Amendment No. 446

Senate Amendment to Senate Bill No. 157	(BDR 40-808)
Proposed by: Senate Committee on Health and Education	
Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes	

Adoption of this amendment will ADD an appropriation where one does not currently exist in S.B. 157.

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) ***green bold italic underlining*** is new language proposed in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill that is proposed to be retained in this amendment; and (6) **green bold dashed underlining** is newly added transitory language.

SLP/KCR Date: 4/19/2009

S.B. No. 157—Limits the amount that certain hospitals and physicians may charge for the provision of certain services and care. (BDR 40-808)

SENATE BILL NO. 157–COMMITTEE ON HEALTH AND EDUCATION

FEBRUARY 24, 2009

Referred to Committee on Health and Education

SUMMARY—~~[Limits the amount that certain hospitals and physicians may charge]~~ **Establishes provisions governing payment** for the provision of certain services and care ~~[.]~~ **and reports relating to those services and care.** (BDR 40-808)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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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; ~~[limiting the amount that]~~ **requiring** certain hospitals and physicians ~~[may charge]~~ **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; authorizing the submission of certain reports relating to policies of health insurance and similar contractual agreements; requiring physicians and hospitals to submit certain information relating to the charges for certain medical services and care; requiring the Department of Health and Human Services to prescribe a usual and customary rate for certain medical services and care under certain circumstances; revising provisions relating to the Director of the Office for Consumer Health Assistance; making an appropriation;** 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) ~~[This]~~ **Section 12 of this** bill ~~[prohibits]~~ **requires** a hospital with 100 or more beds that is not operated by a federal, state or local governmental entity ~~[from charging a rate of more than 200 percent of the amount Medicare pays]~~ **under certain circumstances to accept as payment in full the usual and customary rate prescribed by the Department of Health and Human Services** for the provision of emergency services and care and any other services and care before a patient may be transferred safely to another hospital if the patient has insurance or another contractual agreement for the payment of such services and care at a hospital in this State other than the hospital to which the patient was transported by an emergency vehicle. ~~[This bill places the same limit on charges by physicians.]~~ **Section 13 of this bill requires an out-of-network physician** providing such services and care in **out-of network** hospitals with 100 or more beds ~~[.]~~ **under certain circumstances**

to accept as payment in full a rate of not more than 200 percent of the amount Medicare pays for the provision of emergency services and care.

Section 14 of this bill requires an out-of-network physician providing any medical services and care in an in-network hospital under certain circumstances to accept as payment in full a rate of not more than 200 percent of the amount Medicare pays for the provision of that service or care.

Section 15 of this bill authorizes providers of insurance and other contractual agreements for the provision of health care to submit certain reports to the Department of Health and Human Services and the Legislative Committee on Health Care. If such a provider does not submit the reports, the hospital or physician, as applicable, is not required to accept the specified rate set forth in sections 12, 13 or 14.

Section 17 of this bill requires the Department to analyze the lists of billed charges which a physician is required to submit pursuant to section 16 of this bill and the charge masters submitted by hospitals pursuant to section 18 of this bill and determine the usual and customary charges for certain medical services and care provided in hospitals in this State.

Existing law creates the Office for Consumer Health Assistance within the Office of the Governor and prescribes the duties of the Director of the Office for Consumer Health Assistance. (NRS 223.500-223.580) Section 19 of this bill requires the Director to track and report certain information relating to complaints filed pertaining to the charges of medical services and care and the resolutions of those complaints. Section 20 of this bill appropriates $150,000 to the Office for Consumer Health Assistance.

Section 21 of this bill provides that the provisions of this bill expire by limitation on June 30, 2011.

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 ~~[a new section to read as follows:]~~ *the provisions set forth as sections 2 to 17, inclusive, of this act.*

Sec. 2. *As used in sections 2 to 17, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 11, 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 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. *1. ~~[A]~~ Except as otherwise provided in subsection 3, an out-of-network hospital with 100 or more beds that is not operated by a federal, state or local governmental agency shall ~~[charge]~~ accept as payment in full for the provision of services and care to a patient a rate which is in accordance with subsection 2 if the patient:*

(a) Was transported to the 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 at least one hospital in this State other than the hospital to which the patient was transported.

2. ~~[A]~~ Except as otherwise provided in subsection 3, 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) Emergency services and care; and

(b) Any other services and care before the patient may be transferred safely to another hospital pursuant to NRS 439B.410,

➥ shall ~~[not charge]~~ accept as payment in full for such services and care a rate which is ~~[greater than 200 percent of the amount Medicare would pay for the specific service and care.]~~ equal to the usual and customary charge prescribed for that service and care by the Department pursuant to section 17 of this act. The amount accepted must include any deductible, copayment or coinsurance paid by the patient.

