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Bulletin No. 16-002

April 15, 2016

PROVIDER DIRECTORY STANDARDS FOR INDIVIDUAL AND SMALL EMPLOYER GROUP HEALTH BENEFIT PLANS

Nevada Revised Statute ("NRS") 687B.490 vests in the Commissioner of Insurance ("Commissioner") the authority to determine the adequacy of provider networks to be used by network plans made available for sale in this State. The State's process to review network adequacy for those plans sold on the Exchange must be approved by the Centers for Medicare & Medicaid Services ("CMS").

Regulation R049-14, adopted April 4, 2016, imposes certain requirements on a carrier to update its directory of providers of health care at least once each month. Additionally, each update to the directory must include each provider of health care who, as of the precious month, is no longer in the network plan or has stopped accepting new patients. The Commissioner recognizes that carriers may need time to modify existing systems to accommodate these requirements. A carrier must provide accurate and complete information concerning its directory of providers for each 2017 network plan. A carrier must have its system in place prior to November 1, 2016, the beginning of open enrollment, when consumers will begin shopping for 2017 plans.

This Bulletin applies to all 2017 health benefit plans in the individual and small group markets, as defined in NRS 689A and 689C, respectively, utilizing a network plan, and issued or renewed on or after January 1, 2017. For questions or clarification with regard to this Bulletin, please contact the Life & Health Section at (888-872-3234) or insinfo@doi.nv.

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