Chapters 689B and 695C of NAC

PROPOSED REGULATION OF THE COMMISSIONER OF INSURANCE

LCB File No. T002-12

(This regulation was previously adopted as E001-12
which is effective for 120 days after September 14, 2012)

AUTHORITY: NRS 679B.130 and 233B.0613.

Section 1. NAC 689B.120 is hereby amended to read as follows:

689B.120 A policy of group health insurance issued pursuant to NRS 689B.061:

1. Must include a definition for preferred providers of health care and providers of health care who are not preferred.

2. Must include an explanation of the amount of disincentives to be paid for using the services of providers of health care who are not preferred.

3. Must include in the schedule of benefits the amounts for deductibles and coinsurance payable for preferred providers of health care and providers of health care who are not preferred.

4. Must include a description of the type of plan used for preferred providers of health care and whether it is limited to specific services only, such as services obtained from a physician or hospital or for prescription drugs.

5. Must provide that the services covered, if provided by preferred providers of health care, are the same for providers of health care who are not preferred.

6. Must provide that, if the covered services are provided by a preferred provider facility designated by CMS as a "critical access hospital", the facility shall be reimbursed at an amount not less than any network hospital within a 25 mile radius for those covered services provided.

~~[6.]~~ ***7.*** Must include a statement that the insured should verify whether a provider of health care is a preferred provider of health care.

~~[7.]~~ ***8.*** Must provide that, if the insured is confined in a facility which is a preferred provider of health care at a time when the facility terminates its agreement with the insurer, coverage will

be provided for the period of confinement at the rate negotiated for that facility before it terminated its agreement and at no additional cost to the insured.

~~[8.]~~ ***9.*** Must provide that, if the insured obtains prior authorization for health care services to be rendered by a preferred provider of health care and the provider subsequently terminates his or her agreement with the insurer, coverage will be provided for those services at the rate negotiated for that provider before terminating the agreement and at no additional cost to the insured.

~~[9.]~~ ***10.*** May not require that the payments to a provider of health care who is not preferred be based upon the fee schedule or arrangements for preferred providers of health care.

~~[10.]~~ ***11.*** May not provide for more than a 50 percent difference or reduction in any payment of otherwise eligible expenses for not complying with any procedures requiring the prior authorization of care or notification that treatment was received for an emergency.

Sec. 2. NAC 695C.190 is hereby amended to read as follows:

695C.190 Each agreement between a provider and an organization must:

1. Adequately and completely describe the responsibilities of the provider and organization under the agreement.

2. Provide that, if the covered services are provided by a facility designated by CMS as a "critical access hospital", the facility shall be reimbursed at an amount not less than any network hospital within a 25 mile radius for those covered services provided.

~~[2.]~~ ***3.*** Specify that the provider releases the enrollee from liability for the cost of services rendered pursuant to the organization's health care plan except for any nominal payment made by the enrollee or for a service not covered under the evidence of coverage.

~~[3.]~~ ***4.*** Be effective for not less than 1 year, subject to any right of termination stated in the agreement.

~~[4.]~~ ***5.*** Require the provider to participate in the program to assure the quality of health care provided to enrollees by the organization through its providers.

~~[5.]~~ ***6.*** Require the provider to provide all medically necessary services required by the evidence of coverage and the agreement to each enrollee for the period for which a premium has been paid to the organization.

~~[6.]~~ ***7.*** Require the provider to give evidence of a contract of insurance against loss resulting from injuries resulting to third persons from the practice of his or her profession or a reasonable

substitute for it as determined by the organization. The organization may require the provider to indemnify the organization for any liability resulting from the health care services rendered by the provider.

~~[7.]~~ ***8.*** Require a provider who is a physician to transfer or otherwise arrange for the maintenance of the records of enrollees who are his or her patients if the provider leaves the panel of physicians associated with the organization.