ASSEMBLY BILL NO. 382–ASSEMBLYMEN CARLTON, FRIERSON, ARAUJO, SPIEGEL; BENITEZ-THOMPSON AND SPRINKLE

MARCH 20, 2017

JOINT SPONSORS: SENATORS FORD, PARKS AND CANCELA

Referred to Committee on Health and Human Services

SUMMARY—Establishes provisions governing payment for the provision of emergency services and care to patients. (BDR 40-570)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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

AN ACT relating to health care; requiring certain hospitals, independent centers for emergency medical care and physicians to accept certain rates as payment in full for the provision of emergency services and care to certain patients; providing an exception under certain circumstances; requiring the submission of certain reports relating to policies of health insurance and similar contractual agreements by certain third parties who issue those policies and agreements; requiring certain hospitals and independent centers for emergency medical care to submit reports to the Department of Health and Human Services concerning patient debt and rate increases; requiring the Governor's Consumer Health Advocate to adopt certain regulations; requiring the Commissioner of Insurance to consider certain information when determining the adequacy of a network plan; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Under existing law, a hospital is required to provide emergency services and care and to admit certain patients where appropriate, regardless of the financial status of the patient. (NRS 439B.410) Existing law also requires certain major

hospitals to reduce total billed charges by at least 30 percent for hospital services provided to certain patients who have no insurance or other contractual provision for the payment of the charges by a third party. (NRS 439B.260) **Section 17** of this bill requires an out-of-network hospital with 100 or more beds that is not operated by a federal, state or local governmental entity or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital to accept, under certain circumstances, as payment in full for the provision of emergency services and care, other than services and care provided to stabilize a patient, to certain patients a rate which does not exceed the greater of: (1) the average amount that the third party has negotiated with other hospitals in this State; or (2) one hundred twenty-five percent of the average amount paid by Medicare for the same or similar services in the same geographic area. The Commissioner of Insurance is required to adopt regulations to interpret these provisions in a manner that is similar to the interpretation of the federal regulation establishing the amount that certain health insurance providers must pay to out-of-network hospitals for emergency services. (29 C.F.R. § 2590.715-2719A) Such regulations must provide for a system for verifying negotiated contract prices by a third party or out-of-network facility submitted to the Commissioner of Insurance pursuant to **sections 17-19** of this bill. **Section 18** of this bill requires an out-of-network physician on the medical staff of an out-of-network hospital with 100 or more beds or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital to accept as payment in full for the provision of emergency services and care, other than services and care provided to stabilize a patient, a rate which is similarly calculated to that in **section 17**. **Section 19** of this bill requires an out-of-network physician on the medical staff of an in-network hospital with 100 or more beds or an in-network independent center for emergency medical care that is operated by a person who also operates such a hospital to accept as payment in full for the provision of emergency services and care, other than services and care provided to stabilize a patient, a rate which is similarly calculated to that in **sections 17 and 18**. **Sections 17-19** further provide that, if a hospital, center or physician, as applicable, determines that the amount prescribed pursuant to those sections is not sufficient reimbursement for the provision of emergency services and care to a patient, the hospital, center or physician may negotiate a different rate with the third party and may, under certain circumstances, file a complaint and request for mediation with the Governor's Consumer Health Advocate. **Sections 21.3 and 22** of this bill require the Advocate to establish a procedure for filing and processing such complaints and requests for mediation.

Existing law requires the Commissioner of Insurance to make an annual determination concerning the availability and accessibility of the health care services of any network plan offered for sale in this State. (NRS 687B.490) **Section 20** of this bill requires a third party who wishes to pay the amounts prescribed pursuant to **sections 17-19** to conduct a review of the adequacy of the network of the third party and submit certain reports to the Commissioner and to the Legislative Committee on Health Care. **Section 23** of this bill requires the Commissioner to consider such a report when making a determination concerning the availability and accessibility of the network plan to which the report pertains.

