PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB FILE NO. R067-19I

The following document is the initial draft regulation proposed

by the agency submitted on 09/05/2019

PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R___-__

August 28, 2019

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

AUTHORITY: §§1 and 2, NRS 679B.130 and 687B.490, as amended by section 88 of Assembly Bill No. 83, chapter 376, Statutes of Nevada 2017, at page 2355.

A REGULATION relating to insurance; requiring a network plan to satisfy certain requirements before the Commissioner of Insurance can determine that such a network plan is adequate for sale in this State; and providing other matters properly relating thereto.

Section 1. NAC 687B.768 is hereby amended to read as follows:

1. In order for the Commissioner to determine that a network plan made available for sale in this State is adequate, the network plan must contain, at a minimum:

[~~(a) The standards contained in the most recent~~ ~~Letter to Issuers in the Federally-facilitated Marketplaces~~ ~~issued by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. A copy of the letter may be obtained free of charge at the Internet address~~ https://www.cms.gov/CCIIO/reso~~urces/regulations-and-guidance/.~~]

(a) [~~(b)~~] Evidence that the network plan provides reasonable access to at least one provider in the specialty area listed in the following table for at least 90 percent of enrollees by complying with the area designations for the maximum time or distance standards in the following table:

Specialty Area	Maximum Time or Distance Standards (Minutes/Miles)			
	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Primary Care	15/10	30/20	40/30	70/60
Endocrinology	60/40	100/75	110/90	145/130
Infectious Diseases	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	60/40	100/75	110/90	145/130
~~[Mental Health] (Including Substance Use Disorder Treatment)]~~	~~[45/30]~~	~~[60/45]~~	~~[75/60]~~	~~[110/100]~~
Psychiatrist	*45/30*	*60/45*	*75/60*	*110/100*
Psychologist	*45/30*	*60/45*	*75/60*	*110/100*
Licensed Clinical Social Workers (LCSW)	*45/30*	*60/45*	*75/60*	*110/100*
Pediatrics	25/15	30/20	40/30	105/90
Rheumatology	60/40	100/75	110/90	145/130
Hospitals	45/30	80/60	75/60	110/100
Outpatient Dialysis	45/30	80/60	90/75	125/110

(b) ~~[(c)]~~ Evidence that the network plan:

(1) Contracts with at least 30 percent of the essential community providers in the service area of the network plan that are available to participate in the provider

network of the network plan~~[, as calculated using the methodology contained in the most recent Letter to Issuers in the Federally-facilitated Marketplaces.]~~;

(2) Offers contracts in good faith to all available ECPs in all counties designated as Counties with Extreme Access Considerations (CEAC) included in the plan's service area;

(3) Offers contracts in good faith to all available Indian health care providers in the service area of the network plan, including, without limitation, the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations, as defined in 25 U.S.C. § 1603, which apply the special terms and conditions necessitated by federal statutes and regulations as referenced in the Model Qualified Health Plan Addendum for Indian Health Care Providers. A copy of the Model Qualified Health Plan Addendum for Indian Health Care Providers may be obtained free of charge at the Internet address https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy*; and*

(4) Offers contracts in good faith to at least one essential community provider in each category of essential community provider, *in the following table* [~~as contained in the most recent Letter to Issuers in the Federally-facilitated Marketplaces~~], in each county in the service area of the network plan, where an essential community provider in that category is available and provides medical or dental services that are covered by the network plan.

Major ECP Category	***ECP Provider Types***
Family Planning Providers	*Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics*
Federally Qualified Health Centers (FQHCs)	*FQHCs and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations*
Hospitals	*Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals*
Indian Health Care Providers	*IHS providers, Indian Tribes, Tribal organizations, and urban Indian Organizations*
Ryan White Providers	*Ryan White HIV/AIDS Program Providers*
Other ECP Providers	*STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals*

~~2.~~ [~~If the area designations for the maximum time and distance standards required pursuant to paragraph (b) of subsection 1 are changed by the most recent Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will post on the Internet website maintained by the Division notice of such changes.~~]

[~~3.~~] *2.* To offer a contract in good faith pursuant to paragraph [~~(c)~~] *(b)* of subsection 1, a network plan must offer contract terms comparable to the terms that a carrier or other person or entity which issues a network plan would offer to a similarly situated provider which is not an essential community provider, except for terms that would not be applicable to an essential community provider, including, without limitation, because of

the type of services that an essential community provider provides. A network plan must be able to provide verification of such offers if the *Commissioner of Insurance* [~~Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services~~] requests to verify compliance with this policy.

