APPROVED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R024-23

Filed February 27, 2024

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

AUTHORITY: § 1, NRS 679B.130 and 687B.490.

A REGULATION relating to insurance; revising the requirements that a network plan made available for sale in this State must satisfy in order for the Commissioner of Insurance to determine that the network plan is adequate; 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. (NRS 679B.130) Existing law requires a health carrier that offers coverage in the small employer group or individual market to demonstrate to the Commissioner the capacity to deliver services adequately before making any network plan available for sale in this State. (NRS 687B.490) Existing regulations set forth certain minimum requirements that a network plan must satisfy for the Commissioner to determine that the network plan is adequate. (NAC 687B.768)

This regulation defines "stand-alone dental plan" to mean, in general, a network plan that provides coverage only for dental care. This regulation requires a stand-alone dental plan or a network plan that offers oral pediatric services for the purpose of satisfying certain federal requirements for essential health benefits, in order for the Commissioner to determine that the network plan is adequate, to contain evidence that the network plan provides reasonable access to at least one provider in certain specialty areas for at least 90 percent of enrollees by complying with certain standards for the maximum time or distance an individual should have to travel to see a provider of health care.

Under existing regulations, for the Commissioner to determine that a network plan is adequate, the network plan must contain evidence that the network plan satisfies certain requirements concerning the offering of contracts to and contracting with essential community providers in the service area of the network plan. (NAC 687B.768) This regulation: (1) raises the percentage of essential community providers in the service area of the network plan with whom a network plan is required to contract from 30 percent to 35 percent; and (2) specifies the requirements concerning the offering of contracts to and contracting with essential community providers that a stand-alone dental plan must satisfy for the Commissioner to determine that the stand-alone dental plan is adequate.

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

687B.768 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) ~~[Evidence]~~ ***For a network plan other than a stand-alone dental plan, 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/Surgery	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	60/40	100/75	110/90	145/130
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) ***For a stand-alone dental plan or a network plan that offers oral pediatric services to satisfy the requirements for essential health benefits set forth in 42 U.S.C. § 18022(b)(1)(J), 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)***
General Dentist	***45/45***	***60/60***	***120/100***	***120/100***
Periodontist	***45/45***	***60/60***	***120/100***	***120/100***
Oral Surgeon	***45/45***	***60/60***	***120/100***	***120/100***

Orthodontist	***45/45***	***60/60***	***120/100***	***120/100***

(c) Evidence that the network plan:

(1) Contracts with at least ~~[30]~~ ***35*** 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 ***.*** ~~[;]~~

(2) ~~[Offers contracts in good faith to all available essential community providers in all counties in the service area of the network plan that are designated pursuant to subsection 3 as Counties with Extreme Access Considerations;~~

~~(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 ~~[,]~~ ***established pursuant to 25 U.S.C. § 1661,*** 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)]~~ ***(3) For a network plan other than a stand-alone dental plan:***

(I) Offers contracts in good faith to all available essential community providers in all counties in the service area of the network plan that are designated pursuant to subsection 3 as Counties with Extreme Access Considerations.

(II) Offers contracts in good faith to at least one essential community provider in each category of essential community provider in the following table, 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)	Federally Qualified Health Centers and Federally Qualified Health Center "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 Hospital, Freestanding Cancer Centers, Critical Access Hospitals
Indian Health Care Providers	Indian Health Service 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. To offer a contract in good faith pursuant to paragraph ~~[(b)]~~ ***(c)*** 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 requests to verify compliance with this policy.

3. For the purposes of this section, the area designations for the maximum time or distance standards 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/mi^2
	500,000 - 999,999	10 - 1,499.9/mi^2
	200,000 - 499,999	10 - 4,999.9/mi^2

County Type	Population	Density
	50,000 - 199,999	100 - 4,999.9/mi^2
	10,000 - 49,999	1,000 - 4,999.9/mi^2
Micro	50,000 - 199,999	10 - 49.9/mi^2
	10,000 - 49,999	50 - 999.9/mi^2
Rural	10,000 - 49,999	10 - 49.9/mi^2
	< 10,000	10 - 4,999.9/mi^2
Counties with Extreme Access Considerations or CEAC	Any	< 10/mi^2

4. As used in this section:

(a) "Essential community provider" or "ECP" means a provider of healthcare that serves predominantly low-income, medically underserved individuals. The term includes, without limitation:

(1) Health care providers described in section 340B(a)(4) of the Public Health Service Act, 42 U.S.C. § 256b(a)(4), as amended;

(2) Entities described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, 42 U.S.C. § 1396r-8(c)(1)(D)(i)(IV), as amended, including, without limitation, state-owned family planning service sites, governmental family planning service sites or not-for-profit family planning service sites that do not receive funding that qualifies the service for the drug pricing program established pursuant to section 340B of the Public Health Service Act, 42 U.S.C. § 256b, as amended, without limitation, funding pursuant to Title X of the Public Health Service Act, 42 U.S.C. § 300 et seq., as amended; or

(3) Indian health care providers,

➥ unless any of the providers or entities listed in subparagraphs (1), (2) and (3) has lost its status as a provider described in section 340B(a)(4) of the Public Health Service Act, 42 U.S.C. § 256(b)(a)(4), as amended, or as an entity described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, 42 U.S.C. § 1396r-8(c)(1)(D)(i)(IV), as amended, as a result of violating Federal law.

(b) "Maximum time or distance standards" means the maximum time or distance an individual should have to travel to see a provider of health care based on the area designation determined pursuant to subsection 3.

(c) "Stand-alone dental plan" means a network plan that provides coverage only for dental care, as defined in NRS 695D.030.