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Bulletin 00-004

BALANCE BILLING BY CONTRACTED PROVIDERS

December 15, 2000

The Department of Business and Industry, Division of Insurance (Division), has learned that some providers of healthcare who have executed preferred provider contracts are billing insured patients for amounts greater than the agreed upon discounted contract rate. This practice is known as "balance billing." Some insured patients have paid amounts greater than those specified in the contractual discount arrangement. To knowingly and willingly file a claim for an amount that is not due and is greater than the contracted rate is a violation of the false claims section of the Unfair Trade Practices and Fraud Act, specifically NRS 686A.291.

Discounted charges agreed upon by a preferred provider of healthcare and a payor must be similarly limited to the amounts owed by the insured. Each contract between a payor and a provider of healthcare that establishes reduced rates must state that the contracted rate is the total amount due for the covered service and that the insured is not responsible for amounts above the contracted rate.

Any Explanation of Benefits (EOB), Explanation of Payment (EOP), or similar form of each insurer must clearly disclose that the insured is not responsible for amounts greater than the contracted amount. The insured must be informed that providers are not to balance bill the difference between the billed amount and the contracted amount. The notice on the Explanation of Benefits and Explanation of Payment must include language substantially as follows:

"The billed charges exceed the contracted amounts agreed to by this provider for the covered service. Because this provider is a preferred contracted provider for your plan, you are not responsible for the difference between the billed charges and the contracted charges. This provider is prohibited from billing you for the difference."

Alice A. Molasky-Arman
COMMISSIONER OF INSURANCE

Added, 2001-1

ASSEMBLY COMMERCE & LABOR 1904
DATE: 2/17/03 ROOM: 4100 EXHIBIT E
SUBMITTED BY: Alice Molasky-Arman

§ 686A.290 False representations in insurance applications

1. An agent, broker, solicitor, examining physician, applicant or other person shall not knowingly or willfully make any false or fraudulent statement or representation in or with reference to any application for insurance.

2. A person who violates this section is guilty of a category D felony and shall be punished as provided in NRS 193.130. In addition to any other penalty, the court shall order the person to pay restitution.

History.—Stats. 1971, 1697; 1977, 153; 1983, 1388; 1995, 1318, eff. 7-1-95.

§ 686A.291 False claims or proofs

1. A person commits insurance fraud if he knowingly and willfully:

(a) Presents or causes to be presented any statement to an insurer, a reinsurer, a producer, a broker or any agent thereof, known by him to contain false, incomplete or misleading information concerning any fact material to an application for the issuance of a policy of insurance pursuant to this Title.

(b) Presents or causes to be presented any statement as a part of, or in support of, a claim for payment or other benefits under a policy of insurance issued pursuant to this Title, known by him to contain false, incomplete or misleading information concerning any fact material to that claim.

(c) Assists, abets, solicits or conspires with another person to present or cause to be presented any statement to an insurer, reinsurer, producer, broker or any agent thereof, known by him to contain false, incomplete or misleading information concerning any fact material to an application for the issuance of a policy of insurance pursuant to this Title or a claim for payment or other benefits under such a policy.

(d) Acts or fails to act with the intent of defrauding or deceiving an insurer, a reinsurer, a producer, a broker or any agent thereof, in order to obtain a policy of insurance pursuant to this Title or any proceeds or other benefits under such a policy.

(e) As a practitioner, an insurer or any agent thereof, acts to assist, conspire with or urge another person to violate any provision of this section through deceit, misrepresentation or other fraudulent means.

(f) Accepts any proceeds or other benefits under a policy of insurance

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issued pursuant to this Title known by him to be derived from any act or omission which violates any provision of this section.

(g) Employs a person to procure clients, patients or other persons who obtain services or benefits under a policy of insurance issued pursuant to this Title for the purpose of engaging in any activity prohibited by this section. This paragraph does not prohibit contact or communication by an insurer or his agent or representative with a client, patient or other person if the contact or communication is made for a lawful purpose, including, without limitation, communication by an insurer with a holder of a policy of insurance issued by the insurer or with a claimant concerning the settlement of any claims against the policy.

2. A person commits insurance fraud if he knowingly and willfully participates in, aids, abets, conspires to commit, solicits another person to commit, or permits an employee or agent to commit an act of insurance fraud prohibited by subsection 1.

3. A person who commits insurance fraud is guilty of a category D felony and shall be punished as provided in NRS 193.130.

4. For the purposes of this section, "practitioner" means:

(a) A physician, dentist, nurse, dispensing optician, optometrist, physical therapist, podiatric physician, psychologist, chiropractor, doctor of Oriental medicine in any form, director or technician of a medical laboratory, pharmacist or other provider of health services who is authorized to engage in his occupation by the laws of this state or another state; and

(b) An attorney admitted to practice law in this state or any other state.

History.—Stats. 1983, 1388; 1991, 1042; 1995, 1318; 1995, 2698; 1997, 1541, eff. 10-1-97.

Note.—Pursuant to Stats. 1997, 1542: "The amendatory provisions of section 3 of this act do not apply to offenses that occur before October 1, 1997."

§ 686A.295 Actions by licensing agencies against persons convicted of insurance fraud

If a person who is licensed or registered under the laws of the State of Nevada to engage in a business or profession is convicted of or pleads guilty to engaging in an act of insurance fraud prohibited by NRS 686A.291, the commissioner and the attorney general shall forward to each agency by which the convicted person is licensed or

(b) Which has converted into a domestic insurer.

2. A "foreign" insurer is one:

(a) Formed under the laws of any jurisdiction other than this state, unless it has converted into a domestic insurer; or

(b) Which has converted into a foreign insurer.

3. An "alien" insurer is one formed under the laws of any country other than the United States of America or any of its states.

4. Except where distinguished by context, "foreign" insurer includes also "alien" insurer.

History.—Stats. 1971, 1558; 1983, 683.

§ 679A.095 "Hospice care"

"Hospice care" has the meaning ascribed to it in NRS 449.0115.

History.—Stats. 1983, 1933; 1989, 1031.

§ 679A.100 "Insurer"

"Insurer" includes every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance.

History.—Stats. 1971, 1558.

§ 679A.110 "Individual"

An "individual" is a natural person.

History.—Stats. 1971, 1559; 1985, 537.

§ 679A.112 "Policy"

"Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements and papers which are a part thereof.

History.—Stats. 1981, 1141.

§ 679A.115 "Premium"

"Premium" means the consideration for insurance, by whatever name called. The term includes any "assessment," or any "membership,"

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