Senate Bill No. 115–Committee on
Health and Human Services

CHAPTER.....

AN ACT relating to health care; requiring certain hospitals and physicians to accept certain amounts 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; requiring the Administrator of the Health Division of the Department of Health and Human Services to study issues relating to policies of health insurance and similar contractual agreements; 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 any medical screening and emergency services and care to stabilize a patient who arrives at the out-of-network hospital through an emergency transport an amount which equals 60 percent of the billed charges of the out-of-network hospital for costs associated with services and care provided to a patient for treatment other than treatment of a traumatic injury, and 70 percent of the billed charges of the out-of-network hospital for costs associated with services and care provided to the patient for treatment of a traumatic injury. In addition, **section 13** provides that if the billed charges are increased, the amount required to be paid for the average billed charges must not increase by more than 5 percent. **Section 14** of this bill similarly requires an out-of-network physician of an out-of-network hospital with 100 or more beds to accept as payment in full for the provision of medical screening and emergency services and care to stabilize a patient an amount which is based on the schedule of fees and charges established by the Division of Industrial Relations. A physician who provides services and care to the patient for treatment other than treatment of a traumatic injury will receive an amount equal to 115 percent of the amount set forth in that schedule of fees and charges, an anesthesiologist will receive an amount equal to 120 percent of the amount set forth in that schedule of fees and charges, and a physician who provides services and care to the patient for treatment of a traumatic injury will receive 120 percent of the amount set forth in that schedule of fees and charges. **Section 14** excludes emergency room physicians from these provisions.

Sections 13 and 14 apply only to certain third party insurers organized as nonprofit entities and do not apply to Medicaid or the Children's Health Insurance Program. **Sections 13 and 14** require the third party to provide for the transfer of

the patient to an in-network hospital within 8 hours after the out-of-network hospital notifies the third party that the patient has been stabilized. After that period, if the patient remains at the out-of-network hospital, the parties must negotiate a rate or the total billed charges will apply. **Sections 13 and 14** also allow an out-of-network hospital and an out-of-network physician to negotiate a different amount of payment if the hospital or physician believes that the amount provided pursuant to those sections does not provide a fair and reasonable rate of return in relation to the services provided. **Section 14.5** of this bill provides the process for submitting a dispute regarding the fair and reasonable rate of return to mediation.

Section 16 of this bill requires a third party who wishes to pay the amounts prescribed pursuant to **sections 13 and 14** to maintain an adequate network of providers and submit certain reports to the Administrator of the Health Division of the Department of Health and Human Services and to the Legislative Committee on Health Care. **Section 1** of this bill requires the Administrator of the Health Division to determine whether third parties have adequate networks. **Section 11** of this bill provides that the provisions of this bill apply only to certain insurers that are organized as nonprofit entities. **Section 12.7** of this bill provides that the provisions of this bill do not apply to Medicaid or to the Children's Health Insurance Program.

Section 21.5 of this bill limits the application of the bill so that it applies prospectively to contracts that expire on or after January 1, 2012. **Section 22** of this bill provides that the provisions of this bill expire by limitation on January 1, 2018.

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 439 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 Administrator shall:

(a) Study the information received pursuant to section 16 of this act and prescribe standards of adequacy based on the results of that study.

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

2. On or before July 1 of each year, the Administrator 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 and the Commissioner of Insurance 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. 1.5. 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 12.5, 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. 8.5. ***"Medical screening" means the medical screening required to be provided to a patient in the emergency department of a hospital pursuant to 42 U.S.C. § 1395dd.***

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. ***1. Except as otherwise provided in subsection 2, "third party" includes, without limitation:***

(a) An insurer, as that term is defined in NRS 679B.540;

(b) 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;

(c) 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

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

2. The term includes only an entity described in subsection 1 which is a nonprofit entity that qualifies under section 501(c) of the Internal Revenue Code of 1986, 26 U.S.C. § 501(c), as amended.

