REVISED PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

October 19, 2015

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[**~~omitted material~~**]** 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; 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 29, inclusive, of this regulation.

Sec. 2. ***As used in sections 2 to 29, 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. ***"Carrier" means an insurer who makes a network plan available for sale in this State pursuant to NRS 687B.490.***

Sec. 4. ***"Center for Consumer Information and Insurance Oversight" means the Center for Consumer Information and Insurance Oversight of the Centers for Medicare and Medicaid Services.***

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. *"Established pattern of care" means a clinically appropriate pattern for the referral of a patient to a location for treatment for a particular condition, including, without limitation, the travel expected for the patient.*

Sec. 9. *"Exchange" means the Silver State Health Insurance Exchange established by NRS 695I.200.*

Sec. 10. *"Geographic service area" means a geographic area, as approved by the Commissioner, within which a carrier is authorized to provide coverage.*

Sec. 11. *"Indian Health Service" means the Indian Health Service of the United States Department of Health and Human Services.*

Sec. 12. *"Material change" means any change to a network plan, or a combination of changes that take effect within 30 days of each other, which:*

1. For a specialty or category of health care with more than 10 providers of health care, affects the capacity of the network plan by more than 10 percent in any single specialty or category of health care for which a benefit is offered;

2. For a specialty or category of health care with 10 or fewer providers of health care, affects the capacity of the network plan by more than 20 percent in any single specialty or category of health care for which a benefit is offered; or

3. Does not otherwise satisfy the requirements of a final list issued by the Commissioner pursuant to subsection 2 of section 18 of this regulation.

Sec. 13. *"Medically necessary emergency services" has the meaning ascribed to it in subsection 3 of NRS 695G.170.*

Sec. 14. *"Network plan" has the meaning ascribed to it in subsection 2 of NRS 689B.570.*

Sec. 15. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 16. *"Reasonable travel" means travel that satisfies the requirements for distance or time provided in the preliminary and final lists issued by the Commissioner pursuant to section 18 of this regulation.*

Sec. 17. *A carrier who applies to the Commissioner for the issuance of a network plan must establish that the network plan has contracted with an adequate number and geographic distribution of providers of health care in each geographic service area covered by the network plan to meet the anticipated health care needs of its members based upon the benefits offered under the network plan.*

Sec. 18. *1. On or before the first Tuesday in January of each year, but not earlier than December 1 of the preceding year, the Commissioner will make available a preliminary list of the minimum number of providers of health care and maximum travel distance or time presumed to be reasonable, by county, for the specialties and categories of health care described in subsection 3. The Commissioner will allow any interested person to submit comments concerning the preliminary list to the Commissioner until January 20 of the applicable year.*

2. On or before January 31, but not earlier than January 21, of each year, the Commissioner will make available a final list of the minimum number of providers of health care and maximum travel distance or time presumed to be reasonable, by county, for the specialties and categories of health care described in subsection 3. The final list will be applicable to any network plan issued or renewed on or after January 1 of the calendar year after the list is issued.

3. Unless otherwise approved in writing by the Commissioner, the specialties and categories of health care referenced by subsections 1 and 2 are those which:

(a) Appear as options on the Network Adequacy Template issued and periodically updated by the Centers for Medicare and Medicaid Services; and

(b) Are offered for certification by the American Osteopathic Association or the member boards within the American Board of Medical Specialties.

4. For the purposes of subsections 1 and 2, a change to the specialties and categories of health care described by subsection 3 which occurs after the Commissioner issues a final list pursuant to subsection 2 is deemed to be effective for the preliminary and final lists issued in the calendar year which follows the year in which the change is made.

Sec. 19. *A carrier who applies to the Commissioner for the issuance of a network plan shall, in conjunction with its annual rate and form filing, collect, compile, evaluate, report and submit sufficient data, in a format determined by the Commissioner, to the Commissioner to establish that the proposed network plan has the capacity to adequately serve the anticipated number of covered persons in the network plan.*

Sec. 20. *1. A carrier who applies to the Commissioner for the issuance of a network plan must establish that the carrier has 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 members in each geographic area covered by the network plan.*

2. For the purposes of subsection 1, a network plan that includes:

(a) At least 30 percent of the available essential community providers in each geographic area covered by the network plan; and

(b) At least one essential community provider from each category as follows:

(1) An entity described in 42 U.S.C. § 256b(a)(4)(A);

(2) An entity described in 42 U.S.C. § 256b(a)(4)(C);

(3) An entity described in 42 U.S.C. § 256b(a)(4)(D);