Section 21 of this bill requires a hospital with 100 or more beds that is not operated by a federal, state or local governmental entity or an independent center for emergency medical care that is operated by a person who also operates such a hospital to annually report certain information concerning the collection of debts, rate increases and negotiated payments for emergency services and care to the Department of Health and Human Services.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 439B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 21, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 21, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 16, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Advocate" means the Governor's Consumer Health Advocate appointed pursuant to NRS 223.550.***

Sec. 4. (Deleted by amendment.)

Sec. 5. (Deleted by amendment.)

Sec. 6. ***"Emergency services and care" has the meaning ascribed to it in NRS 439B.410.***

Sec. 7. (Deleted by amendment.)

Sec. 8. ***"Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.***

Sec. 9. ***"In-network hospital" means, for a particular patient, a hospital that has entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.***

Sec. 10. ***"In-network independent center for emergency medical care" means, for a particular patient, an independent center for emergency medical care that has entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.***

Sec. 11. ***"In-network physician" means, for a particular patient, a physician who has entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.***

Sec. 11.5. ***"Medically necessary emergency services" has the meaning ascribed to it in NRS 695G.170.***

Sec. 12. ***"Out-of-network hospital" means, for a particular patient, a hospital that has not entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.***

Sec. 13. *"Out-of-network independent center for emergency medical care" means, for a particular patient, an independent center for emergency medical care that has not entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.*

Sec. 14. *"Out-of-network physician" means, for a particular patient, a physician who has not entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.*

Sec. 15. *"Third party" includes, without limitation:*

1. An insurer as defined in NRS 679B.540;

2. A health benefit plan, as defined in NRS 689A.540, for employees which provides coverage for emergency services and care at a hospital;

3. A participating public agency, as defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of such officers and employees, pursuant to chapter 287 of NRS; and

4. Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

Sec. 16. *"To stabilize" has the meaning ascribed to it in 42 U.S.C. § 1395dd.*

Sec. 17. *1. Except as otherwise provided in subsections 3 and 4, an out-of-network hospital with 100 or more beds that is not operated by a federal, state or local governmental agency or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital shall accept as payment in full for the provision of emergency services and care to a patient, other than services and care provided to stabilize the patient, a rate in accordance with subsection 2 if the patient:*

(a) Was presented to the out-of-network hospital or out-of-network independent center for emergency medical care for the provision of medically necessary emergency services; and

(b) Has a policy of insurance or other contractual agreement with a third party that provides coverage to the patient for emergency services and care provided by more than one hospital and independent center for emergency medical care in this State other than the hospital or independent center for emergency medical care to which the patient was presented.

2. Except as otherwise provided in subsections 3 and 4, an out-of-network hospital with 100 or more beds that is not operated by a federal, state or local governmental agency or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital that provides to a patient described in subsection 1 emergency services and care, other than services and care provided to stabilize the patient, shall accept as payment in full for such emergency services and care a rate which does not exceed the greater of:

(a) The average amount negotiated by the third party with in-network hospitals in this State for the same or similar emergency services and care, excluding any deductible, copayment or coinsurance paid by the patient.

(b) One hundred twenty-five percent of the average amount paid by Medicare pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., on a fee-for-service basis for the same or similar emergency services and care in the geographic region in which the emergency services and care are rendered, excluding any deductible, copayment or coinsurance paid by the patient.

➥ The Commissioner of Insurance shall adopt regulations that interpret the provisions of this subsection which must provide for, without limitation, a system for verifying a negotiated contract price submitted to the Commissioner of Insurance by a third party or entity described in subsection 2, and which must be consistent with the provisions of 29 C.F.R. § 2590.715-2719A to the extent practicable. Except as otherwise provided in NRS 239.0115, any information submitted pursuant to this section must be kept confidential by the Commissioner of Insurance.

