

ASSEMBLY BILL NO. 469—COMMITTEE ON  
HEALTH AND HUMAN SERVICES

MARCH 25, 2019

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions governing billing for certain medically necessary emergency services. (BDR 40-704)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.  
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; limiting the amount a provider of health care may charge a person who has health insurance for certain medically necessary emergency services provided when the provider is out-of-network; requiring a health care facility to transfer a person who has health insurance to another facility under certain circumstances; prescribing procedures for determining the amount that an insurer is required to pay a provider of health care which is out-of-network for certain medically necessary emergency services provided to an insured; 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, which is an insurer. (NRS 439B.260) **Section 7** of this bill defines the term "out-of-network provider" to mean, for a particular person covered by a policy of health insurance, a provider of health care, hospital or independent center for emergency medical care that 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 which provides coverage to the patient and which is issued by that third party. **Section 14** of this bill prohibits an out-of-network provider from charging a person covered by a policy of health insurance an amount for medically necessary emergency services that exceeds the copayment,



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coinsurance or deductible required by that policy. **Section 14** also requires an out-of-network facility that provides medically necessary emergency services to a covered person to: (1) notify the third party that provides coverage for the person that the person is receiving such services at the facility; and (2) transfer the covered person to an in-network facility not later than 24 hours after the person's emergency medical condition is stabilized.

If an out-of-network provider had a contract as an in-network provider with the third party that provides coverage for the covered person within the 24 months immediately preceding the provision of medically necessary emergency services to a covered person, **section 15** of this bill requires the third party to pay, and the provider to accept, as compensation for those services an amount based on the amount that would have been paid for those services under the most recent contract between the third party and the provider. If an out-of-network provider did not have a contract as with the third party that provides coverage for the covered person as an in-network provider during that time, **section 15** requires the third party to make a final offer of payment to the provider for the medically necessary emergency services. If the provider does not accept the offer, **section 15** requires the parties to submit the dispute to binding arbitration. **Section 13** of this bill exempts a critical access hospital and a person covered by a policy of insurance sold outside this State from the provisions of this bill.

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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 the provisions set forth as sections 2 to 15, inclusive, of this act.

**Sec. 2.** *As used in sections 2 to 15, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 12, inclusive, of this act have the meanings ascribed to them in those sections.*

**Sec. 3.** *"Covered person" means a patient who has health insurance coverage issued by a third party.*

**Sec. 4.** *"Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.*

**Sec. 5.** *"In-network provider" means, for a particular covered person, a provider of health care, hospital or independent center for emergency medical care that 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. 6.** *"Medically necessary emergency services" means health care services that are provided by a provider of health care to screen and to stabilize a covered person after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent layperson would believe that the absence of immediate medical attention could result in:*



- 1       1. *Serious jeopardy to the health of the covered person;*
- 2       2. *Serious jeopardy to the health of an unborn child of the*
- 3 *covered person;*
- 4       3. *Serious impairment of a bodily function of the covered*
- 5 *person; or*
- 6       4. *Serious dysfunction of any bodily organ or part of the*
- 7 *covered person.*

8       **Sec. 7.** *“Out-of-network provider” means, for a particular*  
9 *covered person, a provider of health care, hospital or independent*  
10 *center for emergency medical care that has not entered into a*  
11 *contract with a third party for the provision of health care to*  
12 *persons who are covered by a policy of insurance which provides*  
13 *coverage to the patient and which is issued by that third party.*

14       **Sec. 8.** *“Provider of health care” has the meaning ascribed*  
15 *to it in NRS 629.031.*

16       **Sec. 9.** *“Prudent layperson” means a person who:*

- 17       1. *Is not a provider of health care;*
- 18       2. *Possesses an average knowledge of health and medicine;*
- 19 *and*
- 20       3. *Is acting reasonably under the circumstances.*

21       **Sec. 10.** *“Screen” means to conduct the medical screening*  
22 *examination required to be provided to a patient in the emergency*  
23 *department of a hospital pursuant to 42 U.S.C. § 1395dd.*

24       **Sec. 11.** *“Third party” includes, without limitation:*

- 25       1. *An insurer, as defined in NRS 679B.540;*
- 26       2. *A health benefit plan, as defined in NRS 689A.540, for*
- 27 *employees which provides coverage for medically necessary*
- 28 *emergency services;*
- 29       3. *A participating public agency, as defined in NRS*
- 30 *287.04052, and any other local governmental agency of the State*
- 31 *of Nevada which provides a system of health insurance for the*
- 32 *benefit of its officers and employees, and the dependents of such*
- 33 *officers and employees, pursuant to chapter 287 of NRS;*
- 34       4. *The Public Employees’ Benefits Program established*
- 35 *pursuant to subsection 1 of NRS 287.043; and*
- 36       5. *Any other insurer or organization providing health*
- 37 *coverage or benefits in accordance with state or federal law.*

38       **Sec. 12.** *“To stabilize” and “stabilized” have the meanings*  
39 *ascribed to them in 42 U.S.C. § 1395dd(e)(3).*

40       **Sec. 13.** *The provisions of sections 14 and 15 of this act do*  
41 *not apply to:*

- 42       1. *A hospital which has been certified as a critical access*
- 43 *hospital by the Secretary of Health and Human Services pursuant*
- 44 *to 42 U.S.C. § 1395i-4(e) or any medically necessary emergency*
- 45 *services provided at such a hospital;*



2. A person who is covered by a policy of health insurance that was sold outside this State; or

3. Any health care services provided after a person has been stabilized.

**Sec. 14.** 1. An out-of-network provider shall not charge a covered person for medically necessary emergency services an amount that exceeds the copayment, coinsurance or deductible required for the services by the coverage for that person.

