SENATE BILL NO. 115–COMMITTEE ON HEALTH AND HUMAN SERVICES

(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE)

PREFILED FEBRUARY 3, 2011

Referred to Committee on Health and Human Services

SUMMARY—Establishes provisions governing payment for the provision of certain services and care to patients and reports relating to those services and care. (BDR 40-192)

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 and physicians to accept certain rates as payment in full for the provision of certain 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; revising provisions relating to the duties of the Director of the Office for Consumer Health Assistance; requiring the Commissioner of Insurance to study issues relating to policies of health insurance and similar contractual agreements; requiring the Commissioner to adopt related 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 13** 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 to accept, under certain circumstances, as payment in full for the provision of emergency services and care to certain patients a rate which does not exceed the greater of: (1) the amount that the third party negotiated with other hospitals in this State; (2) the amount calculated using the same method the third party uses to determine payments to out-of-network hospitals, without reducing the calculation for cost sharing; or (3) the amount that would be paid by Medicare. The Commissioner of Insurance may 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) **Section 14** of this bill requires an out-of-network physician on the medical staff of an out-of-network hospital with 100 or more beds 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 13**. **Section 15** of this bill requires an out-of-network physician on the medical staff of an in-network hospital with 100 or more beds to accept as payment in full for the provision of medical services and care, other than services and care provided to stabilize a patient, a rate which is similarly calculated to that in **section 13**. **Sections 13-15** further provide that, if a hospital or physician, as applicable, determines that the amount prescribed pursuant to those sections is not sufficient to reimburse for the provision of services and care to a patient, the hospital 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 Director of the Office for Consumer Health Assistance. **Section 17** of this bill requires the Director to establish a procedure for filing and processing such complaints and requests for mediation.

Section 16 of this bill requires a third party who wishes to pay the amounts prescribed pursuant to **sections 13-15** to maintain an adequate network of providers and submit certain reports to the Commissioner of Insurance and to the Legislative Committee on Health Care. **Section 18** of this bill requires the Commissioner of Insurance to prescribe the standards of adequacy for the networks of third parties in this State and to determine whether third parties have adequate networks.

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 16, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 16, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 12, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Air ambulance" has the meaning ascribed to it in NRS 450B.030.***

Sec. 4. ***"Ambulance" has the meaning ascribed to it in NRS 450B.040.***

Sec. 5. ***"Emergency services and care" has the meaning ascribed to it in NRS 439B.410.***

Sec. 6. *"Fire-fighting agency" has the meaning ascribed to it in NRS 450B.072.*

Sec. 7. *"In-network hospital" means, for a particular patient, a hospital which 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. 8. *"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. 9. *"Out-of-network hospital" means, for a particular patient, a hospital which 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. 10. *"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. 11. *"Third party" includes, without limitation:*

1. An insurer, as that term is defined in NRS 679B.540;

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

3. A participating public agency, as that term is 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. 12. *"To stabilize" has the meaning ascribed to it in 42 U.S.C. § 1395dd.*

Sec. 13. *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 shall accept as payment in full for the provision of emergency services and care to a patient a rate in accordance with subsection 2 if the patient:*

(a) Was transported to the out-of-network hospital for the provision of emergency services and care by an ambulance, air ambulance or vehicle of a fire-fighting agency which has received a permit to operate pursuant to chapter 450B of NRS; and

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

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

(a) The amount negotiated by the third party with in-network hospitals in this State for the emergency services and care provided, excluding any deductible, copayment or coinsurance paid by the patient. If there is more than one amount negotiated with in-network hospitals for the emergency services and care, the amount prescribed in this paragraph must be equal to the median of the amounts negotiated by the third party with all in-network hospitals. The median must be determined by treating the amount negotiated with each in-network hospital as a separate amount, even if the same amount is paid to more than one hospital.

(b) The amount for the emergency services and care calculated using the same method the third party uses to determine payments to out-of-network hospitals, including, without limitation, the usual, customary and reasonable amount, excluding any deductible, copayment or coinsurance paid by the patient. The amount prescribed in this paragraph must be determined without reducing the calculation for cost sharing that is applied by the third party with respect to emergency services and care provided by an out-of-network hospital.

(c) The amount that would be paid by Medicare pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., for the emergency services and care, excluding any deductible, copayment or coinsurance paid by the patient.

➥ The Commissioner of Insurance may adopt regulations that interpret the provisions of this subsection, which must be consistent with the provisions of 29 C.F.R. § 2590.715-2719A to the extent practicable.