3. An out-of-network hospital or out-of-network independent center for emergency medical care is not required to accept as payment in full the amount specified pursuant to subsection 2 if:

(a) The third party that issued the policy of insurance or other contractual agreement which provides coverage to the patient has not submitted the quarterly reports required by section 20 of this act;

(b) The third party which provides coverage to the patient has not, in good faith, participated in a negotiation or mediation pursuant to subsection 4 and has not documented the occurrence and outcome of any negotiation or mediation;

(c) The patient has not paid the deductible, copayment or coinsurance that the patient would have paid for the provision of emergency services and care at an in-network hospital or in-network independent center for emergency medical care; or

(d) The third party has not paid the out-of-network hospital or out-of-network independent center for emergency medical care, as applicable, for the emergency services and care within 60 days after receipt of the bill and all necessary medical records required to pay the claim or, if applicable, within 60 days after the conclusion of any negotiation or mediation between the third party and the out-of-network hospital or out-of-network independent center for emergency medical care.

4. If an out-of-network hospital or out-of-network independent center for emergency medical care believes that the amounts prescribed in subsection 2 are insufficient to compensate the out-of-network hospital or out-of-network independent center for emergency medical care for the emergency services and care provided by the out-of-network hospital or out-of-network independent center for emergency medical care, the out-of-network hospital or out-of-network independent center for emergency medical care must, within 30 days of receiving written notice of such amount from the third party, request in writing to enter into negotiations with the third party which provides coverage to the patient to resolve the difference between the amount charged by the out-of-network hospital or out-of-network independent center for emergency medical care and the amount paid by the third party. Such negotiations must begin within 2 weeks of the out-of-network hospital or out-of-network independent center for emergency medical care making the request for negotiation. If such negotiations do not result in an agreement on the amount that will be paid for the emergency services and care, the out-of-network hospital or out-of-network independent center for emergency medical care may file a complaint with the Advocate pursuant to NRS 223.560 and request that the Advocate mediate to determine the amount that must be paid for such emergency services and care.

5. In no event shall the patient who received emergency services and care be:

(a) Responsible for payment of any amount greater than any deductible, copayment or coinsurance paid by the patient pursuant to his or her policy of insurance; or

(b) Required to participate in any negotiation entered into pursuant to this section or any mediation entered into pursuant to NRS 223.560.

Sec. 18. *1. Except as otherwise provided in subsections 3 and 4, an out-of-network physician on the medical staff of an out-of-network hospital with 100 or more beds or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital shall accept as*

payment in full for the provision of emergency services and care to a patient, other than services and care provided to stabilize the patient, a rate in accordance with subsection 2 if the patient:

(a) Was presented to the out-of-network hospital or out-of-network independent center for emergency medical care for the provision of medically necessary emergency services; and

(b) Has a policy of insurance or other contractual agreement with a third party that provides coverage to the patient for the provision of emergency services and care by more than one in-network physician in this State who provides the same type of emergency services and care other than the out-of-network physician who provided the emergency services and care at the out-of-network hospital or out-of-network independent center for emergency medical care to which the patient was presented.

2. Except as otherwise provided in subsections 3 and 4, an out-of-network physician on the medical staff of an out-of-network hospital with 100 or more beds or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital who provides to a patient described in subsection 1 emergency services and care, other than services and care provided to stabilize the patient, shall accept as payment in full for such emergency services and care a rate which does not exceed the greater of:

(a) The average amount negotiated by the third party with in-network physicians in this State for the same or similar emergency services and care, excluding any deductible, copayment or coinsurance paid by the patient.

(b) One hundred twenty-five percent of the average amount paid by Medicare pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., on a fee-for-service basis for the same or similar emergency services and care in the geographic region in which the emergency services and care are rendered, excluding any deductible, copayment or coinsurance paid by the patient.

➥ The Commissioner of Insurance shall adopt regulations that interpret the provisions of this subsection which must provide for, without limitation, a system for verifying a negotiated contract price submitted to the Commissioner of Insurance by a third party or entity described in subsection 2, and which must be consistent with the provisions of 29 C.F.R. § 2590.715-2719A to the extent practicable. Except as otherwise provided in NRS 239.0115, any information submitted pursuant to this section must be kept confidential by the Commissioner of Insurance.

