SENATE BILL NO. 290–SENATOR HARDY

MARCH 18, 2019

Referred to Committee on Commerce and Labor

SUMMARY—Requires network plans to reimburse out-of-network providers of health care for certain services. (BDR 57-72)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

CONTAINS UNFUNDED MANDATE (§ 9)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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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 insurance; requiring a health carrier that issues a network plan to provide for the reimbursement of unanticipated out-of-network care that is provided by an out-of-network provider of health care; authorizing an out-of-network provider of health care to seek the recovery of the deductible, coinsurance or copayment from a covered person for such care; requiring an out-of-network provider of health care who receives reimbursement in the amount specified to accept the reimbursement as payment in full; providing that any provision of a network plan which conflicts with such requirements for reimbursement is void; requiring a health carrier to ensure that each network plan of the health carrier includes certain information; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law sets forth certain requirements governing network plans. (NRS 687B.600-687B.850) Existing law defines a network plan as a policy, contract, certificate or agreement of health insurance that: (1) is offered or issued by a health carrier; and (2) pays for or delivers health care services which are provided through a defined group of providers of health care who are under contract with the health carrier. (NRS 687B.645) Existing law defines a health carrier as an entity that contracts to reimburse any of the costs of health care services. (NRS 687B.625)

Sections 2-13 of this bill requires health carriers that issue network plans to provide for the reimbursement of unanticipated out-of-network care that is provided by an out-of-network provider of health care. In order to receive reimbursement for unanticipated out-of-network care, **section 7** of this bill requires an out-of-network provider of health care to submit a claim for reimbursement directly to the health carrier. **Section 8** of this bill authorizes an out-of-network provider of health care to recover the deductible, copayment or coinsurance from the covered person who received the unanticipated out-of-network care. **Section 9** of this bill requires a health carrier, within 30 days after receiving a claim for reimbursement, to reimburse the out-of-network provider of health care up to certain amounts. **Section 10** of this bill requires an out-of-network provider of health care to accept such reimbursement as payment in full and prohibits the out-of-network provider of health care from seeking additional reimbursement from the covered person who received the unanticipated out-of-network care. **Section 13** of this bill provides that any provision of a network plan which conflicts with **sections 2-13** is void.

Existing law requires a health carrier that offers or issues a network plan to: (1) comply with the requirements governing network plans; and (2) ensure that the network plan complies with such requirements. (NRS 687B.670) **Section 15** of this bill requires a health carrier that offers or issues a network plan to also: (1) ensure that its network plans clearly disclose that the health carrier shall reimburse an out-of-network provider of health care for any unanticipated out-of-network care; and (2) provide a directory listing all participating providers of health care.

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

Section 1. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 13, inclusive, of this act.

Sec. 2. ***"Medically necessary emergency services" means health care services that are provided to a covered person by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:***

1. Serious jeopardy to the health of a covered person;

2. Serious jeopardy to the health of an unborn child;

3. Serious impairment of a bodily function; or

4. Serious dysfunction of any bodily organ or part.

Sec. 3. ***"Out-of-network provider of health care" means a provider of health care who:***

1. Provides health care services; and

2. Is not a participating provider of health care.

Sec. 4. ***"Unanticipated out-of-network care" means:***

1. Any health care services received by a covered person from an out-of-network provider of health care when the covered person did not have the ability or control to select such health care services from a participating provider of health care; or

2. Any medically necessary emergency services provided to a covered person by an out-of-network provider of health care.

Sec. 5. *"Uncovered services" means any health care services received by a covered person from an out-of-network provider of health care that are not unanticipated out-of-network care.*

Sec. 6. *1. A health carrier which offers or issues a network plan shall provide in the network plan for the reimbursement of unanticipated out-of-network care that is provided by an out-of-network provider of health care to a covered person upon submission of a claim by the out-of-network provider of health care.*

2. Such provisions of reimbursement described in subsection 1 must include the provisions set forth in sections 7 to 13, inclusive, of this act.

Sec. 7. *An out-of-network provider of health care who has provided unanticipated out-of-network care to a covered person must submit a claim for reimbursement directly to the health carrier of the covered person.*

Sec. 8. *1. The health carrier of the covered person shall notify the out-of-network provider of health care of any deductible, copayment or coinsurance requirement of the covered person within 10 business days of receiving a claim for reimbursement from the out-of-network provider of health care for the reimbursement of unanticipated out-of-network care pursuant to section 7 of this act.*

2. Upon receiving a notice concerning the deductible, copayment or coinsurance requirements of the covered person pursuant to subsection 1, the out-of-network provider of health care may submit to the covered person a claim for reimbursement for not more than the deductible, copayment or coinsurance of the covered person that would be applicable if the unanticipated out-of-network care had been provided by a participating provider of health care.