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

(a) The network of the third party that issued the policy of insurance or other contractual agreement which provides

coverage to the patient does not meet the standards of adequacy, as determined by the Commissioner of Insurance pursuant to section 18 of this act;

(b) 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 16 of this act;

(c) 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;

(d) 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

(e) The third party has not paid the out-of-network hospital for the emergency services and care within 60 days after receipt of the bill or, if applicable, within 60 days after the conclusion of any negotiation or mediation between the third party and the hospital.

4. If an out-of-network hospital believes that the amounts prescribed in subsection 2 are insufficient to compensate the out-of-network hospital for the emergency services and care provided by the hospital, the hospital may enter into negotiations with the third party which provides coverage to the patient to resolve the difference between the amount charged by the hospital and the amount paid by 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 may file a complaint with the Director of the Office for Consumer Health Assistance pursuant to NRS 223.560 and request that the Director mediate to determine the amount that must be paid for such emergency services and care.

Sec. 14. *1. Except as otherwise provided in this section, an out-of-network physician on the medical staff of an out-of-network hospital with 100 or more beds 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 transported to the out-of-network hospital for the provision of emergency services and care by an ambulance, air ambulance or vehicle of a fire-fighting agency which has received a permit to operate pursuant to chapter 450B of NRS; and

(b) Has a policy of insurance or other contractual agreement with a third party that provides coverage for the provision of health care by more than one in-network physician in this State who provides the type of services and care other than the

out-of-network physician who provided the emergency services and care at the out-of-network hospital to which the patient was transported.

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 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 amount negotiated by the third party with in-network physicians in this State for the emergency services and care provided, excluding any deductible, copayment or coinsurance paid by the patient. If there is more than one amount negotiated with in-network physicians for the emergency services and care, the amount prescribed in this paragraph must be equal to the median of the amounts negotiated by the third party with all in-network physicians. The median must be determined by treating the amount negotiated with each in-network physician as a separate amount, even if the same amount is paid to more than one physician.

(b) The amount for the emergency services and care calculated using the same method the third party uses to determine payments to out-of-network physicians, including, without limitation, the usual, customary and reasonable amount, excluding any deductible, copayment or coinsurance paid by the patient. The amount prescribed in this paragraph must be determined without reducing the calculation for cost sharing that is applied by the third party with respect to emergency services and care provided by an out-of-network physician.

(c) The amount that would be paid by Medicare pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., for the emergency services and care, excluding any deductible, copayment or coinsurance paid by the patient.

➥ The Commissioner of Insurance may adopt regulations that interpret the provisions of this subsection, which must be consistent with the provisions of 29 C.F.R. § 2590.715-2719A to the extent practicable.

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 network of the third party that issued the policy of insurance or other contractual agreement which provides coverage to the patient does not meet the standards of adequacy, as determined by the Commissioner of Insurance pursuant to section 18 of this act;

(b) 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 16 of this act;

(c) 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;

(d) 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

(e) The third party has not paid the out-of-network physician for the services and care within 60 days after receipt of the bill or, if applicable, within 60 days after the conclusion of any negotiation or mediation between the third party and the 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 physician, the physician may enter into negotiations with the third party which provides coverage to the patient to resolve the difference between the amount charged by the physician and the amount paid by 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 Director of the Office for Consumer Health Assistance pursuant to NRS 223.560 and request that the Director mediate to determine the amount that must be paid for such emergency services and care.

Sec. 15. *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 shall accept as payment in full for the provision of medical 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 for the provision of medical services and care by more than one physician in this State who provides the type of services and care other than the physician who provided the 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 that provides to a patient described in subsection 1 medical services and care, other than services and care provided to stabilize the patient, shall accept as payment in

full for such services and care a rate which does not exceed the greater of:

(a) The amount negotiated by the third party with in-network physicians in this State for the medical services and care provided, excluding any deductible, copayment or coinsurance paid by the patient. If there is more than one amount negotiated with in-network physicians for the medical services and care, the amount prescribed in this paragraph must be equal to the median of the amounts negotiated by the third party with all in-network physicians. The median must be determined by treating the amount negotiated with each in-network physician as a separate amount, even if the same amount is paid to more than one physician.

(b) The amount for the medical services and care calculated using the same method the third party uses to determine payments to out-of-network physicians, including, without limitation, the usual, customary and reasonable amount, excluding any deductible, copayment or coinsurance paid by the patient. The amount prescribed in this paragraph must be determined without reducing the calculation for cost sharing that is applied by the third party with respect to medical services and care provided by an out-of-network physician.

(c) The amount that would be paid by Medicare pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., for the medical services and care, excluding any deductible, copayment or coinsurance paid by the patient.