3. An out-of-network physician is not required to accept as payment in full the amount specified pursuant to subsection 2 if:

(a) The third party that issued the policy of insurance or other contractual agreement which provides coverage to the patient has not submitted the quarterly reports required by section 20 of this act;

(b) The third party which provides coverage to the patient has not, in good faith, participated in a negotiation or mediation pursuant to subsection 4 and has not documented the occurrence and outcome of any negotiation or mediation;

(c) The patient has not paid the deductible, copayment or coinsurance that the patient would have paid for the provision of emergency services and care by an in-network physician; or

(d) The third party has not paid the out-of-network physician for the emergency services and care within 60 days after receipt of the bill and all necessary medical records required to pay the claim or, if applicable, within 60 days after the conclusion of any negotiation or mediation between the third party and the out-of-network physician.

4. If an out-of-network physician believes that the amounts prescribed in subsection 2 are insufficient to compensate the out-of-network physician for the emergency services and care provided by the out-of-network physician, the out-of-network physician must, within 30 days of receiving written notice of such amount from the third party, request in writing to enter into negotiations with the third party which provides coverage to the patient to resolve the difference between the amount charged by the out-of-network physician and the amount paid by the third party. Such negotiations must begin within 2 weeks of the out-of-network physician making the request for negotiation. If such negotiations do not result in an agreement on the amount that will be paid for emergency services and care, the out-of-network physician may file a complaint with the Advocate pursuant to NRS 223.560 and request that the Advocate mediate to determine the amount that must be paid for such emergency services and care.

5. In no event shall the patient who received emergency services and care be:

(a) Responsible for payment of any amount greater than any deductible, copayment or coinsurance paid by the patient pursuant to his or her policy of insurance; or

(b) Required to participate in any negotiation entered into pursuant to this section or any mediation entered into pursuant to NRS 223.560.

Sec. 19. ***1. Except as otherwise provided in subsections 3 and 4, an out-of-network physician on the medical staff of an in-network hospital with 100 or more beds or an in-network independent center for emergency medical care that is operated by***

a person who also operates such a hospital shall accept as payment in full for the provision of emergency services and care to a patient, other than services and care provided to stabilize the patient, a rate in accordance with subsection 2 if the patient has a policy of insurance or other contractual agreement with a third party that provides coverage to the patient for the provision of emergency services and care by more than one physician in this State who provides the same type of emergency services and care other than the physician who provided the emergency services and care.

2. Except as otherwise provided in subsections 3 and 4, an out-of-network physician on the medical staff of an in-network hospital with 100 or more beds or an in-network independent center for emergency medical care that is operated by a person who also operates such a hospital who provides to a patient described in subsection 1 emergency services and care, other than services and care provided to stabilize the patient, shall accept as payment in full for such emergency services and care a rate which does not exceed the greater of:

(a) The average amount negotiated by the third party with in-network physicians in this State for the same or similar emergency services and care, excluding any deductible, copayment or coinsurance paid by the patient.

(b) One hundred twenty-five percent of the average amount paid by Medicare pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., on a fee-for-service basis for the same or similar emergency services and care in the geographic region in which the services are rendered, excluding any deductible, copayment or coinsurance paid by the patient.

➥ The Commissioner of Insurance shall adopt regulations that interpret the provisions of this subsection which must provide for, without limitation, a system for verifying a negotiated contract price submitted to the Commissioner of Insurance by a third party or entity described in subsection 2, and which must be consistent with the provisions of 29 C.F.R. § 2590.715-2719A to the extent practicable. Except as otherwise provided in NRS 239.0115, any information submitted pursuant to this section must be kept confidential by the Commissioner of Insurance.

3. An out-of-network physician is not required to accept as payment in full the amount specified pursuant to subsection 2 if:

(a) The third party that issued the policy of insurance or other contractual agreement which provides coverage to the patient has not submitted the quarterly reports required by section 20 of this act;

(b) The third party which provides coverage to the patient has not, in good faith, participated in a negotiation or mediation pursuant to subsection 4 and has not documented the occurrence and outcome of any negotiation or mediation;

(c) The patient has not paid the deductible, copayment or coinsurance that the patient would have paid for the provision of emergency services and care to an in-network physician; or

(d) The third party has not paid the out-of-network physician for the emergency services and care within 60 days after receipt of the bill and all necessary medical records required to pay the claim or, if applicable, within 60 days after the conclusion of any negotiation or mediation between the third party and the out-of-network physician.