~~3. [A physician on the medical staff of a hospital with 100 or more beds shall charge for the provision of services and care to a patient in accordance with subsection 4 if the patient:~~

~~(a) Was transported to the 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 at least one physician in this State other than the physician who provided the services and care at the hospital to which the patient was transported.~~

~~4. A physician on the medical staff of a hospital with 100 or more beds who provides to a patient described in subsection 3:~~

~~(a) Emergency services and care; and~~

~~(b) Any other services and care before the patient may be transferred safely to another hospital pursuant to NRS 439B.410,~~

~~" shall not charge for such services and care a rate which is greater than 200 percent of the amount Medicare would pay for the specific service and care.~~

~~5. As used in this section:~~

~~(a) "Air ambulance" has the meaning ascribed to it in NRS 450B.030.~~

~~(b) "Ambulance" has the meaning ascribed to it in NRS 450B.040.~~

~~(c) "Emergency services and care" has the meaning ascribed to it in NRS 439B.410.~~

~~(d) "Fire-fighting agency" has the meaning ascribed to it in NRS 450B.072.~~

~~(e) "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 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.]~~ *An out-of-network hospital is not required to accept as payment in full the amount specified pursuant to subsection 2 if:*

(a) The third party that issued the policy of insurance or other contractual agreement which provides coverage to the patient has not submitted reports pursuant to section 15 of this act;

(b) The third party which provides coverage to the patient has not, in good faith, negotiated with the hospital to resolve the difference between the amount charged by the hospital and the amount paid by the third party and has not documented the occurrence and outcome of any negotiations; or

(c) The patient has not paid the deductible, copayment or coinsurance that the patient would have paid for the provision of health care at an in-network hospital.

Sec. 13. *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 services and care to a patient a rate in accordance with subsection 2 if the patient:*

(a) Was transported to the 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 at least one physician in this State who provides the type of services and care other than the physician who provided the services and care at the hospital to which the patient was transported.

2. Except as otherwise provided in subsection 3, an out-of-network physician on the medical staff of an out-of-network hospital with 100 or more beds who provides to a patient described in subsection 1:

(a) Emergency services and care; and

(b) Any other services and care before the patient may be transferred safely to another hospital pursuant to NRS 439B.410,

➥ shall accept as payment in full for such services and care a rate which is not greater than 200 percent of the amount Medicare would pay for the specific service and care. The amount accepted must include any deductible, copayment or coinsurance paid by the patient.

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 third party that issued the policy of insurance or other contractual agreement which provides coverage for the patient has not submitted reports pursuant to section 15 of this act;

(b) The third party has not, in good faith, negotiated with the physician to resolve the difference between the amount charged by the physician and the amount paid by the third party and has not documented the occurrence and outcome of any negotiations; or

(c) 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.

Sec. 14. *1. Except as otherwise provided in this section, 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 any services and care to a 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 health care by at least 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 subsection 3, an out-of-network physician on the medical staff of an in-network hospital with 100 or more beds who provides to a patient described in subsection 1 any services and care shall accept as payment in full for such services and care a rate which is not greater than 200 percent of the amount Medicare would pay for the specific service and care. The amount accepted must include any deductible, copayment or coinsurance paid by the patient.

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 third party that issued the policy of insurance or other contractual agreement has not submitted reports pursuant to section 15 of this act;

(b) The third party has not, in good faith, negotiated with the physician to resolve the difference between the amount charged by the physician and the amount paid by the third party and has not documented the occurrence and outcome of any negotiations; or

(c) 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.

Sec. 15. *Each third party who issues a policy of insurance or other contractual agreement that provides coverage for health care in this State may:*

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) A review of 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 contracted with a sufficient number of providers of health care to ensure access to emergency services and care; and

(d) A review of 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 services and care from an out-of-network physician on the medical staff of an in-network hospital.

4. Submit once each calendar quarter to the Department and the Legislative Committee on Health Care a summary of the reviews conducted pursuant to subsections 1 and 2 and the educational efforts undertaken pursuant to subsection 3.

Sec. 16. ***Each physician who provides services and care in a hospital in this State shall submit a complete and current list of all billed charges of the physician for those services performed in a hospital to the Department in an electronic format prescribed by the Department. The Department shall use the electronic copy of the list of billed charges to review and analyze the data contained in the list and, except as otherwise provided in section 17 of this act, shall not release or publish the information contained in the list.***

Sec. 17. ***1. The Department shall annually review and analyze the data contained in the lists of billed charges submitted pursuant to section 16 of this act and the charge masters submitted pursuant to subsection 4 of NRS 449.490 and determine the usual and customary charges for each specific type of service and care provided in hospitals in this State. The usual and customary charges may be different for each region of the State if the Department determines such differences are necessary to accurately reflect the usual and customary rates in those regions.***

2. The Department shall publish a list of each third party that submits the summaries pursuant to section 15 of this act.

