Assembly Bill No. 382–Assemblymen Carlton, Frierson, Araujo, Spiegel; Benitez-Thompson and Sprinkle

Joint Sponsors: Senators Ford, Parks and Cancela

CHAPTER.....

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 Governor's Consumer Health Advocate concerning patient debt and rate increases; requiring the Advocate to adopt certain regulations; 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 to accept, under certain circumstances, as payment in full for the provision of emergency services and care to stabilize a patient a reasonable rate offered by the third party. **Section 18** of this bill requires an out-of-network physician at an in-network or out-of-network hospital with 100 or more beds or an in-network or out-of-network independent center for emergency medical care to accept as payment in full for the provision of emergency services and care to stabilize a patient a reasonable rate which is offered by the third party. **Sections 17 and 18** further provide that, if a hospital, center or physician, as applicable, rejects the amount offered by the third party pursuant to those sections as full payment 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 17 and 18** also authorize a third party to file a complaint and request such mediation under similar circumstances. **Sections 21.4 and 22** of this bill require the Advocate to establish a procedure for filing and processing such complaints and requests for mediation.

Section 20 of this bill requires a third party who wishes to pay the amounts offered pursuant to **sections 17 and 18** to conduct a review of the adequacy of the network of the third party and submit certain reports to the Governor's Consumer Health Advocate.

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 to annually report certain information concerning the collection of debts, rate increases and negotiated payments for emergency services and care to the Governor's Consumer Health Advocate. **Section 21.5** of this bill requires the Advocate to annually report, in aggregate form, a summary of the data received pursuant to **section 21** to the Legislative Committee on Health Care.

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

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.***

Secs. 4 and 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. *1. "Third party" includes, without limitation:*

(a) An insurer as defined in NRS 679B.540;

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

(c) 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

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

2. The term does not include the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043.

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

Sec. 16.5. *The provisions of sections 2 to 21, inclusive, of this act apply only to persons who:*

1. Are residents of Nevada; or

2. Are covered by or receive benefits from:

(a) A policy of health insurance sold in this State; or

(b) Other contractual agreement issued in this State.

Sec. 17. *1. Except as otherwise provided in subsections 7 and 8, 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 shall accept as payment in full for the provision of emergency services and care to a patient to stabilize the patient a reasonable rate offered by the third-party 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. The third party shall approve or deny a claim submitted by an out-of-network hospital or out-of-network independent center for emergency medical care, as applicable, for the emergency services and care described in subsection 1 within 30 days after the third party receives the claim. If the claim is approved, the third party shall pay the claim within 30 days after it is approved.

3. If the third party requires additional information to determine whether to approve or deny the claim submitted pursuant to subsection 1, it shall notify the out-of-network hospital or out-of-network independent center for emergency medical care of its request for the additional information within 20 days after it receives the claim. The third party shall notify the out-of-network hospital or out-of-network independent center for emergency care of all the specific reasons for the delay in approving or denying the claim. The third party shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the third party shall pay the claim within 30 days after it receives the additional information.

4. A third party shall not request an out-of-network hospital or out-of-network independent center for emergency medical care to resubmit information that the out-of-network hospital or out-of-network independent center for emergency medical care has already provided to the third party, unless the third party provides a legitimate reason for the request and the purpose of the request

is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

5. A third party shall not pay only part of a claim that has been approved and is fully payable.

6. An offer made by a third party as payment for emergency services and care described in subsection 1 must include a statement that:

(a) If such an offer is not accepted as payment in full within 90 days, 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; or

(b) If such an offer is accepted as payment in full, mediation conducted pursuant to NRS 223.560 may not be requested.

7. If an out-of-network hospital or out-of-network independent center for emergency medical care rejects the amount offered by the third party as full payment 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 after 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 after the out-of-network hospital or out-of-network independent center for emergency medical care makes the request for negotiation, or at a time agreed upon by the out-of-network hospital or out-of-network independent center for emergency medical care and the third party. 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.

8. If an out-of-network hospital or out-of-network independent center for emergency medical care does not make a

request for negotiation pursuant to subsection 7 or accept as payment in full the amount offered by the third party, the third party 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.

9. 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 7 and 8, an out-of-network physician who provides services at an in-network or out-of-network hospital with 100 or more beds or at an in-network or out-of-network independent center for emergency medical care shall accept as payment in full for the provision of emergency services and care to a patient to stabilize the patient a reasonable rate offered by the third party if the patient:***

(a) Was presented to the in-network or out-of-network hospital or in-network 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 in-network or out-of-network hospital or in-network or out-of-network independent center for emergency medical care to which the patient was presented.

2. The third party shall approve or deny a claim submitted by an out-of-network physician for the emergency services and care described in subsection 1 within 30 days after the third party receives the claim. If the claim is approved, the third party shall pay the claim within 30 days after it is approved.

3. If the third party requires additional information to determine whether to approve or deny the claim submitted pursuant to subsection 1, it shall notify the out-of-network physician of its request for the additional information within 20 days after it receives the claim. The third party shall notify the

out-of-network physician of all the specific reasons for the delay in approving or denying the claim. The third party shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the third party shall pay the claim within 30 days after it receives the additional information.

4. A third party shall not request an out-of-network physician to resubmit information that the out-of-network physician has already provided to the third party, unless the third party provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

5. A third party shall not pay only part of a claim that has been approved and is fully payable.

6. An offer made by a third party as payment for emergency services and care described in subsection 1 must include a statement that:

(a) If such an offer is not accepted as payment in full within 90 days, 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; or

(b) If such an offer is accepted as payment in full, mediation conducted pursuant to NRS 223.560 may not be requested.

7. If an out-of-network physician rejects the amount offered by the third party as full payment 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 after 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 after the out-of-network physician makes the request for negotiation, or at a time agreed upon by the out-of-network physician and the third party. 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.

8. If an out-of-network physician does not make a request for negotiation pursuant to subsection 7 or accept as payment in full the amount offered by the third party, the third party 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.

9. 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. (Deleted by amendment.)

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 amount offered pursuant to sections 17 and 18 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 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.

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.

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 at 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 year to the Advocate 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 Advocate 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 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 7 of section 17 of this act or a physician at the hospital or independent center for emergency medical care pursuant to subsection 7 of section 18 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 the provisions set forth as sections 21.4 and 21.5 of this act.

Sec. 21.4. ***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***

offered pursuant to sections 17 and 18 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. The procedure established by regulation pursuant to paragraph (j) of subsection 1 of NRS 223.560 must require the Advocate, in determining an acceptable rate that must be paid to a hospital, independent center for emergency medical care or physician to consider:

(a) The average amount the third party pays for the same or similar emergency services and care in the county in which the services were rendered;

(b) 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 were rendered; and

(c) The usual and customary charges for the same or similar emergency services and care rendered by an out-of-network hospital, out-of-network independent center for emergency medical care or out-of-network physician in the geographic region in which the services were rendered.

3. 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. 21.5. ***The Advocate shall submit once each calendar year to the Legislative Committee on Health Care a report containing a summary, in aggregate form, of the data received pursuant to section 21 of this act.***

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 sections 21.4 and 21.5 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 sections 21.4 and 21.5 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 21.4 of this act, establish by regulation a procedure for filing and processing complaints concerning the rate of payment offered pursuant to sections 17 and 18 of this act and the mediation of those complaints to determine:***

(1) Whether the rates paid pursuant to sections 17 and 18 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.

Secs. 22.5 and 23. (Deleted by amendment.)

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. (Deleted by amendment.)

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.