4. If an out-of-network physician believes that the amounts prescribed in subsection 2 are insufficient to compensate the out-of-network physician for the emergency services and care provided by the out-of-network physician, the out-of-network physician must, within 30 days of receiving written notice of such amount from the third party, request in writing to enter into negotiations with the third party which provides coverage to the patient to resolve the difference between the amount charged by the out-of-network physician and the amount paid by the third party. Such negotiations must begin within 2 weeks of the out-of-network physician making the request for negotiation. If such negotiations do not result in an agreement on the amount that will be paid for emergency services and care, the out-of-network physician may file a complaint with the Advocate pursuant to NRS 223.560 and request that the Advocate mediate to determine the amount that must be paid for such emergency services and care.

5. In no event shall the patient who received emergency services and care be:

(a) Responsible for payment of any amount greater than any deductible, copayment or coinsurance paid by the patient pursuant to his or her policy of insurance; or

(b) Required to participate in any negotiation entered into pursuant to this section or any mediation entered into pursuant to NRS 223.560.

Sec. 20. ***If a third party who issues a policy of insurance or other contractual agreement that provides coverage for health care in this State wishes for out-of-network hospitals, out-of-network independent centers for emergency medical care and out-of-network physicians to accept as payment in full the amounts prescribed in sections 17, 18 and 19 of this act, the third party shall:***

1. Review the in-network hospitals, in-network independent centers for emergency medical care and in-network physicians of the third party to determine whether a person who is covered by that policy of insurance or other contractual agreement that provides coverage for health care has adequate access to health care, including, without limitation, a review of:

(a) The number and types of in-network hospitals, in-network independent centers for emergency medical care and in-network physicians, including, without limitation, emergency room physicians, anesthesiologists and specialty physicians;

(b) Whether a person who is covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care has access to in-network hospitals, in-network independent centers for emergency medical care and in-network physicians without experiencing an unreasonable delay in the provision of health care; and

(c) The in-network hospitals and in-network independent centers for emergency medical care which provide emergency services and care and the number and type of in-network physicians on the medical staff of those in-network hospitals and in-network independent centers for emergency medical care to ensure that the third party has contracted with a sufficient number and type of physicians who are on the medical staff of those in-network hospitals and in-network independent centers for emergency medical care.

2. Review the frequency with which persons covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care are treated for emergency services and care by out-of-network physicians at in-network hospitals and in-network independent centers for emergency medical care and the rate at which those services and care are reimbursed by the third party.

3. Ensure that persons covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care receive adequate information regarding in-network hospitals, in-network independent centers for emergency medical care and in-network physicians and the financial impact of receiving emergency services and care from out-of-network hospitals, out-of-network independent centers for emergency medical care and out-of-network physicians, including, without limitation, the financial impact of receiving emergency services and care from an out-of-network physician on the medical staff of an in-network hospital or in-network independent center for emergency medical care. The information must be provided in a format that is meaningful for persons making an

informed decision concerning emergency services and care and must be accessible to persons covered by the policy of insurance or other contractual agreement.

4. Submit once each calendar quarter to the Commissioner of Insurance and the Legislative Committee on Health Care a report containing a summary of the reviews conducted pursuant to subsections 1 and 2 and the educational efforts undertaken pursuant to subsection 3.

Sec. 21. *Each hospital with 100 or more beds that is not operated by a federal, state or local governmental agency and each independent center for emergency medical care that is operated by a person who also operates such a hospital shall submit to the Department an annual report which must include:*

1. The number of patients from whom the hospital or independent center for emergency medical care or a person acting on its behalf has attempted to collect a debt for any amount owed to the hospital or independent center for emergency medical care for emergency services and care;

2. The number of patients from whom a physician on the medical staff at the hospital or independent center for emergency medical care or a person acting on behalf of such a physician has attempted to collect a debt for any amount owed to the physician for emergency services and care;

3. The amount of any increase in the rate negotiated with a third party for emergency services and care that exceeds the percentage of increase in the Consumer Price Index, Medical Care Component, for the year in which the rate is increased and any justification for the increase; and

4. The amount of each payment negotiated by the hospital or independent center for emergency medical care pursuant to subsection 4 of section 17 of this act or a physician on the medical staff of the hospital or independent center for emergency medical care pursuant to subsection 4 of section 18 or subsection 4 of section 19 of this act and the emergency services and care for which the payment was made.

