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M E M O R A N D U M

TO: Assembly Committee on Commerce & Labor

FROM: Nevada Hospital Association

DATE: February 17, 2003

RE: A.B. 70

The attached exhibits are presented to the Committee on behalf of the Nevada Hospital Association in conjunction with the testimony presented by their representative, Jim Wadams, regarding A.B. 70.

ASSEMBLY COMMERCE & LABOR 108
DATE: 2/17/03 ROOM: 4100 EXHIBIT F
SUBMITTED BY: Jim Wadams

NRS 689B.061 Limitations on deductibles and copayments charged under policy which offers difference of payment between preferred providers of health care and providers who are not preferred. A policy of group health insurance which offers a difference of payment between **preferred** providers of health care and providers of health care who are not **preferred**:

1. May not require a deductible of more than $600 difference per admission to a facility for inpatient treatment which is not a **preferred** provider of health care.

2. May not require a deductible of more than $500 difference per treatment, other than inpatient treatment at a hospital, by a provider which is not **preferred**.

3. May not require an insured, another insurer who issues policies of group health insurance, a nonprofit medical service corporation or a health maintenance organization to pay any amount in excess of the deductible or coinsurance due from the insured based on the rates agreed upon with a provider.

4. May not provide for a difference in percentage rates of payment for coinsurance of more than 30 percentage points between the payment for coinsurance required to be paid by the insured to a **preferred** provider of health care and the payment for coinsurance required to be paid by the insured to a provider of health care who is not **preferred**.

5. Must require that the deductible and payment for coinsurance paid by the insured to a **preferred** provider of health care be applied to the negotiated reduced rates of that provider.

6. Must include for providers of health care who are not **preferred** a provision establishing the point at which an insured's payment for coinsurance is no longer required to be paid if such a provision is included for **preferred** providers of health care. Such provisions must be based on a calendar year. The point at which an insured's payment for coinsurance is no longer required to be paid for providers of health care who are not **preferred** must not be greater than twice the amount for **preferred** providers of health care, regardless of the method of payment.

7. Must provide that if there is a particular service which a **preferred** provider of health care does not provide and the provider of health care who is treating the insured requests the service and the insurer determines that the use of the service is necessary for the health of the insured, the service shall be deemed to be provided by the **preferred** provider of health care.

8. Must require the insurer to process a claim of a provider of health care who is not **preferred** not later than 30 working days after the date on which proof of the claim is received.

(Added to NRS by 1987, 1781; A 1991, 1329; 1995, 1629)

REVISER'S NOTE.

Ch. 729, Stats. 1987, the source of this section, contains the following provision not included in NRS:

"The provisions of sections 1 (NRS 689B.061) and 2 (NRS 695B.185) of this act apply to all policies or coverages issued or renewed on or after January 1, 1988."

ADMINISTRATIVE REGULATIONS.

Group benefits payable by more than one insurer, NAC 689B.190

Use of **preferred** providers of health care, NAC 689B.110-689B.160

NRS 689C.350 Health benefit plan with preferred providers of health care: Deductible; percentage rate of payment; when coinsurance is no longer required; when service is deemed to be provided by preferred provider; processing claims of provider who is not preferred. A health benefit plan which offers a difference of payment between **preferred** providers of health care and providers of health care who are not **preferred**:

1. May not require a deductible of more than $600 difference per admission to a facility for inpatient treatment which is not a **preferred** provider of health care.

2. May not require a deductible of more than $500 difference per treatment, other than inpatient treatment at a hospital, by a provider which is not **preferred**.

3. May not provide for a difference in percentage rates of payment for coinsurance of more than 30 percentage points between the payment for coinsurance required to be paid by the insured to a **preferred** provider of health care and the payment for coinsurance required to be paid by the insured to a provider of health care who is not **preferred**.

4. Must require that the deductible and payment for coinsurance paid by the insured to a **preferred** provider of health care be applied to the negotiated reduced rates of that provider.

5. Must include for providers of health care who are not **preferred** a provision establishing the point at which an insured's payment for coinsurance is no longer required to be paid if such a provision is included for **preferred** providers of health care. Such provisions must be based on a calendar year. The point at which an insured's payment for coinsurance is no longer required to be paid for providers of health care who are not **preferred** must not be greater than twice the amount for **preferred** providers of health care, regardless of the method of payment.

6. Must provide that if there is a particular service which a **preferred** provider of health care does not provide and the provider of health care who is treating the insured requests the service and the insurer determines that the use of the service is necessary for the health of the insured, the service shall be deemed to be provided by the **preferred** provider of health care.

7. Must require the insurer to process a claim of a provider of health care who is not **preferred** not later than 30 working days after the date on which proof of the claim is received.

(Added to NRS by 1995, 987)

USE OF PREFERRED PROVIDERS OF HEALTH CARE

NAC 689B.110 Disclosure of points at which insured's payment for coinsurance is no longer required; sample calculation of claim; limitation on approval of policy.

1. The point at which an insured's payment for coinsurance is no longer required to be paid for **preferred** providers of health care and for providers who are not **preferred** in a policy of group health insurance pursuant to subsection 6 of NRS 689B.061 must be disclosed to the insured and included in the disclosure filed pursuant to NRS 689B.027.