Sec. 12. *"To stabilize" and "stabilized" have the meanings ascribed to them in 42 U.S.C. § 1395dd.*

Sec. 12.5. *"Traumatic injury" means any acute injury which, according to standardized criteria for triage in the field, involves a significant risk of death or the precipitation of complications or disabilities.*

Sec. 12.7. *The provisions of sections 2 to 16, inclusive, of this act do not apply to the services of a hospital or physician provided to a recipient of Medicaid under the State Plan for Medicaid or to a person who is covered by insurance through the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.*

Sec. 13. *1. Except as otherwise provided in this section, 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 any medical screening and emergency services and care to stabilize a patient an amount in accordance with subsection 2 if:*

(a) The patient was transported to the out-of-network hospital 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;

(b) The patient has a policy of insurance or other contractual agreement with a third party that provides coverage for medical screening and emergency services and care;

(c) The third party that provides coverage to the patient has more than one in-network hospital in this State; and

(d) The out-of-network hospital, within the immediately preceding 12 months, had a contractual agreement with the third party that provides coverage to the patient to be an in-network hospital for the provision of all types of services and care to persons for whom the third party provided coverage.

2. Except as otherwise provided in this section, 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 a medical screening or emergency services and care to stabilize the patient shall accept as payment in full for such medical screening or emergency services and care an amount which equals:

(a) For costs associated with services and care provided to the patient for treatment other than treatment of a traumatic injury, 60 percent of the billed charges of the out-of-network hospital.

(b) For costs associated with services and care provided to the patient for treatment of a traumatic injury, 70 percent of the billed charges of the out-of-network hospital.

3. An out-of-network hospital is not required to accept as payment in full the amount prescribed in 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 prescribed by the Administrator of the Health Division of the Department pursuant to section 1 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) When applicable, the third party which provides coverage to the patient has not, in good faith, participated in a negotiation or mediation pursuant to subsection 5;

(d) The patient does not pay or arrange with the out-of-network hospital for the payment of the deductible, copayment or coinsurance that the patient would otherwise have paid for the provision of the emergency services and care at an in-network hospital within 30 days after the patient received the bill from the out-of-network hospital for the amount owed by the patient; or

(e) The third party does not pay the out-of-network hospital for the emergency services and care within 30 days after receipt of the bill or, if applicable, within 30 days after the conclusion of any negotiation, mediation, arbitration or action between the third party and the out-of-network hospital.

4. If the out-of-network hospital increases the average amount of billed charges at any time within 12 months after the expiration of a contractual agreement with a third party that is subject to the provisions of this section, the out-of-network hospital must inform the third party of the increase and, if the average amount of the increase in billed charges is greater than 5 percent, the percentages listed in paragraphs (a) and (b) of subsection 2 must be adjusted so that the increase in the actual amount of the average billed charges required to be paid does not exceed an increase of 5 percent. When such an increase occurs, upon request, the out-of-network hospital must allow the third party to review the billed charges of the out-of-network hospital.

5. If an out-of-network hospital believes that the amounts prescribed in subsection 2 do not provide a fair and reasonable rate of return in relation to the services and care provided by the out-of-network hospital, the out-of-network hospital may enter into negotiations with the third party which provides coverage to the patient to reach an agreement regarding a fair and reasonable rate of return. If such negotiations do not result in an agreement regarding a fair and reasonable rate of return, the out-of-network hospital may request mediation as provided in section 14.5 of this act. An out-of-network hospital may not commence an action in court until the matter has been submitted to mediation pursuant to section 14.5 of this act unless the parties agree in writing to waive mediation.

6. If an out-of-network hospital becomes aware that a patient is covered by a policy of insurance or other contractual agreement with a third party, the out-of-network hospital must notify the third party of the status of the patient not later than 2 hours after determining that the patient has such coverage and shall notify the third party when the patient has been stabilized. The third party which has been notified that the patient has been stabilized shall ensure that the patient is transferred to an in-network hospital within 8 hours after the out-of-network hospital informs the third party that the patient has been stabilized, unless the out-of-network hospital and the third party agree to allow the patient to remain at the out-of-network hospital and agree to the amount that may be billed for any services provided after that time. If no such agreement is reached within 8 hours and the patient is not transferred to an in-network hospital, the third party must pay the billed charges of the out-of-network hospital for any services provided after that time.

7. During the period that a patient remains at an out-of-network hospital before the patient is required to be transferred pursuant subsection 6, the out-of-network hospital shall continue to accept as payment in full for costs associated with any care or services provided to the patient the amount prescribed in subsection 2.