(4) An entity described in 42 U.S.C. § 256b(a)(4)(I); and

(5) An entity described in 42 U.S.C. § 256b(a)(4)(L), 256b(a)(4)(M), 256b(a)(4)(N) or 256b(a)(4)(O),

➥ *shall be deemed sufficient.*

3. An essential community provider is deemed to satisfy the requirements of paragraph (b) of subsection 2 if:

(a) The carrier follows the procedure for essential community providers outlined in the most current "Letter to Issuers in the Federally-facilitated Marketplaces," as issued and updated periodically by the Center for Consumer Information and Insurance Oversight, regardless of whether the essential community provider is an entity described in subparagraphs (1) to (5), inclusive, of paragraph (b) of subsection 2; or

(b) The essential community provider is described in subparagraph (4) of paragraph (b) of subsection 2 and the carrier and the essential community provider enter into a letter of agreement.

Sec. 21. *1. A carrier who offers a network plan through the Exchange must use its best efforts to establish and maintain arrangements to ensure that American Indians and Alaskan Natives who are members within the network plan have access to health care services and facilities that are part of the Indian Health Service at no greater cost to the member than if the services were obtained from a provider of health care that is part of the network plan.*

2. Nothing in this section prohibits a carrier from limiting coverage for the health care services described in subsection 1 that meet the carrier's standards for medical necessity, care management and claim administration or from limiting payment to that amount payable if the health care services were obtained from a provider or facility that is part of the network plan.

3. A carrier is not responsible for examining the credentials of a provider of health care who:

(a) Is part of the Indian Health Service; and

(b) Does not have a contract with the carrier to provide health care services as part of the network plan offered by the carrier through the Exchange.

Sec. 22. *1. To determine whether a network plan is adequate, the Commissioner may consider, without limitation:*

(a) The relative availability of providers of health care in the geographic service area covered by the network plan, including, without limitation:

(1) The operating hours, or their equivalent, during which the providers of health care are available; and

(2) Any established patterns of care;

(b) The ability of the carrier to enter into a contract with a provider of health care which allows for reasonable travel for covered persons;

(c) The system for the delivery of care to be furnished by the providers of health care under contract with the carrier in the network plan;

(d) The availability of services that may be provided through telehealth;

(e) The availability of providers of health care located outside of the geographic service area of the network plan but which would allow for reasonable travel for covered persons; and

(f) The availability of nonemergency services which are accessible during normal business hours and medically necessary emergency services which are accessible at any time.

2. As used in this section, "telehealth" has the meaning ascribed to it in section 3 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 621.

Sec. 23. *A carrier shall, on an ongoing basis, monitor the ability and clinical capacity of the providers of health care included in its network plan to provide health care services to covered persons.*

Sec. 24. *1. A carrier shall update its directory of providers of health care 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:

(a) Update its directory of providers of health care within 3 business days after the effective date of the material change, including a clear indication of the providers of health care which:

(1) Have left the network plan since the directory was last updated; and

(2) Are no longer accepting new patients.

(b) Notify all covered persons who are affected by the material change that the material change has occurred. Such a notice must indicate how a covered person may receive more information regarding the material change to the network plan. A notice may be sent via electronic mail if the carrier has received affirmative permission from a covered person to communicate in that manner.

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

(a) Posted to the Internet website maintained by the carrier within 3 business days after the update is made to a page on the website that is accessible without a username and password or which otherwise 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. 25. *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. Such notice must indicate the effective date of the material change and describe the cause of the material change and the impact of the material change on the network plan.*

Sec. 26. *1. If a material change in a carrier's network plan results in a deficiency in the network plan, the carrier shall, within 60 days after the effective date of the material change, submit a corrective action plan to resolve the deficiency.*

2. Except as otherwise provided in subsection 3, during the period in which the corrective action plan is being implemented, 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. 27. *If a network plan is deemed deficient by the Commissioner at the end of the time period for a corrective action plan, the Commissioner may:*

1. For a network plan containing a health benefit plan made available for purchase through the Exchange, declare the network plan inadequate pursuant to NRS 687B.490 and declare the health benefit plan deficient pursuant to 42 U.S.C. § 18031(c)(1) and subject to decertification pursuant to 45 C.F.R. § 156.290.

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. 28. *1. The provisions of sections 20, 21, 22, 26 and 27 of this regulation do not apply to a network plan issued by a carrier which:*

(a) Is licensed pursuant to chapter 680A of NRS;

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

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

2. A network plan described in subsection 1 is deemed to satisfy the requirements of NRS 687B.490.

Sec. 29. *The provisions of sections 2 to 29, 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. 30. 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.