Amendment No. 846

Senate Amendment to Senate Bill No. 115 (BDR 40-192)
Proposed by: Senate Committee on Finance
Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes

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 underlining** is newly added transitory language.

RBL Date: 6/2/2011

S.B. No. 115—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)

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.]~~ **Provides requirements** 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]~~ **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; ~~[revising provisions relating to the duties of the Director of the Office for Consumer Health Assistance;]~~ requiring the ~~[Commissioner of Insurance]~~ **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; ~~[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 **any medical screening and** emergency services and care to ~~[certain patients a rate]~~ **stabilize a patient who arrives at the out-of-network hospital through an emergency transport an amount** 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)~~ **equals 115 percent of the amount set forth in the schedule of fees and charges established by the Division of Industrial Relations of the Department of Business and Industry for costs associated with services and care provided to a patient for treatment other than treatment of a traumatic injury, and 120 percent of the amount set forth in that schedule of fees and charges for costs associated with services and care provided to the patient for treatment of a traumatic injury.** **Section 14** of this bill **similarly** 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 **medical screening and** emergency services and care ~~[, other than services and care provided]~~ to stabilize a patient ~~[, a rate]~~ **an amount** 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.]~~ **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 allow an out-of-network hospital and an out-of-network physician to negotiate a different amount 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. In addition, section 13 requires that a patient be transferred to an in-network hospital within a certain period after which the third party will be responsible for the billed charges if the patient has not been transferred. 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** ~~[, 15]~~ **and 14** to maintain an adequate network of providers and submit certain reports to the ~~[Commissioner of Insurance]~~ **Administrator of the Health Division of the Department of Health and Human Services** and to the Legislative Committee on Health Care. **Section** ~~[18]~~ **1** of this bill requires the ~~[Commissioner of Insurance]~~ **Administrator of the Health Division** to ~~[prescribe the standards of adequacy for the networks of third parties in this State and 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.**

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter ~~[439B]~~ **439** of NRS is hereby amended by adding thereto ~~[the provisions set forth as sections 2 to 16, inclusive, of this act.]~~ **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,]~~ 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. ~~*[*"Third*]*~~

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

~~*[1.]*~~ *(a) An insurer, as that term is defined in NRS 679B.540;*

~~[2.]~~ (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;

~~[3.]~~ (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

~~[4.]~~ (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" ~~[has]~~ and "stabilized" have the ~~[meaning]~~ meanings ascribed to ~~[it]~~ 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 1 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 ~~[subsections 3 and 4,]~~ 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 ~~[a rate]~~ an amount in accordance with subsection 2 if : ~~[the patient:]~~

(a) ~~[Was]~~ The patient 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]~~ 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 ~~[provided by]~~ ; and

(c) The third party that provides coverage to the patient has more than one in-network hospital in this State . ~~[other than the hospital to which the patient was transported.]~~

2. Except as otherwise provided in ~~[subsections 3 and 4,]~~ 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 ~~[a rate]~~ an amount 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.~~

~~4. 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.]~~ equals:

(a) For costs associated with 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 costs associated with 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 hospital is not required to accept as payment in full the amount ~~[specified pursuant to]~~ 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 ~~[determined]~~ prescribed by the ~~[Commissioner of Insurance]~~ Administrator of the Health Division of the Department pursuant to section ~~[18]~~ 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) ~~[The]~~ 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 ; ~~and has not documented the occurrence and outcome of any negotiation or mediation;]~~

(d) The patient ~~[has not paid]~~ 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 explaining the amount owed by the patient; or

(e) The third party ~~[has not paid]~~ does not pay the out-of-network hospital for the emergency services and care within ~~[60]~~ 30 days after receipt of the bill or, if applicable, within ~~[60]~~ 30 days after the conclusion of any negotiation , ~~[or]~~ mediation , arbitration or action between the third party and the out-of-network 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]~~ do not provide a fair and reasonable rate of return in relation to the ~~[emergency]~~ 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 ~~[resolve the difference between the amount charged by the hospital and the amount paid by the third party,]~~ reach an agreement regarding a fair and reasonable rate of return. If such negotiations do not result in an agreement ~~[on the amount that will be paid for the emergency services and care,]~~ regarding a fair and reasonable rate of return, 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,]~~ 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.

5. A person who is covered by a policy of insurance or other contractual agreement that provides coverage for the provision of health care who is a patient at an out-of-network hospital must be transferred to an in-network hospital within 12 hours after:

(a) The out-of-network hospital becomes aware that the patient is covered by the third party; or

(b) The out-of-network hospital informs the third party that the patient has been stabilized,

➥ whichever is later, 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 12 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.