Sec. 21.3. Chapter 223 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The procedure established by regulation pursuant to paragraph (j) of subsection 1 of NRS 223.560 for filing and processing complaints concerning the rate of payment prescribed by sections 17, 18 and 19 of this act and the mediation of those complaints must:

(a) Require the Advocate or the Advocate's designee to determine, if an agreement between the parties cannot be reached, an acceptable rate that must be paid to the hospital, independent

center for emergency medical care or physician within 10 days of the conclusion of the mediation;

(b) Provide that a decision made by the Advocate or the Advocate's designee is binding on both parties subject to the mediation; and

(c) Provide that the costs of the mediation must be equally shared between the two parties subject to the mediation.

2. Except as otherwise provided in NRS 239.0115, any information received by the Advocate or the Advocate's designee during the mediation procedure established pursuant to paragraph (j) of subsection 1 of NRS 233.560 must be kept confidential by the Advocate or the Advocate's designee.

Sec. 21.6. NRS 223.500 is hereby amended to read as follows:

223.500 As used in NRS 223.500 to 223.575, inclusive, ***and section 21.3 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 223.505 to 223.535, inclusive, have the meanings ascribed to them in those sections.

Sec. 21.9. NRS 223.540 is hereby amended to read as follows:

223.540 The provisions of NRS 223.085 do not apply to the provisions of NRS 223.500 to 223.575, inclusive ~~,~~ ***, and section 21.3 of this act.***

Sec. 22. NRS 223.560 is hereby amended to read as follows:

223.560 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance;

(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the

Public Employees' Benefits Program, and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State; ~~[and]~~

(j) ***In accordance with section 21.3 of this act, establish by regulation a procedure for filing and processing complaints concerning the rate of payment prescribed by sections 17, 18 and 19 of this act and the mediation of those complaints to determine:***

(1) Whether the rates paid pursuant to sections 17, 18 and 19 of this act are sufficient in a particular circumstance; and

(2) If a determination is made that a rate is not sufficient, an acceptable rate that must be paid to the hospital, independent center for emergency medical care or physician that filed the complaint; and

(k) Assist consumers with filing complaints against health care facilities and health care professionals. As used in this paragraph, "health care facility" has the meaning ascribed to it in NRS 162A.740.

2. The Advocate may adopt regulations to carry out the provisions of NRS 223.560 to 223.575, inclusive.

Sec. 22.5. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 41.071, 49.095, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119B.370, 119B.382, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 130.312, 130.712, 136.050, 159.044, 172.075, 172.245, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 179.495, 179A.070, 179A.165, 179A.450, 179D.160, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3925, 209.419, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1473, 233.190, 237.300, 239.0105, 239.0113, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 250.087, 250.130, 250.140, 250.150, 268.095, 268.490, 268.910, 271A.105, 281.195, 281A.350, 281A.440, 281A.550, 284.4068, 286.110, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.5002, 293.503, 293.558, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.16925, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.610, 365.138, 366.160, 368A.180, 372A.080, 378.290, 378.300, 379.008, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 391.035, 392.029, 392.147, 392.264, 392.271, 392.850, 394.167, 394.1698, 394.447, 394.460, 394.465, 396.3295, 396.405, 396.525, 396.535, 398.403, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 432.205, 432B.175, 432B.280, 432B.290, 432B.407, 432B.430, 432B.560, 433.534, 433A.360, 439.840, 439B.420, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 445A.665, 445B.570, 449.209, 449.245, 449.720, 450.140, 453.164, 453.720, 453A.610, 453A.700, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.365, 481.063, 482.170, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484E.070, 485.316, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655,

