

**PROPOSED REGULATION OF THE
COMMISSIONER OF INSURANCE**

LCB File No. R049-14

April 21, 2014

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

AUTHORITY: §§1-13, NRS 679B.130 and 687B.490.

A REGULATION relating to insurance; establishing certain requirements relating to the adequacy of a network plan issued by a carrier; authorizing the Commissioner of Insurance to determine whether a network plan is adequate under certain circumstances; requiring a carrier whose network plan is deemed or determined to be adequate to notify the Commissioner of any significant 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.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 13, inclusive, of this regulation.

Sec. 2. 1. *A carrier who applies to the Commissioner for the issuance of a network plan must establish that the network plan has an adequate number of providers in each category of health care necessary to serve its members in each geographic area covered by the network plan.*

2. The categories of health care necessary to serve members pursuant to subsection 1 are:

(a) Cardiology;

(b) Dermatology;

(c) Emergency medicine;

(d) Gastroenterology;

- (e) Hematology and oncology;*
- (f) Internal medicine, general practice and family practice;*
- (g) Mental health;*
- (h) Nephrology;*
- (i) Obstetrics and gynecology;*
- (j) Ophthalmology;*
- (k) Orthopedics, including, without limitation, general orthopedic surgery, hand surgery and neurosurgery;*
- (l) Otolaryngology;*
- (m) Pediatrics, not including pediatric dentistry;*
- (n) Except as otherwise provided in subsection 3, pediatric dentistry;*
- (o) Pulmonology;*
- (p) Substance abuse;*
- (q) Surgery, including, without limitation, general, cardiovascular, cardiothoracic, vascular and colorectal;*
- (r) Urgent care; and*
- (s) Urology.*

3. If a network plan does not offer pediatric dental coverage pursuant to 42 U.S.C. § 18022(b)(4)(F), the carrier is not required to establish that the network plan has an adequate number of providers of pediatric dentistry pursuant to paragraph (n) of subsection 2.

Sec. 3. 1. *A carrier who applies to the Commissioner for the issuance of a network plan must establish that the providers of health care with whom the organization has contracted to*

provide services within the network plan are located so that the members of the network plan may obtain health care without unreasonable travel.

2. On or before April 1 of each year, the Commissioner will make available a list of the minimum number of providers and maximum travel distance or time, by county, for each category of health care necessary to serve members within network plans. The list will be applicable to health benefit plans issued or renewed on or after January 1 of the calendar year after the list is issued.

3. A carrier shall ensure that nonemergency services are available and accessible during normal business hours and that emergency services are available at any time.

Sec. 4. *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 at least 20 percent of the available essential community providers in each geographic area covered by the network plan shall be deemed sufficient.

3. As used in this section, “essential community provider” has the meaning ascribed to it in 45 C.F.R. § 156.235(c).

Sec. 5. *1. A carrier who applies to the Commissioner for the issuance of a network plan 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.*

2. A member described in subsection 1 must be able to obtain covered services from the Indian Health Service at no greater cost to the member than if the service were obtained from a provider or facility that is part of the network plan.

3. Nothing in this section prohibits a health benefit plan from limiting coverage to those health care services that meet its standards for medical necessity, care management and claim administration or from limiting payment to that amount payable if the health care service were obtained from a provider or facility that is part of the network plan.

Sec. 6. *A carrier which is a health maintenance organization who applies to the Commissioner for the issuance of a network plan must ensure that:*

1. Each member of the network plan has access to his or her primary care physician through on-call procedures after normal business hours;

2. Each provider of health care with whom the health maintenance organization has contracted to provide services maintains health care records for the members of the network plan which are accessible to other professionals within the health maintenance organization;

3. The health maintenance organization provides a health care professional who is primarily responsible for coordinating the overall health care services offered to members of its network plan; and

4. The health maintenance organization has established a quality assurance program required pursuant to NAC 695C.400.

Sec. 7. *A carrier who applies to the Commissioner for the issuance of a network plan must establish a system to collect data related to the health care services provided to members of the network plan.*

Sec. 8. 1. *If a carrier applies to the Commissioner for the issuance of a network plan that meets the requirements of sections 2 to 7, inclusive, of this regulation, the network plan is deemed to be adequate.*

