ASSEMBLY BILL NO. 85–ASSEMBLYMAN ORENTLICHER

PREFILED JANUARY 30, 2023

Referred to Committee on Health and Human Services

SUMMARY—Establishes procedures to fix rates for certain health care goods and services. (BDR 40-169)

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

CONTAINS UNFUNDED MANDATE (§ 23)
(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 health care; creating the Independent Commission on Rates for Health Care Services; establishing procedures for fixing the rates charged by hospitals, independent centers for emergency medical care and surgical centers for ambulatory patients for certain goods and services; authorizing the imposition of a civil penalty and initiation of disciplinary action against such a facility that fails to comply with provisions concerning rate fixing; creating certain causes of action to enforce those provisions; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prescribes a procedure to determine the amount that a third party which provides health coverage to a person is required to pay to an out-of-network hospital, independent center for emergency medical care or other provider of health care for medically necessary emergency services rendered to that person. (NRS 439B.700-439B.760) Existing law also requires certain major hospitals to reduce the total billed charge by at least 30 percent for hospital services provided to certain patients who have no insurance or other contractual agreement for the payment of the charges by a third party that provides health coverage. (NRS 439B.260) **Sections 2-13** of this bill establish procedures to fix rates charged by hospitals, independent centers for emergency medical care and surgical centers for ambulatory patients for goods and services that are reimbursable through Medicare when provided to a patient who is: (1) not indigent; and (2) not covered by Medicare or Medicaid. **Sections 3-5** of this bill define necessary terms. **Section 6** of this bill creates the Independent Commission on Rates for Health Care Services,

which consists of members who are representatives of various health care and business entities. **Section 7** of this bill establishes procedures governing the meetings and operations of the Independent Commission.

Section 8 of this bill generally prohibits hospitals, independent centers for emergency medical care and surgical centers for ambulatory patients from charging rates different from those fixed under **sections 2-13**. **Section 9** of this bill requires the Independent Commission to fix rates to ensure that each health care facility is able to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to its employees. **Section 9** requires the Independent Commission to generally: (1) presume that the rates paid by Medicare allow a health care facility to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to employees; and (2) fix rates at that amount. However, **section 9** authorizes a health care facility to request a different rate if the health care facility determines the rates paid by Medicare do not allow the health care facility to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to employees. **Section 10** of this bill: (1) requires the Division of Health Care Financing and Policy of the Department of Health and Human Services to evaluate such requests; and (2) prescribes the procedure for evaluating such a request and the criteria that the Division is required to consider during the evaluation. **Section 11** of this bill: (1) requires the Division to make a recommendation on the request to the Independent Commission; (2) requires the Independent Commission to review that recommendation and issue an order fixing rates for the health care facility that requested a different rate; and (3) prescribes the procedure and requirements concerning such a recommendation and order relating to such a request. **Section 11** provides that such an order is valid for 1 year and authorizes a health care facility to request to renew a rate.

Section 12 of this bill requires the Division to adopt certain regulations governing rate fixing, including regulations establishing civil penalties to be imposed against a health care facility that violates provisions governing rate fixing. **Sections 13 and 21** of this bill provide for the imposition of disciplinary action against a health care facility for such a violation. **Section 13** also authorizes: (1) the Division or Attorney General to maintain a suit for an injunction against such a violation; and (2) any person or entity injured by such a violation to maintain a suit for damages. **Sections 14, 15 and 22-27** of this bill make conforming changes to clarify the application of or remove existing provisions concerning the rates that a health care facility may charge for certain services. **Sections 16-20 and 30** of this bill remove the applicability of provisions that establish a procedure for determining rates for medically necessary emergency medical care to hospitals and independent centers for emergency medical care because **sections 2-13** require the Independent Commission to fix the rates for such care.

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 13, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 13, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3, 4 and 5 of this act have the meanings ascribed to them in those sections.***

Sec. 3. *"Division" means the Division of Health Care Financing and Policy of the Department.*

Sec. 4. *"Health care facility" means:*

1. A hospital, as defined in NRS 449.012, other than a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

2. An independent center for emergency medical care, as defined in NRS 449.013.

3. A surgical center for ambulatory patients, as defined in NRS 449.019.

Sec. 5. *"Independent Commission" means the Independent Commission on Rates for Health Care Services created by section 6 of this act.*

Sec. 6. *1. The Independent Commission on Rates for Health Care Services is hereby created within the Division.*

2. The Governor shall appoint nine members to the Independent Commission.

3. Each member of the Independent Commission must:

(a) Be a citizen of the United States and resident of this State;

(b) Have demonstrated leadership skills in his or her professional and civil life; and

(c) Offer expertise, knowledge and experience in consumer advocacy, management of a company that offers health insurance to its employees, public health, finance, organized labor, health care or operation of a small business.