3. The health carrier must treat any deductible, copayment or coinsurance paid by the covered person to the out-of-network provider of health care as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that a covered person must pay.

Sec. 9. *A health carrier that receives a claim for reimbursement from an out-of-network provider of health care for the reimbursement of unanticipated out-of-network care pursuant to section 7 of this act shall provide reimbursement directly to the out-of-network provider of health care within 30 days after receipt of the claim in an amount equal to the lesser of:*

1. The amount billed by the out-of-network provider of health care in the claim submitted by the out-of-network provider of health care pursuant to section 7 of this act; or

2. The 80th percentile of all charges for the particular service in the geographic area where the service was provided, as reported in the database selected by the Commissioner pursuant to section 12 of this act,

➥ less the amount of any deductible, copayment or coinsurance specified by the health carrier pursuant to subsection 1 of section 8 of this act.

Sec. 10. *1. An out-of-network provider of health care who receives reimbursement pursuant to section 9 of this act shall accept such reimbursement, combined with the amount of any deductible, copayment or coinsurance paid by the covered person pursuant to subsection 2 of section 8 of this act, as payment in full for the unanticipated out-of-network care provided.*

2. If the reimbursement amount is based upon the 80th percentile as described in subsection 2 of section 9 of this act, the out-of-network provider of health care shall not send a claim for reimbursement to the covered person for any difference between the payments received by the out-of-network provider of health care pursuant to sections 8 and 9 of this act and the payments that would have been received by the out-of-network provider of health care if the reimbursement amount had been based on the claim for reimbursement that the out-of-network provider of health care submitted pursuant to section 7 of this act.

Sec. 11. *An out-of-network provider of health care that receives payment pursuant to section 9 of this act shall, if the covered person paid the out-of-network provider of health care directly for the unanticipated out-of-network care, refund to the covered person the amount that the covered person paid directly to the out-of-network provider of health care for such care, less any applicable deductible, copayment or coinsurance described in subsection 1 of section 8 of this act, not later than 45 days after the out-of-network provider of health care receives reimbursement pursuant to section 9 of this act.*

Sec. 12. *The Commissioner shall, by regulation, select a database containing benchmarks for charges for health care services provided by a provider of health care. The database selected pursuant to this section must:*

1. Distinguish among health care services provided on the basis of the:

(a) Provider of health care who provides such services; and

(b) Geographic area in which the health care services are provided; and

2. Be maintained by an organization which is not for profit and is independent of any health carrier or provider of health care.

Sec. 13. ***Any provision of a network plan which conflicts with any provision of sections 2 to 13, inclusive, of this act is void.***

Sec. 14. NRS 687B.600 is hereby amended to read as follows:

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, ***and sections 2 to 13, inclusive, of this act,*** unless the context otherwise requires, the words and terms defined in NRS 687B.605 to 687B.665, inclusive, ***and sections 2 to 5, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 15. NRS 687B.670 is hereby amended to read as follows:

687B.670 If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:

1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[;]~~ ***, and sections 2 to 13, inclusive, of this act;***

2. As applicable, ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ***,*** ~~[;]~~ and ***sections 2 to 13, inclusive, of this act;***

3. As applicable, ensure that the network plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***; and sections 2 to 13, inclusive, of this act;***

4. Ensure that the network plan clearly discloses:

(a) That the health carrier will reimburse an out-of-network provider of health care directly for any unanticipated out-of-network care provided to a covered person; and

(b) The methodology used to determine reimbursement for services provided by an out-of-network provider of health care; and

5. Provide to the covered person under the network plan a directory, in both an online and in-print version, that lists each participating provider of health care. The health carrier shall annually audit a reasonable sample size of the information of the participating providers of health care listed in the directory for accuracy. The health carrier shall update the online version of the directory at least once per month. The health carrier shall disclose in the in-print version of the directory that the directory was accurate at the time of printing and that a covered person should consult the online version of the directory to ensure that the information in the in-print version of the directory is current.

Sec. 16. NRS 687B.850 is hereby amended to read as follows:

687B.850 The Commissioner may adopt any regulations necessary to carry out the purposes and provisions of NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***, and sections 2 to 13, inclusive, of this act.***

Sec. 17. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 18. This act becomes effective on January 1, 2020.

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