2. If a network plan is not deemed to be adequate pursuant to subsection 1, a carrier may request that the Commissioner determine whether the network plan is adequate. To determine whether a network plan is adequate, the Commissioner may consider:

(a) The relative availability of health care providers or facilities in the geographic area covered by the network plan;

(b) The willingness of providers or facilities in the geographic area covered by the network plan to contract with the carrier under reasonable terms and conditions;

(c) The system for the delivery of care to be furnished by the providers or facilities in the geographic area covered by the network plan; and

(d) The clinical safety of the providers or facilities in the geographic area covered by the network plan.

3. The Commissioner will not determine that a network plan is adequate pursuant to subsection 2 if the network plan fails to meet the requirements of section 4 or 5 of this regulation.

4. The Commissioner may determine that a network plan which fails to meet the requirements of section 2 or 3 of this regulation is adequate pursuant to subsection 2. If such a network plan is determined to be adequate, the Commissioner will notify the carrier of the requirements of sections 2 and 3 of this regulation which the network plan:

(a) Satisfies; and

(b) Does not satisfy.

5. For each requirement of sections 2 and 3 of this regulation which a carrier has been notified by the Commissioner pursuant to subsection 4 that its network plan does not satisfy, the carrier shall:

(a) Ensure, through referral by the primary care provider or otherwise, that each covered person may obtain covered services from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers or facilities; or

(b) Make other arrangements acceptable to the Commissioner.

Sec. 9. A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health care services to covered persons.

Sec. 10. 1. A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall update its provider directory no less frequently than every 30 days.

2. The provider directory and each update thereto must be posted to the Internet website maintained by the carrier and filed with the Division within 24 hours after the update is made in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners.

Sec. 11. 1. Each carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall attest that its network or networks meet the requirements of sections 2 to 13, inclusive, of this regulation:

(a) For a health benefit plan for individuals available for sale during the open enrollment period described in NRS 686B.080, by January 1 of the calendar year in which the coverage is to be effective.

(b) For a health benefit plan for individuals not available for sale during the open enrollment period described in NRS 686B.080, at least 30 days before the health benefit plan is made available for purchase by any individual.

(c) For a health benefit plan for small employers, at least 30 days before the health benefit plan is made available for purchase by any small employer.

2. Each carrier shall renew its attestation on or before January 1 of each subsequent calendar year.

3. The attestation must be made on a form prescribed by the Commissioner and signed by an officer of the carrier issuing the health benefit plan.

4. Each attestation must be accompanied by an Access Plan-Cover Sheet Template specified by the Centers for Medicare and Medicaid Services and filed in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners.

Sec. 12. *1. A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall notify the Commissioner within 30 days of any significant change to its network.*

2. If a significant change in a carrier's network results in a deficiency in the network, the notification must include a corrective action plan to resolve the deficiency within 60 days.

3. If a significant change in a carrier's network results in a deficiency in the network with respect to any category of provider or facility, the carrier shall, during the period the

corrective action plan is being implemented and with respect to that category of provider or facility:

(a) Ensure through referral by the primary care provider or otherwise that each covered person may obtain the covered service for which there is a deficiency from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers or facilities; or

(b) Make other arrangements acceptable to the Commissioner.

4. If the network is still deficient at the end of the time period for the corrective action plan:

(a) For a health benefit plan made available for purchase through the Silver State Health Insurance Exchange, the health benefit plan will be declared deficient pursuant to 42 U.S.C. § 18031(c)(1) and decertified pursuant to 45 C.F.R. § 156.290.

(b) For any other health benefit plan, the health benefit plan shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

Sec. 13. 1. *A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation may, upon the approval of the Commissioner, make health benefit plans using that network plan available to persons outside of the approved service area.*

2. A health benefit plan made available outside of the approved service area pursuant to subsection 1:

(a) Must include a disclaimer, the content and placement of which must be approved by the Commissioner, notifying potential enrollees located outside of the approved service area that

the network plan may not provide contracted physicians or facilities within the enrollee's service area; and

(b) Is subject to all relevant state and federal laws regarding guaranteed availability of coverage.