4. Not more than four members of the Independent Commission may be persons whose household income, during the tenure of the person on the Independent Commission or within the 12 months immediately preceding the appointment of the person to the Independent Commission, is derived from health care or a field related to health care.

5. At least one member of the Independent Commission must be a provider of health care in this State.

6. After the initial terms, each member of the Independent Commission serves for a term of 4 years, and members serve at the pleasure of the Governor. Each member of the Independent Commission continues in office until his or her successor is appointed. Any vacancy in the membership must be filled by the Governor for the remainder of the unexpired term. Each member may serve not more than two consecutive full terms.

7. Members of the Independent Commission serve without compensation but are entitled to the per diem allowance and travel expenses provided for state officers and employees generally.

8. A member of the Independent Commission who is an officer or employee of this State or a political subdivision of this State must be relieved from the duties of the member without loss of regular compensation so that the member may prepare for and attend meetings of the Independent Commission and perform any work necessary to carry out the duties of the Independent Commission in the most timely manner practicable. A state agency or political subdivision of this State shall not require an officer or employee who is a member of the Independent Commission to:

(a) Make up the time the member is absent from work to carry out the duties required as a member of the Independent Commission; or

(b) Take annual leave or compensatory time for the absence.

9. As used in this section, "provider of health care" means a person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

Sec. 7. *1. At its first meeting and annually thereafter, the Independent Commission shall elect a Chair from its members.*

2. The Independent Commission shall meet at the call of the Chair or the Governor as is necessary to achieve its objectives and carry out its duties.

3. A majority of the Independent Commission constitutes a quorum for the transaction of business and a majority of a quorum present at a meeting is sufficient for any official action taken by the Independent Commission.

4. The Division shall provide any additional personnel, facilities, equipment and supplies required by the Independent Commission to carry out the provisions of sections 2 to 13, inclusive, of this act.

Sec. 8. *1. A health care facility shall charge rates fixed in accordance with sections 2 to 13, inclusive, of this act for any goods or services described in subsection 2 that are provided to a patient who is not covered by Medicare, Medicaid or the Children's Health Insurance Program and is not entitled to relief under the provisions of chapter 428 of NRS.*

2. The provisions of sections 2 to 13, inclusive, of this act apply to goods and services that are reimbursable through Medicare. As used in this subsection, "reimbursable" means that Medicare provides reimbursement for a good or service when that good or service is provided to a patient who is covered by Medicare.

3. A health care facility shall not provide any person with a discount, incentive or price reduction or enter into any arrangement where the effective amount paid to the health care

facility for goods or services is different from the rate established for those goods or services pursuant to sections 2 to 13, inclusive, of this act.

4. To the extent of their applicability, the provisions of sections 2 to 13, inclusive, of this act supersede any other provision of law relating to the rates charged by a health care facility, including, without limitation, provisions requiring or authorizing reduced or discounted rates.

Sec. 9. *1. The Independent Commission shall fix rates pursuant to sections 2 to 13, inclusive, of this act to ensure that each health care facility is able to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to employees. If a health care facility does not request a different rate pursuant to subsection 2, the Independent Commission shall:*

(a) Presume that the rates at which Medicare provides reimbursement for the goods and services provided by the health care facility allow the health care facility to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to employees; and

(b) Fix the rates that the health care facility may charge for goods or services at rates equal to the rates set forth in paragraph (a).

2. A health care facility which determines that the rates set forth in paragraph (a) of subsection 1 do not allow the health care facility to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to employees may, on or before March 1 of any year, submit to the Independent Commission a request for a rate different from the rate set forth in paragraph (a) of subsection 1. A request for different rates:

(a) May apply to particular goods or services provided by the health care facility or to all goods and services provided by the health care facility.

(b) Must include, without limitation:

(1) The goods and services for which the health care facility is requesting a different rate;

(2) An explanation of why the health care facility is unable to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to employees charging the rates set forth in paragraph (a) of subsection 1;

(3) The rates that the health care facility has determined are necessary to cover reasonable costs, earn a fair and reasonable profit and provide fair and adequate compensation to employees; and

(4) Any other information required by the regulations adopted pursuant to section 12 of this act.