2. An out-of-network facility that provides medically necessary emergency services to a covered person shall:

(a) When possible, notify the third party that provides coverage for the covered person not later than 3 hours after admitting the covered person that the covered person is receiving medically necessary emergency services at the out-of-network facility; and

(b) Transfer the covered person to an in-network facility not later than 24 hours after the person's emergency medical condition is stabilized.

3. As used in this section:

(a) "In-network facility" means, for a particular covered person, a hospital or independent center for emergency medical care that 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.

(b) "Out-of-network facility" means, for a particular covered person, a hospital or independent center for emergency medical care that 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. 15.** 1. If an out-of-network provider had a contract as an in-network provider within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage for the covered person shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services:

(a) If the out-of-network provider was an in-network provider within the 12 months immediately preceding the provision of medically necessary emergency services, 108 percent of the amount that would have been paid for those services pursuant to the most recent applicable contract between the third party and the out-of-network provider.

(b) If the out-of-network provider was an in-network provider within the 24 months immediately preceding the provision of



1 *medically necessary emergency services, but not within the 12*  
2 *months immediately preceding the provision of those services, 115*  
3 *percent of the amount that would have been paid for those services*  
4 *pursuant to the most recent applicable contract between the third*  
5 *party and the out-of-network provider.*

6 2. *If an out-of-network provider did not have a contract as an*  
7 *in-network provider within the 24 months immediately preceding*  
8 *the date on which the medically necessary emergency services*  
9 *were rendered to a covered person, the third party that provides*  
10 *coverage to the covered person shall submit to the out-of-network*  
11 *provider an offer of payment in full for the medically necessary*  
12 *emergency services. The out-of-network provider shall accept or*  
13 *reject the offer of payment within 30 days after receiving the offer.*  
14 *If the offer is accepted, the third party must pay the claim within*  
15 *30 days after the acceptance.*

16 3. *An offer made by a third party pursuant to subsection 2 as*  
17 *payment in full for medically necessary emergency services must*  
18 *include a statement of the provisions of subsections 4 to 7,*  
19 *inclusive.*

20 4. *If an out-of-network provider rejects the amount offered as*  
21 *payment in full by the third party to compensate the out-of-*  
22 *network provider for the medically necessary emergency services,*  
23 *the out-of-network provider must submit to the third party a*  
24 *counter-offer in an amount which the out-of-network provider is*  
25 *willing to accept as payment in full for the medically necessary*  
26 *emergency services.*

27 5. *If the third party rejects the counter-offer submitted by the*  
28 *out-of-network provider pursuant to subsection 4 or fails to accept*  
29 *such a counter-offer within 30 days after receiving the counter-*  
30 *offer, the out-of-network provider must request a list of five*  
31 *randomly selected arbitrators from the voluntary program for the*  
32 *use of binding arbitration established in the judicial district*  
33 *pursuant to NRS 38.255 or, if no such program has been*  
34 *established in the judicial district, from the program established in*  
35 *the nearest judicial district that has established such a program.*

36 6. *Upon receiving the list of randomly selected arbitrators*  
37 *pursuant to subsection 5, the out-of-network provider and the*  
38 *third party shall each strike two arbitrators from the list. If one*  
39 *arbitrator remains, that arbitrator must arbitrate the dispute*  
40 *concerning the amount to be paid for the medically necessary*  
41 *emergency services. If more than one arbitrator remains, an*  
42 *arbitrator randomly selected from the remaining arbitrators by the*  
43 *voluntary program for the use of binding arbitration that provided*  
44 *the list of arbitrators pursuant to subsection 5 must arbitrate that*  
45 *dispute.*



1       7. The out-of-network provider and the third party shall  
2 participate in binding arbitration of the dispute concerning the  
3 amount to be paid for the medically necessary emergency services  
4 conducted by the arbitrator selected pursuant to subsection 6. The  
5 arbitrator shall require the third party to pay the out-of-network  
6 provider, and the out-of-network provider to accept as payment in  
7 full for the provision of the medically necessary emergency  
8 services:

9       (a) The amount offered by the third party pursuant to  
10 subsection 2; or

11       (b) The amount counter-offered by the out-of-network  
12 provider pursuant to subsection 4.

13       8. If the arbitrator requires:

14       (a) The out-of-network provider to accept as payment in full  
15 for the medically necessary emergency services the offer made by  
16 the third party pursuant to subsection 2, the out-of-network  
17 provider must pay the costs of the arbitration.

18       (b) The third party to pay to the out-of-network provider as  
19 payment in full for the medically necessary emergency services the  
20 amount counter-offered by the out-of-network provider pursuant  
21 to subsection 4, the third party must pay the costs of the  
22 arbitration.

23       9. A third party that provides coverage for emergency medical  
24 services pursuant to Employee Retirement Income Security Act of  
25 1974, 29 U.S.C. §§ 1001 et seq., may elect for the provisions of this  
26 section to apply to the provision of medically necessary emergency  
27 services by out-of-network providers to covered persons. The  
28 Commissioner shall:

29       (a) Publish on an Internet website maintained by the  
30 Commissioner a list of third parties that have made such an  
31 election; and

32       (b) Adopt regulations governing such an election, which may  
33 include, without limitation, regulations that establish the  
34 procedure by which a third party may make such an election.