[~~4. Upon the issuance of a new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will determine whether the requirements of NAC 687B.750 to 687B.784, inclusive, including, without limitation, the standards required pursuant to subsection 1, conform with any similar standards prescribed in the new Letter to Issuers in the Federally-facilitated Marketplaces. If the Commissioner determines that the requirements of NAC 687B.750 to 687B.784, inclusive, do not conform with any similar standards prescribed in the new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will hold a public hearing concerning possible amendments to NAC 687B.750 to 687B.784, inclusive, and give notice of that hearing in accordance with NRS 233B.060.~~]

[~~5.~~] *3.* As used in this section:

(a) "Essential community provider" *or "ECP" are defined as providers that serve predominantly low-income, medically underserved individuals, and specifically include health care providers defined in section 340B(a)(4) of the Public Health Service (PHS) Act; entities described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA), including State-owned family planning service sites, governmental family planning service sites, not-for-profit family planning service sites that do not receive 340B-qualifying funding, including under Title X of the PHS Act; or Indian health care providers, unless any of the above providers has lost its status under either*

section, 340(B) of the PHS Act or 1927 of the Act, as a result of violating Federal law.

[~~has the meaning ascribed to it in the most recent Letter to Issuers in the Federally-facilitated Marketplaces.~~]

(b) "Maximum time or distance standards" [~~has the meaning ascribed to "maximum time and distance standards" in the most recent Letter to Issuers in the Federally-facilitated Marketplaces.~~] *are defined as the maximum time or distance an individual should have to travel to see a provider based on the area designation.*

(c) Area designations for the maximum time or distance standards required pursuant to paragraph (a) of subsection 1 are based upon the population size and density parameters of individual counties within the plan's service area. The population and density parameters applied to determine county type designations are listed in the following table:

County Type	*Population*	*Density*
Metro	*≥ 1,000,000*	*10 – 999.9/mi²*
	500,000 – 999,999	*10 – 1,499.9/mi²*
	200,000 – 499,999	*10 – 4,999.9/mi²*
	50,000 – 199,999	*100 – 4,999.9/mi²*
	10,000 – 49,999	*1,000 – 4,999.9/mi²*
Micro	*50,000 – 199,999*	*10 – 49.9/mi²*
	10,000 – 49,999	*50 – 999.9/mi²*
Rural	*10,000 – 49,999*	*10 – 49.9/mi²*
	< 10,000	*10 – 4,999.9/mi²*
CEAC	*Any*	*< 10/mi²*

Sec. 2. NAC 687B.772 is hereby amended to read as follows:

1. The Council shall consider the standards required pursuant to NAC 687B.768 and any other requirements of NAC 687B.750 to 687B.784, inclusive, and may recommend additional or alternative standards for determining whether a network plan is adequate.

2. The recommendations proposed by the Council to the Commissioner:

(a) Must include quantifiable metrics commonly used in the health care industry to measure the adequacy of a network plan;

(b) Must include, without limitation, recommendations for standards to determine the adequacy of a network plan with regard to the number of providers of health care that [~~:~~

~~(1) Practice in a specialty or are facilities that appear on the Essential Community Providers/Network Adequacy Template issued by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and available at the Internet address https://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/qhp.html free of charge, which is hereby adopted by reference; and~~]

[~~(2) Are~~] *are* necessary to provide the coverage required by law, including, without limitation, the provisions of NRS 689A.0435, 689C.1655, 695C.1717 and 695G.1645;

(c) May propose standards to determine the adequacy of a network plan with regard to types of providers of health care other than those described in paragraph (b); and

(d) May, if a sufficient number of essential community providers, as defined in 45 C.F.R. §156.235(c), are available and willing to enter into an agreement with a carrier to participate in network plans, propose requiring a network plan to include a greater number of such providers than the number of providers of health care of that type that a network plan is required to include pursuant to the standards required pursuant to NAC 687B.768 and any other requirements of NAC 687B.750 to 687B.784, inclusive.

3. The Council must submit its recommendations to the Commissioner on or before September 15 of each year. On or before October 15 of each year, the Commissioner will determine whether to accept any of the recommendations of the Council and take any action necessary to issue any new requirements for determining the adequacy of a network plan. Any such new requirements will become effective on the second January 1 next ensuing after the adoption of the requirements.

Sec. 3. This regulation becomes effective on January 1, 2020.