587.877, 598.0964, 598.098, 598A.110, 599B.090, 603.070, 603A.210, 604A.710, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.30665, 630.336, 630A.555, 631.368, 632.121, 632.125, 632.405, 633.283, 633.301, 633.524, 634.055, 634.214, 634A.185, 635.158, 636.107, 637.085, 637B.288, 638.087, 638.089, 639.2485, 639.570, 640.075, 640A.220, 640B.730, 640C.400, 640C.745, 640C.760, 640D.190, 640E.340, 641.090, 641A.191, 641B.170, 641C.760, 642.524, 643.189, 644.446, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645E.300, 645E.375, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.228, 654.110, 656.105, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 671.170, 673.430, 675.380, 676A.340, 676A.370, 677.243, 679B.122, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.110, 687A.115, 687C.010, 688C.230, 688C.480, 688C.490, 692A.117, 692C.190, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 703.196, 704B.320, 704B.325, 706.1725, 706A.230, 710.159, 711.600, ***and sections 17, 18 and 19 of this act,*** sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate the confidential information from

the information included in the public book or record that is not otherwise confidential.

4. A person may request a copy of a public record in any medium in which the public record is readily available. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in a readily available medium because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 23. NRS 687B.490 is hereby amended to read as follows:

687B.490 1. A carrier that offers coverage in the group or individual market must, before making any network plan available for sale in this State, demonstrate the capacity to deliver services adequately by applying to the Commissioner for the issuance of a network plan and submitting a description of the procedures and programs to be implemented to meet the requirements described in subsection 2.

2. The Commissioner shall determine, within 90 days after receipt of the application required pursuant to subsection 1, if the carrier, with respect to the network plan:

(a) Has demonstrated the willingness and ability to ensure that health care services will be provided in a manner to ensure both availability and accessibility of adequate personnel and facilities in a manner that enhances availability, accessibility and continuity of service;

(b) Has organizational arrangements established in accordance with regulations promulgated by the Commissioner; and

(c) Has a procedure established in accordance with regulations promulgated by the Commissioner to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner.

3. The Commissioner may certify that the carrier and the network plan meet the requirements of subsection 2, or may determine that the carrier and the network plan do not meet such requirements. Upon a determination that the carrier and the network plan do not meet the requirements of subsection 2, the Commissioner shall specify in what respects the carrier and the network plan are deficient.

4. A carrier approved to issue a network plan pursuant to this section must file annually with the Commissioner a summary of information compiled pursuant to subsection 2 in a manner determined by the Commissioner.

5. The Commissioner shall, not less than once each year, or more often if deemed necessary by the Commissioner for the protection of the interests of the people of this State, make a determination concerning the availability and accessibility of the health care services of any network plan approved pursuant to this section.

6. The expense of any determination made by the Commissioner pursuant to this section must be assessed against the carrier and remitted to the Commissioner.

7. When making any determination concerning the availability and accessibility of the services of any network plan or proposed network plan pursuant to this section, the Commissioner shall consider ~~[services]~~ ***:***

(a) Services that may be provided through telehealth, as defined in NRS 629.515, pursuant to the network plan or proposed network plan to be available services.

(b) The information contained in the most recent report submitted pursuant to section 20 of this act that pertains to the network plan, if such a report has been submitted.

8. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 24. The Governor's Consumer Health Advocate appointed pursuant to NRS 223.550 shall adopt the regulations required by NRS 223.560, as amended by section 22 of this act, on or before October 1, 2017.

Sec. 25. 1. On or before June 30, 2018, the Legislative Committee on Health Care shall review the provisions of this act, including, without limitation, the rate of payment set forth in sections 17, 18 and 19 of this act, to determine whether providers of health care are being adequately compensated for the provision of emergency services and care.

2. The Legislative Committee on Health Care shall forward to the Assembly Standing Committee on Health and Human Services and the Senate Standing Committee on Health and Human Services the results of the review conducted pursuant to subsection 1 and any proposed changes to the provisions of this act, including, without limitation, the rate of payment set forth in sections 17, 18 and 19 of this act.

Sec. 26. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 27. This act becomes effective:

1. Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

2. On January 1, 2018, for all other purposes.

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