➥ The Commissioner of Insurance may adopt regulations that interpret the provisions of this subsection, which must be consistent with the provisions of 29 C.F.R. § 2590.715-2719A to the extent practicable.

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 network of the third party that issued the policy of insurance or other contractual agreement which provides coverage to the patient does not meet the standards of adequacy, as determined by the Commissioner of Insurance pursuant to section 18 of this act;

(b) 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 16 of this act;

(c) 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;

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

(e) The third party has not paid the out-of-network physician for the services and care within 60 days after receipt of the bill or, if applicable, within 60 days after the conclusion of any negotiation or mediation between the third party and the physician.

4. If an out-of-network physician believes that the amounts prescribed in subsection 2 are insufficient to compensate the physician for the medical services and care provided by the physician, the physician may enter into negotiations with the third party which provides coverage to the patient to resolve the difference between the amount charged by the physician and the amount paid by the third party. If such negotiations do not result in an agreement on the amount that will be paid for the services and care, the out-of-network physician may file a complaint with the Director of the Office for Consumer Health Assistance pursuant to NRS 223.560 and request that the Director mediate to determine the amount that must be paid for such services and care.

Sec. 16. ***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 and out-of-network physicians to accept as payment in full the amounts prescribed in sections 13, 14 and 15 of this act, the third party shall:***

1. Review the in-network hospitals 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 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 and in-network physicians without experiencing an unreasonable delay in the provision of health care;

(c) Whether the third party has an adequate number of providers of health care in its network to ensure access to medical services and care, as determined by the Commissioner of Insurance pursuant to section 18 of this act; and

(d) The in-network hospitals which provide emergency services and care and the number and type of in-network physicians on the medical staff of those in-network hospitals 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.

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 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 and in-network physicians and the financial impact of receiving medical services and care from out-of-network hospitals and out-of-network physicians, including, without limitation, the financial impact of receiving medical services and care from an out-of-network physician on the medical staff of an in-network hospital. The information must be provided in a format that is meaningful for persons making an informed decision concerning medical 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. 17. NRS 223.560 is hereby amended to read as follows:

223.560 The Director shall:

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

2. 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;

3. 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:

(a) 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

(b) 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;

4. 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;

5. 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;

6. Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Director pursuant to this section;

7. In appropriate cases and pursuant to the direction of the Governor, refer a complaint or the results of an investigation to the Attorney General for further action;

8. Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

9. Establish and maintain an Internet website which includes:

(a) 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;

(b) 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

(c) 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]~~

10. ***Establish by regulation a procedure for filing and processing complaints concerning the rate of payment prescribed by sections 13, 14 and 15 of this act and the mediation of those complaints to determine:***

(a) Whether the rates paid pursuant to sections 13, 14 and 15 of this act are sufficient in a particular circumstance; and

(b) If a determination is made that a rate is not sufficient, an acceptable rate that must be paid to the hospital or physician that filed the complaint; and

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

Sec. 18. Chapter 232 of NRS is hereby amended by adding thereto a new section to read as follows:

1. For the purposes of sections 2 to 16, inclusive, of this act, the Commissioner shall:

(a) Study the providers of health care that are included in the networks established by third parties and prescribe by regulation standards of adequacy based on the results of that study.

(b) Determine whether the network established by each third party in this State meets the standards of adequacy prescribed by the Commissioner.

2. On or before July 1 of each year, the Commissioner shall prepare a report of the standards of adequacy for networks prescribed pursuant to subsection 1 and:

(a) Make the report available to the public; and

(b) Provide to the Legislative Committee on Health Care a copy of the report.

3. As used in this section, "third party" has the meaning ascribed to it in section 11 of this act.

Sec. 19. NRS 232.805 is hereby amended to read as follows:

232.805 As used in NRS 232.805 to 232.840, inclusive, ***and section 18 of this act,*** unless the context otherwise requires:

1. "Commissioner" means the Commissioner of Insurance.

2. "Division" means the Division of Insurance of the Department of Business and Industry.

Sec. 20. 1. The Director of the Office for Consumer Health Assistance shall adopt the regulations required by NRS 223.560, as amended by section 17 of this act, on or before October 1, 2011.

2. The Commissioner of Insurance shall adopt the regulations required by section 18 of this act on or before October 1, 2011.

Sec. 21. 1. On or before June 30, 2014, the Legislative Committee on Health Care shall review the provisions of this act, including, without limitation, the rate of payment set forth in sections 13, 14 and 15 of this act, to determine whether providers of health care are being adequately compensated for the provision of 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 Education 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 13, 14 and 15 of this act.

Sec. 22. This act becomes effective upon passage and approval for the purpose of adopting regulations and on January 1, 2012, for all other purposes.

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