within 10 business days after the effective date of the material change in its network plan, the carrier must provide to the Commissioner a description of the cause of the material change, the impact of the material change on the network plan, and a summary of the steps being taken to correct the material change.*

Sec. 24. *1. The carrier shall, within 45 days after the effective date of the material change, submit its corrective action plan to the Commissioner for approval.*

2. Except as otherwise provided in subsection 3, until the network plan meets the requirements, the carrier shall, at no greater cost to the covered person:

(a) Ensure that each covered person affected by the material change may obtain the covered service from a provider of health care:

(1) Within the network plan; or

(2) Not within the network plan by entering into an agreement with the nonparticipating provider of health care pursuant to NRS 695G.164; or

(b) Make other arrangements approved by the Commissioner to ensure that each covered person affected by the material change may obtain the covered service.

3. The provisions of subsection 2 do not apply to services received from a nonparticipating provider of health care without the prior authorization of the carrier unless the services received are medically necessary emergency services.

Sec. 25. *If the Commissioner does not approve the corrective action plan and the network plan is still fails to meet the requirements, the Commissioner may:*

1. For a qualified health plan, declare the network plan inadequate pursuant to NRS 687B.490.

2. For any other network plan, declare the network plan inadequate pursuant to NRS 687B.490 and require the carrier to submit a statement of network capacity to the Commissioner containing the information described in 42 U.S.C. § 300gg-1(c).

Sec. 26. *1. The provisions of sections 21 through 25 of this regulation do not apply to a network plan issued by a carrier licensed pursuant to chapter 680A of NRS, which:*

(a) Had a statewide enrollment of 1,000 or fewer covered persons in the immediately preceding calendar year; and

(b) Has an anticipated statewide enrollment of 1,250 or fewer covered persons in the succeeding calendar year.

2. The provisions of this Section do not apply to qualified health plans.

Sec. 27. ***The provisions of sections 2 to 26, inclusive, of this regulation do not apply to:***

1. A plan issued pursuant to NRS 422.273 for the purpose of providing services through a Medicaid managed care program on behalf of the Department of Health and Human Services;

2. A network plan issued for a health benefit plan regulated under chapter 689B of NRS and which is not available for sale to small employers as defined in NRS 689C.095;

3. A grandfathered plan, as defined in NRS 679A.094; or

4. A plan issued pursuant to Medicare, as defined in NAC 687B.2028, or a Medicare Advantage plan, as defined in NAC 687B.2034.

Sec. 28. NAC 695C.160 and 695C.200 are hereby repealed.

TEXT OF REPEALED SECTIONS

695C.160 Geographic area of service: Definition. (NRS 679B.130, 695C.130, 695C.275)

1. An organization shall clearly define the geographic area it intends to serve which:

(a) In a county having a population of 100,000 or more, must have a radius of not more than 25 miles between the subscriber or individual enrollee and a primary physician and the hospital

used by the organization. This subsection does not apply to services rendered pursuant to Medicaid or Nevada Check Up.

(b) In any other county, must be defined by the organization under a plan for the provision of health care services if the organization receives the written approval of the Division for such a geographic area by:

(1) Demonstrating the availability and accessibility of services to its enrollees, including reasonable access to primary physicians, a hospital and to medically necessary services or services in an emergency; and

(2) Submitting a statement concerning the standards within that community regarding the availability and accessibility of other health care services and demonstrating that the organization will meet the community's standards for such services.

2. As used in this section, “Nevada Check Up” has the meaning ascribed to it in NAC 442.688.

695C.200 List of providers: Submission; changes; extension of submission date; excessive reduction. (NRS 679B.130, 695C.070, 695C.275)

1. Each applicant for a certificate of authority shall:

(a) Submit a list of the providers in its health care plan and a description of the type of providers based upon a projected number of enrollees;

(b) Sufficiently describe its list of providers to demonstrate the accessibility and availability of health care to its enrollees; and

(c) Describe a plan for increasing the number of providers based upon increased enrollment.

2. The organization shall notify:

(a) For a health maintenance organization, the Division and the State Board of Health in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the health maintenance organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(b) For a provider-sponsored organization, the Division in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the provider-sponsored organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(c) An enrollee in writing of the disassociation of his or her primary physician from the organization not later than 30 working days after such disassociation.

3. Based upon the current list of providers of an organization, an overall reduction of more than 30 percent in the number of primary physicians in a geographic area of service or a material change in the panel of specialists shall be deemed by the Division to jeopardize the ability of the organization to meet its obligations to its enrollees, and the Division will so notify the organization, and for a health maintenance organization, the Division will also notify the State Board of Health. The organization may rebut this presumption by providing written information to the Division within 14 days after the notice is sent to the organization.

4. The provisions of subsection 3 do not apply if the organization:

(a) Notifies the Division in writing;

(b) Submits information concerning the number of persons enrolled in the organization and the reasons for any reductions; and

(c) Obtains the approval of the Division in advance for the reduction.