Sec. 14. *1. Except as otherwise provided in this section, an out-of-network physician who provides services to a patient at a hospital with 100 or more beds shall accept as payment in full for the provision of any medical screening and emergency services and care to stabilize the patient an amount in accordance with subsection 2 if:*

(a) The patient was transported to the out-of-network hospital 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;

(b) The patient has a policy of insurance or other contractual agreement with a third party that provides coverage for the provision of health care; and

(c) The third party has more than one in-network physician in this State who provides the type of services and care that were provided by the out-of-network physician.

2. Except as otherwise provided in this section, an out-of-network physician who provides to a patient described in subsection 1 a medical screening or emergency services and care to stabilize the patient shall accept as payment in full for such medical screening or emergency services and care an amount which equals:

(a) For services and care provided to the patient for treatment other than treatment of a traumatic injury, 115 percent of the amount set forth in the current schedule of fees and charges established by the Division of Industrial Relations of the Department of Business and Industry pursuant to NRS 616C.260.

(b) For services and care provided to the patient by an anesthesiologist, regardless of whether the services and care are for treatment of a traumatic injury, 120 percent of the amount set forth in the current schedule of fees and charges established by the Division of Industrial Relations of the Department of Business and Industry pursuant to NRS 616C.260.

(c) For services and care provided to the patient for treatment of a traumatic injury, 120 percent of the amount set forth in the current schedule of fees and charges established by the Division of

Industrial Relations of the Department of Business and Industry pursuant to NRS 616C.260.

3. An out-of-network physician is not required to accept as payment in full the amount prescribed in 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 prescribed by the Administrator of the Health Division of the Department pursuant to section 1 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) When applicable, the third party which provides coverage to the patient has not, in good faith, participated in a negotiation or mediation pursuant to subsection 4;

(d) The patient does not pay or arrange for the payment of the deductible, copayment or coinsurance that the patient would otherwise have paid for the provision of emergency services and care to an in-network physician within 30 days after the patient has received the bill from the out-of-network physician for the amount owed by the patient; or

(e) The third party does not pay the out-of-network physician for the services and care within 30 days after receipt of the bill or, if applicable, within 30 days after the conclusion of any negotiation, mediation, arbitration or action 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 do not provide a fair and reasonable rate of return in relation to the services and care provided by the out-of-network physician, the out-of-network physician may enter into negotiations with the third party which provides coverage to the patient to reach an agreement regarding a fair and reasonable rate of return. If such negotiations do not result in an agreement regarding a fair and reasonable rate of return, the out-of-network physician may request mediation as provided in section 14.5 of this act. An out-of-network physician may not commence an action in court until the matter has been submitted to mediation pursuant to section 14.5 of this act unless the parties agree in writing to waive mediation.

5. During the period that a patient remains at an out-of-network hospital before the patient is required to be transferred pursuant to subsection 6 of section 13 of this act, the

out-of-network physician shall continue to accept as payment in full for services or care provided to the patient the amount prescribed in subsection 2. If a patient remains at the out-of-network hospital after the time by which the patient is required to be transferred pursuant to subsection 6 of section 13 of this act to an in-network hospital, the third party which provides coverage to the patient must pay the billed charges to the out-of-network physician after that time unless the third party and the out-of-network physician have agreed to a different amount that may be billed.

6. The provisions of this section do not apply to an emergency room physician who has a contract with the hospital or who is on the staff of the hospital and who provides services to patients in the emergency department of the hospital.

Sec. 14.5. ***1. If negotiations pursuant to subsection 5 of section 13 or subsection 4 of section 14 of this act have not resulted in an agreement regarding a fair and reasonable rate of return in relation to the services and care provided to a patient and the out-of-network hospital or out-of-network physician, as applicable, requests mediation, the parties may select a mediator, or if the parties do not agree upon a mediator, either party may request from the American Arbitration Association or the Federal Mediation and Conciliation Service a list of seven potential mediators. If the parties are unable to agree upon which mediation service to use, the Federal Mediation and Conciliation Service must be used. The parties shall select the mediator from the list by alternately striking one name until the name of only one mediator remains, who will be the mediator to hear the dispute. The out-of-network hospital or the out-of-network physician, as applicable, shall strike the first name.***

2. If mediation is requested, the mediator must be selected at the time the parties agree to mediation or, if the parties do not agree upon a mediator, within 5 days after the parties receive the list of potential mediators.