Sec. 14. *1. Except as otherwise provided in this section, an out-of-network physician ~~[on the medical staff of an out-of-network]~~ 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 ~~[a patient, other than services and care provided to]~~ stabilize the patient ~~[, a rate]~~ an amount in accordance with subsection 2 if : ~~[the patient:]~~*

(a) ~~[Was]~~ The patient 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]~~ 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]~~ ; and

(c) The third party has more than one in-network physician in this State who provides the type of services and care ~~[other than]~~ that were provided by 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,]~~ this section, an out-of-network physician ~~[on the medical staff of an out-of-network hospital with 100 or more beds that]~~ who provides to a patient described in subsection 1 a medical screening or emergency services and care ~~[, other than services and care provided]~~ to stabilize the patient ~~[,]~~ shall accept as payment in full for such medical screening or emergency services and care ~~[a rate]~~ an amount 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.]~~ *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 ~~[specified pursuant to]~~ 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 ~~[determined]~~ prescribed by the ~~[Commissioner of Insurance]~~ Administrator of the Health Division of the Department pursuant to section ~~[18]~~ 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) ~~[The]~~ 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 ; ~~[and has not documented the occurrence and outcome of any negotiation or mediation;]~~

(d) The patient ~~[has not paid]~~ 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 explaining the amount owed by the patient; or

(e) The third party ~~[has not paid]~~ does not pay the out-of-network physician for the services and care within ~~[60]~~ 30 days after receipt of the bill or, if

applicable, within ~~[60]~~ 30 days after the conclusion of any negotiation , ~~[or]~~ 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 ~~[are insufficient to compensate the out-of-network physician for]~~ do not provide a fair and reasonable rate of return in relation to the ~~[emergency]~~ 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 ~~[resolve the difference between the amount charged by the physician and the amount paid by the third party.]~~ reach an agreement regarding a fair and reasonable rate of return. If such negotiations do not result in an agreement ~~[on the amount that will be paid for emergency services and care,]~~ regarding a fair and reasonable rate of return, 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.]~~ 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. If a patient remains at an out-of-network hospital after the time by which the patient is required to be transferred pursuant to subsection 5 of section 13 of this act to an in-network hospital, the third party 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 4 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. ~~*[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.]~~ **(Deleted by amendment.)**

Sec. 16. *1. If a third party ~~[who]~~ 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 ~~[and 15]~~ of this act, the third party shall:*

~~[1. Review]~~

(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:

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

~~[(b)]~~ (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;

~~[(c)]~~ (4) Whether the third party has an adequate number of providers of health care in its network to ensure access to ~~[medical]~~ emergency services and care, as determined by the ~~[Commissioner of Insurance]~~ Administrator of the Health Division of the Department pursuant to section ~~[18]~~ 1 of this act; and

~~[(d)]~~ (5) The in-network hospitals which provide medical screenings and emergency services and care and the number and type of in-network physicians ~~[on the medical staff of]~~ who have privileges at 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]~~ at those in-network hospitals.

~~[2.]~~ (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 ~~[are treated for]~~ 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.

~~[3.]~~ (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]~~ 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]~~ medical screenings and emergency services and care from an out-of-network physician ~~[on the medical staff of]~~ at an in-network hospital. The information must be provided in a format that is meaningful for persons making an informed decision concerning ~~[medical]~~ medical screenings and emergency services and care and must be accessible to persons covered by the policy of insurance or other contractual agreement.

~~[4.]~~ (d) Submit once each calendar quarter to the ~~[Commissioner of Insurance]~~ Administrator of the Health Division of the Department and the Legislative Committee on Health Care a report containing a summary of the ~~[reviews conducted pursuant to subsections 1 and 2]~~ information collected pursuant to this subsection and the educational efforts undertaken pursuant to ~~[subsection 3,]~~ 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.

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.]~~ **(Deleted by amendment.)**

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.]*~~ **(Deleted by amendment.)**

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.]~~ **(Deleted by amendment.)**

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.]~~ **(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 ~~[rate]~~ **amount** of payment set forth in sections 13 ~~[,]~~ **and** 14 ~~[and 15]~~ of this act, to determine whether ~~[providers of health care]~~ **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 ~~[rate]~~ **amount** of payment ~~[set forth in]~~ **prescribed by** sections 13 ~~[,]~~ **and** 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.]~~