Chapters 689B and 695C of NAC

PROPOSED REGULATION OF THE COMMISSIONER OF INSURANCE

LCB File No. T002-12

(Filed with the Secretary of State on January 11, 2013)

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

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

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. This provision does not apply to a policy of group health insurance issued by a carrier that has entered into a new agreement with the facility after January 1, 2013.

[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 agreement with the insurer, coverage will be provided for those services at the rate negotiated for that provider before he terminated his 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. This provision does not apply to a policy of group health insurance issued by an organization that has entered into a new agreement with the facility after January 1, 2013.

~~[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.

INFORMATIONAL STATEMENT

Temporary Regulation Relating to Reimbursement for Critical Access Hospitals
LCB File No. T002-12
Cause No. 12.0758

A workshop was held on November 29, 2012, and a hearing was held on December 6, 2012, at the offices of the offices of the State of Nevada, Department of Business and Industry, Division of Insurance ("Division"), 1818 East College Parkway, Suite 103, Carson City, Nevada 89706, with a simultaneous video-conference conducted at the Bradley Building, 2501 East Sahara Avenue, 2nd Floor Conference Room, Las Vegas, Nevada 89104, regarding the adoption of the temporary regulation concerning reimbursement for critical access hospitals.

Public comment was solicited by posting notice of the hearing in the following public locations: the Division's Website, the Division's Carson City and Las Vegas offices, Carson City Courthouse, Office of the Attorney General, Capitol Building Lobby, Capitol Building Press Room, Blasdel Building, and Legislative Counsel Bureau; and by providing notice of the hearing to the Donald W. Reynolds Press Center, Nevada State Library, Carson City Library, Churchill County Library, Clark County District Library, Douglas County Library, Elko County Library, Esmeralda County Library, Eureka Branch Library, Humboldt County Library, Lander County Library, Lincoln County Library, Lyon County Library, Mineral County Library, Pershing County Library, Storey County Library, Tonopah Public Library, Washoe County Library, and White Pine County Library.

The Division maintains a list of interested parties, comprised mainly of insurance companies, agencies and other persons regulated by the Division. These persons were notified of the workshop and hearing and that copies of the regulation could be obtained from or examined at the offices of the Division in Carson City.

The workshop was attended by three interested parties in Las Vegas. The Division received written comments from Jack Kim, Vice President of State Government Affairs, UnitedHealth Group. Oral testimony, in the form of suggested changes to the proposed temporary regulation, was also provided by Mr. Kim. Larry Hurst, Nevada Government Relations Director for Anthem Blue Cross and Blue Shield, testified in opposition to the proposed regulation citing numerous carrier administrative concerns, as well as the appropriateness of a regulation that has an effect on contracts that are already in place. James Wadhams, representing Fennemore Craig Jones Vargas, expressed concerns regarding the policy underlying the proposed regulation. During the hearing, oral testimony was provided by Glenn Shippey, representing the Division.

This temporary regulation is needed to replace Emergency Regulation E001-12, which expires 120 days after September 14, 2012. Certain rural hospitals in Nevada are designated by the Centers for Medicare and Medicaid Services as critical access hospitals. Although a number of these hospitals are in-network providers for health insurance carriers in Nevada, some within a 25 mile radius of a non-rural in-network hospital are not receiving comparable reimbursement for the same services rendered. This temporary regulation would require reimbursement for an

in-network critical access hospital to be no less than the reimbursement for any other in-network hospital within a 25 mile radius, unless the carrier has entered into a new agreement with the facility after January 1, 2013.

There was an amendment recommended and made to the proposed temporary regulation, LCB File No. T002-12. A revised version of the proposed temporary regulation is attached. The proposed temporary regulation amends Chapters 689B and 695C of the Nevada Administrative Code ("NAC") to require comparable reimbursement for in-network critical access hospitals.

Based upon the testimony received at the hearing, the temporary regulation is amended as follows:

1. Subsection 6 of Section 1 to read as follows:

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. This provision does not apply to a policy of group health insurance issued by a carrier that has entered into a new agreement with the facility after January 1, 2013.

2. Subsection 2 of Section 2 to read as follows:

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. This provision does not apply to a policy of group health insurance issued by an organization that has entered into a new agreement with the facility after January 1, 2013.

After considering the record, the Commissioner has issued an order adopting the regulation, LCB File No. T002-12, as amended, as a temporary regulation of the Division.

The economic impact of the regulation is as follows:

(a) On the business it is to regulate: This may be burdensome for insurance companies to administer and could encourage carriers to remove these facilities from their provider networks.
(b) On small business: Preferred provider critical access hospitals within or in close proximity to urban areas will receive reimbursement comparable to any other network facility within the area. This will encourage these facilities to maintain or expand the business relationships established within these communities.
(c) On the public: The higher levels of reimbursement will help ensure that these facilities continue to meet the critical access needs of their communities.

There would be little or no cost to the Division for enforcement of this regulation. The Division is not aware of any overlap or duplication of the temporary regulation with any state, local or federal regulation.