2. Each form of policy filed with the commissioner must include a sample calculation of a claim using the method of calculation selected by the insurer.

3. The commissioner will not approve a policy if the point at which an insured's payment for coinsurance is no longer required to be paid for **preferred** providers of health care and for providers who are not **preferred** is misleading or deceptively affects the risk purported to be assumed.

(Added to NAC by Comm'r of Insurance, eff. 6-1-88; A 6-20-90; 9-16-92)

NAC 689B.120 Contents of policy: General requirements. A policy of group health insurance issued pursuant to NRS 689B.061:

1. Must include a definition for **preferred** providers of health care and providers of health care who are not **preferred**.

2. Must include an explanation of the amount of disincentives to be paid for using the services of providers of health care who are not **preferred**.

3. Must include in the schedule of benefits the amounts for deductibles and coinsurance payable for **preferred** providers of health care and providers of health care who are not **preferred**.

4. Must include a description of the type of plan used for **preferred** providers of health care and whether it is limited to specific services only, such as services obtained from a physician or hospital or for prescription drugs.

5. Must provide that the services covered, if provided by **preferred** providers of health care, are the same for providers of health care who are not **preferred**.

6. Must include a statement that the insured should verify whether a provider of health care is a **preferred** provider of health care.

7. Must provide that, if the insured is confined in a facility which is a **preferred** provider of health care at a time when the facility terminates its agreement with the insurer, coverage will be provided for the period of confinement at the rate negotiated for that facility before it terminated its agreement and at no additional cost to the insured.

8. Must provide that, if the insured obtains prior authorization for health care services to be rendered by a **preferred** provider of health care and the provider subsequently terminates his agreement with the insurer, coverage will be provided for those services at the rate negotiated for

that provider before he terminated his agreement and at no additional cost to the insured.

9. May not require that the payments to a provider of health care who is not **preferred** be based upon the fee schedule or arrangements for **preferred** providers of health care.

10. May not provide for more than a 50 percent difference or reduction in any payment of otherwise eligible expenses for not complying with any procedures requiring the prior authorization of care or notification that treatment was received for an emergency.

(Added to NAC by Comm'r of Insurance, 7-19-90, eff. 10-1-90)

NAC 689B.130 Contents of policy: Provisions concerning emergencies and medical necessity. A policy of group health insurance issued pursuant to NRS 689B.061 must:

1. Include the criteria used to determine what is an emergency or treatment for an emergency.

2. Contain a description of any procedures used to determine whether health care services rendered are medically necessary.

3. If necessary, contain a description of the benefits payable for emergency care.

(Added to NAC by Comm'r of Insurance, 7-19-90, eff. 10-1-90)

NAC 689B.140 Filing of information with division. Each insurer offering a policy of group health insurance pursuant to NRS 689B.061 shall file with the division:

1. A copy of each standard agreement made with each **preferred** provider of health care and a list of the **preferred** providers of health care used by the insurer according to their specialties.

2. A copy of any agreement made with a third party to act as an administrator for the payment of claims or the collection of premiums. A copy of the rates or payments to be made to the administrator by the insurer may be omitted.

3. A copy of any contracts requiring a preauthorization review or procedures for obtaining authorization for care which may be separate from the policy.

4. A copy of any contracts entered into with persons who conduct utilization reviews or a brief description of the standards or guidelines used for a utilization review and the assurance of quality which may be separate from the policy.

(Added to NAC by Comm'r of Insurance, 7-19-90, eff. 10-1-90; A 5-27-92)

NAC 689B.150 Dissemination of list of preferred providers and any geographic limitations. An insurer offering a policy of group health insurance pursuant to NRS 689B.061 shall include with its health disclosure form a list of its **preferred** providers of health care and a description of any geographic limitation to the availability of services.

(Added to NAC by Comm'r of Insurance, 7-19-90, eff. 10-1-90)

NAC 689B.160 Agreements with preferred providers: Notice of termination. Each agreement entered into by an insurer and a **preferred** provider of health care must require a party who wishes to terminate the agreement to give notice to the other party at least 90 days

before the date of termination.

(Added to NAC by Comm'r of Insurance, 7-19-90, eff. 10-1-90)

NAC 689C.170 Contents of disclosure form. The disclosure required to be filed with the commissioner pursuant to NRS 689C.270 must be on a form which is in at least 10-point type and include:

1. The name, address and telephone number of the carrier;
2. The name, address and telephone number of the agent, broker and administrator, if applicable;
3. A statement describing the principal benefits and the type of coverage provided; and
4. A description of any provision of the policy which significantly excludes, eliminates, reduces or limits the payment of benefits, including limitations on access to an emergency room, requirements concerning prior authorization, and limitations relating to the use of **preferred** or other providers.

(Added to NAC by Comm'r of Insurance, eff. 3-28-96)

F 708

NAC 689A.421 Programs of health insurance using preferred providers of health care. An insurer may file with the division a program of health insurance using **preferred** providers of health care for any individual policy offered pursuant to chapter 689A of NRS if it complies with the requirements set forth in NAC 689B.120 to 689B.160, inclusive.

(Added to NAC by Comm'r of Insurance, 7-19-90, eff. 10-1-90; 5-27-92)