3. The Department may adopt regulations to carry out the provisions of sections 2 to 17, inclusive, of this act.

Sec. 18. **NRS 449.490 is hereby amended to read as follows:**

449.490 1. Every institution which is subject to the provisions of NRS 449.450 to 449.530, inclusive, shall file with the Department the following financial statements or reports in a form and at intervals specified by the Director but at least annually:

(a) A balance sheet detailing the assets, liabilities and net worth of the institution for its fiscal year; and

(b) A statement of income and expenses for the fiscal year.

2. Each hospital with 100 or more beds shall file with the Department, in a form and at intervals specified by the Director but at least annually, a capital improvement report which includes, without limitation, any major service line that the hospital has added or is in the process of adding since the previous report was filed, any major expansion of the existing facilities of the hospital that has been completed or is in the process of being completed since the previous report was filed, and any major piece of equipment that the hospital has acquired or is in the process of acquiring since the previous report was filed.

3. In addition to the information required to be filed pursuant to subsections 1 and 2, each hospital with 100 or more beds shall file with the Department, in a form and at intervals specified by the Director but at least annually:

(a) The corporate home office allocation methodology of the hospital, if any.

(b) The expenses that the hospital has incurred for providing community benefits and the in-kind services that the hospital has provided to the community in which it is located. For the purposes of this paragraph, "community benefits" includes, without limitation, goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, services provided by a hospital to the uninsured and underserved persons in that community, training programs for employees in a community and health care services provided in areas of a community that have a critical shortage of such services, for which the hospital does not receive full reimbursement.

(c) A statement of its policies and procedures for providing discounted services to, or reducing charges for services provided to, persons without health insurance that are in addition to any reduction or discount required to be provided pursuant to NRS 439B.260.

(d) A statement of its policies regarding patients' account receivables, including, without limitation, the manner in which a hospital collects or makes payment arrangements for patients' account receivables, the factors that initiate collections and the method by which unpaid account receivables are collected.

4. A complete current charge master must be available at each hospital during normal business hours for review by the Director, any payor that has a contract with the hospital to pay for services provided by the hospital, any payor that has received a bill from the hospital and any state agency that is authorized to review such information. The ***hospital shall submit the*** complete and current charge master ~~[must be made available]~~ to the Department ~~[, at the request of the Director,]~~ in an electronic format specified by the Department. The Department ~~[may]~~ ***shall*** use the electronic copy of the charge master to review and analyze the data contained in the charge master and, except as otherwise provided in NRS 439A.200 to 439A.290, inclusive, ***and section 17 of this act,*** shall not release or publish the information contained in the charge master.

5. The Director shall require the certification of specified financial reports by an independent certified public accountant and may require attestations from responsible officers of the institution that the reports are, to the best of their knowledge and belief, accurate and complete to the extent that the certifications and attestations are not required by federal law.

6. The Director shall require the filing of all reports by specified dates, and may adopt regulations which assess penalties for failure to file as required, but he shall not require the submission of a final annual report sooner than 6 months after the close of the fiscal year, and may grant extensions to institutions which can show that the required information is not available on the required reporting date.

7. All reports, except privileged medical information, filed under any provisions of NRS 449.450 to 449.530, inclusive, are open to public inspection and

must be available for examination at the office of the Department during regular business hours.

Sec. 19. **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; ~~[and]~~

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. ~~[.]~~ **;**

10. Track the complaints and inquiries from persons who received medical services and care that was not covered by a health care plan, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance in this State, which must include, without limitation:

(a) The total number of such complaints that were filed with the Office for Consumer Health Assistance;

(b) A list of each physician, health care plan and hospital against which a complaint is filed;

(c) The concessions made by each physician, health care plan and hospital in reaching a resolution to the complaint; and

(d) The percentage of complaints that are resolved by negotiating discounts from the amount initially charged by the physician or hospital, the percentage of complaints that are resolved by negotiating an increase in the amount initially paid by the health care plan and the percentage of complaints that are resolved by negotiating both a discount and an increase; and

11. Each quarter, submit to the Legislative Committee on Health Care a report concerning the complaints filed by consumers against physicians, health care plans and hospitals in this State and any other information required by the Committee.

Sec. 20. **1. There is hereby appropriated from the State General Fund to the Office for Consumer Health Assistance the sum of $150,000 for support of the Office and personnel necessary to carry out the provisions of NRS 223.560, as amended by section 19 of this act.**

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2011, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 16, 2011, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 16, 2011.

~~[Sec. 2.]~~ ***Sec. 21.*** This act becomes effective on July 1, 2009~~.~~ **~~[.]~~ , and expires by limitation on June 30, 2011.**