Sec. 10. *1. The Independent Commission shall refer requests submitted pursuant to subsection 2 of section 9 of this act to the Division for evaluation pursuant to this section.*

2. When evaluating requests submitted pursuant to subsection 2 of section 9 of this act, the Division shall ensure that each health care facility is able to cover reasonable costs and earn a fair and reasonable profit and that the employees of the facility are able to receive fair and adequate compensation. The health care facility that submitted the request has the burden of demonstrating that the health care facility will not cover reasonable costs, earn a fair and reasonable profit or provide fair and adequate compensation to employees charging the rates set forth in paragraph (a) of subsection 1 of section 9 of this act. When determining whether a health care facility has met that burden and, if so, the appropriate rate, the Division shall consider, without limitation:

(a) The relative populations of persons and entities who pay for goods and services provided by the health care facility and the relative amounts of reimbursement paid by those persons and entities;

(b) Where applicable, the disparities in compensation between providers of primary care and specialty services or between providers of different types of specialty services;

(c) The effectiveness and efficiency of the services provided by the health care facility;

(d) Any financial hardship that rapidly reducing the rates that a health care facility is authorized to charge would impose upon the health care facility;

(e) The extent to which the health care facility provides care to patients who are more vulnerable or who suffer from comorbidities that make treatment more difficult;

(f) The emphasis placed by the health care facility on promoting population health;

(g) Issues relating to the health care workforce and quality of jobs in health care; and

(h) Any other criteria prescribed by the regulations adopted pursuant to section 12 of this act.

3. When evaluating a request submitted pursuant to subsection 2 of section 9 of this act, the Division:

(a) May request from the health care facility any information that the Division determines to be necessary to make its recommendation; and

(b) Shall solicit input on the request from affected persons and entities, including, without limitation, insurers and patients.

Sec. 11. ***1. After evaluating a request pursuant to section 10 of this act, the Division shall issue a recommendation to the Independent Commission to:***

(a) Deny the request and fix rates for the health care facility in the amount set forth in paragraph (a) of subsection 1 of section 9 of this act, which recommendation must state the reasons therefor;

(b) Fix the rates as requested by the health care facility pursuant to subsection 2 of section 9 of this act; or

(c) Fix specified rates for the health care facility that are different from the rates requested by the health care facility pursuant to subsection 2 of section 9 of this act.

2. A recommendation issued pursuant to subsection 1 concerning a request submitted pursuant to subsection 2 of section 9 of this act must be made on or before April 1 of the year in which the request was filed.

3. The Independent Commission shall review the recommendation issued by the Division pursuant to subsection 1 and the record underlying the recommendation, including, without limitation, all documents the Division reviewed in making its decision and arguments made, and issue an order on or before May 1 of the year, which:

(a) Denies the request and fixes rates for the health care facility in the amount set forth in paragraph (a) of subsection 1 of section 9 of this act and states the reasons therefor;

(b) Fixes the rates as requested by the health care facility pursuant to subsection 2 of section 9 of this act;

(c) Fixes specified rates for the health care facility that are different from the rates requested by the health care facility pursuant to subsection 2 of section 9 of this act; or

(d) Requests the Division to evaluate the request again under conditions specified by the Independent Commission and issue a new recommendation to the Independent Commission.

4. If the Independent Commission requests the Division to reevaluate a request and issue a new recommendation, the Division shall issue its new recommendation not later than 15 days after the issuance of the order by the Independent Commission pursuant to paragraph (d) of subsection 3. The Independent Commission shall issue a new order not later than 15 days after receiving the new recommendation. Such an order may take any action described in paragraph (a), (b) or (c) of subsection 3.

5. All rates fixed by the Independent Commission are in force, and are prima facie lawful, from the date of the order until 1 year after that date.

6. The Division shall publish all rates fixed by the Independent Commission pursuant to this section or section 9 of this act on an Internet website maintained by the Division.

7. A health care facility may request to renew a fixed rate on or before March 1 of the year in which the rate is set to expire. The health care facility has the burden of demonstrating that the health care facility will not cover reasonable costs, earn a fair and reasonable profit or provide fair and adequate compensation to employees charging the rates set forth in paragraph (a) of subsection 1 of section 9 of this act.

Sec. 12. *The Division shall adopt any regulations necessary to carry out the provisions of sections 2 to 13, inclusive, of this act. Those regulations must include, without limitation, regulations prescribing:*

1. Any information that must be included in a request made pursuant to subsection 2 of section 9 of this act;

2. The procedure and specific criteria, in addition to those prescribed by section 10 of this act, that the Division will and the Independent Commission must use when considering such a request;

3. A streamlined process for making and considering a request pursuant to subsection 7 of section 11 of this act to renew a rate established by the Independent Commission; and

4. Civil penalties that may be imposed against a health care facility that charges a rate different from those established for the health care facility pursuant to sections 2 to 13, inclusive, of this act.