3. The mediator shall bring the parties together as soon as possible and, unless otherwise agreed upon by the parties, attempt to settle the dispute within 30 days after being notified of the mediator's selection as mediator. The mediator may establish the times and dates for meetings and compel the parties to attend but has no power to compel the parties to agree.

4. Each party to the mediation shall pay one-half of the cost of mediation and shall pay its own costs of preparation and presentation of its case in mediation.

5. The patient must not be required to participate in the mediation.

6. If the parties are unable to reach an agreement through mediation, the parties may agree to submit the dispute to arbitration for resolution or an action may be commenced in a court of competent jurisdiction within 30 days after the completion of the mediation. If submitted to arbitration, the decision is final and binding upon the parties and the provisions of NRS 38.206 to 38.248, inclusive, apply.

Sec. 15. (Deleted by amendment.)

Sec. 16. ***1. If a third party which 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 and 14 of this act, the third party shall:***

(a) Compile a list of the in-network hospitals and in-network physicians of the third party and review information concerning the in-network hospitals and in-network physicians 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:

(1) The number and types of in-network hospitals and in-network physicians, including, without limitation, emergency room physicians, anesthesiologists and specialty physicians;

(2) The location of the in-network hospitals and in-network physicians compared to the location where the persons covered by the policy of insurance or other contractual agreement that provides coverage for the provision of health care live and work;

(3) 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;

(4) Whether the third party has an adequate number of providers of health care in its network to ensure access to emergency services and care, as determined by the Administrator of the Health Division of the Department pursuant to section 1 of this act; and

(5) The in-network hospitals which provide medical screenings and emergency services and care and the number and type of in-network physicians who have privileges at those

in-network hospitals to ensure that the third party has contracted with a sufficient number and type of physicians at those in-network hospitals.

(b) 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 receive medical screenings and emergency services and care by out-of-network physicians at in-network hospitals and the rate at which those medical screening and emergency services and care are reimbursed by the third party.

(c) 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 screenings or emergency services and care from out-of-network hospitals and out-of-network physicians, including, without limitation, the financial impact of receiving medical screenings and emergency services and care from an out-of-network physician at an in-network hospital. The information must be provided in a format that is meaningful for persons making an informed decision concerning medical screenings and emergency services and care and must be accessible to persons covered by the policy of insurance or other contractual agreement.

(d) Submit once each calendar quarter to the Administrator of the Health Division of the Department and the Legislative Committee on Health Care a report containing a summary of the information collected pursuant to this subsection and the educational efforts undertaken pursuant to paragraph (c).

2. If an out-of-network hospital or out-of-network physician is required to accept as payment in full the amounts prescribed in section 13 and 14 of this act, as applicable, the third party which issues a policy of insurance or other contractual agreement that provides coverage for health care in this State is not entitled to any other discount from the out-of-network hospital or out-of-network physician and, except as otherwise provided in sections 13 and 14 of this act, must pay the amount provided pursuant to sections 13 and 14 of this act, as applicable, for each charge covered by those sections for care provided to the patient.

3. An out-of-network hospital or out-of-network physician which is required to accept as payment in full the amount prescribed in sections 13 and 14 of this act, as applicable, shall not collect or attempt to collect from the patient any amount other than any deductible, copayment or coinsurance which the patient

would otherwise be required to pay had the medical screening or emergency services and care been provided at an in-network hospital or by an in-network physician, as applicable.

Secs. 17-20. (Deleted by amendment.)

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 amount of payment set forth in sections 13 and 14 of this act, to determine whether out-of-network hospitals and out-of-network physicians subject to the provisions of this act are being adequately compensated for the provision of medical screenings and emergency services and care, as those terms are defined in sections 5 and 8.5 of this act.

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 amount of payment prescribed by sections 13 and 14 of this act.

Sec. 21.5. The provisions of this act apply only if a third party, as defined in section 11 of this act, and a hospital or physician, as applicable, have a contractual agreement whereby the hospital or physician provides services as an in-network hospital for the provision of all types of services and care or as an in-network physician, as applicable, for persons for whom the third party provides coverage which expires on or after January 1, 2012.

Sec. 22. This act becomes effective on January 1, 2012 and expires by limitation on January 1, 2018.