Sec. 13. *1. The Division may report any failure by a health care facility to comply with the provisions of sections 2 to 13, inclusive, of this act to the Division of Public and Behavioral Health of the Department for the initiation of disciplinary proceedings.*

2. The Division or the Attorney General may maintain in any court of competent jurisdiction a suit to enjoin any person from charging rates different from those established for the health care facility under the provisions of sections 2 to 13, inclusive, of this act. Such an injunction:

(a) May be issued without proof of actual damage sustained by any person as a preventive or punitive measure.

(b) Does not relieve any person or business entity from any other legal action.

3. Any person or entity injured by the failure of a health care facility to charge rates in accordance with the provisions of sections 2 to 13, inclusive, of this act may maintain in any court of competent jurisdiction a suit to recover:

(a) Damages resulting from such failure; and

(b) Attorney's fees and costs.

Sec. 14. NRS 439B.260 is hereby amended to read as follows:

439B.260 1. A major hospital shall reduce or discount the total billed charge by at least 30 percent for hospital services ***, other than services subject to the provisions of sections 2 to 13, inclusive, of this act,*** provided to an inpatient who:

(a) Has no policy of health insurance or other contractual agreement with a third party that provides health coverage for the charge;

(b) Is not eligible for coverage by a state or federal program of public assistance that would provide for the payment of the charge; and

(c) Makes reasonable arrangements within 30 days after the date that notice was sent pursuant to subsection 2 to pay the hospital bill.

2. A major hospital shall include on or with the first statement of the hospital bill provided to the patient after his or her discharge a notice of ~~[the]~~ ***any*** reduction or discount available pursuant to this section, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount.

3. A major hospital or patient who disputes the reasonableness of arrangements made pursuant to paragraph (c) of subsection 1 may submit the dispute to the Bureau for Hospital Patients for resolution as provided in NRS 232.462.

4. A major hospital shall reduce or discount the total billed charge of its outpatient pharmacy by at least 30 percent to a patient who is eligible for Medicare.

5. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(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 officers and employees, pursuant to chapter 287 of NRS; or

(d) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 15. NRS 439B.400 is hereby amended to read as follows:

439B.400 Each hospital in this State shall maintain and use a uniform list of billed charges for that hospital for units of service or goods provided to all inpatients. A hospital may not use a billed

charge for an inpatient that is different than the billed charge used for another inpatient for the same service or goods provided. This section does not restrict the ability of a hospital or other person to negotiate a discounted rate from the hospital's billed charges or to contract for a different rate or mechanism for payment of the hospital ~~[.]~~ ***for services and goods that are not subject to the provisions of sections 2 to 13, inclusive, of this act.***

Sec. 16. NRS 439B.727 is hereby amended to read as follows:

439B.727 "Provider of health care" has the meaning ascribed to it in NRS 695G.070 ~~[.]~~ ***, except that the term does not include a health care facility, as defined in section 4 of this act.***

Sec. 17. NRS 439B.742 is hereby amended to read as follows:

439B.742 The provisions of NRS 439B.745 ~~[and 439B.748]~~ do not apply to ~~[:~~

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

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

~~3. Any health care services provided more than 24 hours after notification is provided pursuant to NRS 439B.745 that a person has been stabilized.]~~

Sec. 18. NRS 439B.745 is hereby amended to read as follows:

439B.745 ~~[1.]~~ An out-of-network provider shall not collect from a covered person for medically necessary emergency services, and a covered person is not responsible for paying, an amount that exceeds the copayment, coinsurance or deductible required for such services provided by an in-network provider by the coverage for that person.

~~[2. An out-of-network emergency 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 8 hours after the covered person presents at the out-of-network emergency facility to receive medically necessary emergency services; and~~

~~(b) Notify the third party that the condition of the covered person has stabilized to such a degree that the person may be transferred to an in-network emergency facility not later than 24 hours after the person's emergency medical condition is stabilized. Not later than 24 hours after the third party receives such notice, the third party shall arrange for the transfer of the person to such a facility.]~~

Sec. 19. NRS 439B.751 is hereby amended to read as follows:

439B.751 1. If an out-of-network provider ~~[, other than an out-of-network emergency facility,]~~ had a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person and:

(a) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider without cause before it was scheduled to expire, the third party 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, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount that would have been paid for those services pursuant to that provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider for cause before it was scheduled to expire or the third party terminated the contract without cause, the third party 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, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, 108 percent of the amount that would have been paid for those services pursuant to the provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(c) The third party that provides coverage for the covered person terminated the most recent applicable provider contract between the third party and the out-of-network provider for cause before it was scheduled to expire, the third party shall pay to the out-of-network provider an amount that the third party has determined to be fair and reasonable as payment for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

(d) The contract was not terminated by either party, 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, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided

by an in-network provider, the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network provider plus an amount equal to the percentage of increase in the Consumer Price Index, Medical Care Component, during the immediately preceding calendar year, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network provider ~~[, other than an out-of-network emergency facility,]~~ did not have a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage to the covered person shall submit to the out-of-network provider an offer of payment in full for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

Sec. 20. NRS 439B.754 is hereby amended to read as follows:

439B.754 1. An out-of-network provider shall accept or reject an amount paid pursuant to ~~[subsection 2 of NRS 439B.748 or]~~ paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751 as payment in full for the medically necessary emergency services for which the payment was offered within 30 days after receiving the payment. If an out-of-network provider fails to comply with the requirements of this section, the amount paid shall be deemed accepted as payment in full for the medically necessary emergency services for which the payment was offered 30 days after the out-of-network provider received the payment.

2. If an out-of-network provider rejects the amount paid as payment in full, the out-of-network provider must request from the third party an additional amount which, when combined with the amount previously paid, the out-of-network provider is willing to accept as payment in full for the medically necessary emergency services.

3. If the third party refuses to pay the additional amount requested by the out-of-network provider pursuant to subsection 2 or fails to pay that amount within 30 days after receiving the request for the additional amount, the out-of-network provider must request a list of five randomly selected arbitrators from an entity authorized by regulations of the Director of the Department to provide such arbitrators. Such regulations must require:

(a) For claims of less than $5,000, the use of arbitrators who will conduct the arbitration in an economically efficient manner. Such arbitrators may include, without limitation, qualified employees of the State and arbitrators from the voluntary program for the use of

binding arbitration established in the judicial district pursuant to NRS 38.255 or, if no such program has been established in the judicial district, from the program established in the nearest judicial district that has established such a program.

(b) For claims of $5,000 or more, the use of arbitrators from nationally recognized providers of arbitration services, which may include, without limitation, the American Arbitration Association, JAMS or their successor organizations.

4. Upon receiving the list of randomly selected arbitrators pursuant to subsection 3, the out-of-network provider and the third party shall each strike two arbitrators from the list. If one arbitrator remains, that arbitrator must arbitrate the dispute concerning the amount to be paid for the medically necessary emergency services. If more than one arbitrator remains, an arbitrator randomly selected from the remaining arbitrators by the entity that provided the list of arbitrators pursuant to subsection 3 must arbitrate that dispute.

5. The out-of-network provider and the third party shall participate in binding arbitration of the dispute concerning the amount to be paid for the medically necessary emergency services conducted by the arbitrator selected pursuant to subsection 4. The out-of-network provider or third party may provide the arbitrator with any relevant information to assist the arbitrator in making a determination.

6. The arbitrator shall require:

(a) The out-of-network provider to accept as payment in full for the provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount paid by the third party pursuant to ~~[subsection 2 of NRS 439B.748 or]~~ paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable; or

(b) The third party to pay the additional amount requested by the out-of-network provider pursuant to subsection 2.

7. If the arbitrator requires:

(a) The out-of-network provider to accept the amount paid by the third party pursuant to ~~[subsection 2 of NRS 439B.748 or]~~ paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, as payment in full for the provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the out-of-network provider must pay the costs of the arbitrator.

(b) The third party to pay the additional amount requested by the out-of-network provider pursuant to subsection 2, the third party must pay the costs of the arbitrator.

8. An out-of-network provider or a third party must pay its own attorney's fees incurred during the process prescribed by this section.

9. Interest does not accrue on any claim for which an offer of payment is rejected pursuant to subsection 1 for the period beginning on the date of the rejection and ending 30 days after the arbitrator renders a decision.

10. Except as otherwise provided in this subsection and NRS 439B.760, any decision of an arbitrator pursuant to this section and any documents associated with such a decision are confidential and are not admissible as evidence during a legal proceeding, including, without limitation, a legal proceeding between the third party and the out-of-network provider. The decision of an arbitrator and any documents associated with such a decision may be disclosed and are admissible as evidence during a legal proceeding to enforce the decision.

Sec. 21. NRS 449.160 is hereby amended to read as follows:

449.160 1. The Division may deny an application for a license or may suspend or revoke any license issued under the provisions of NRS 449.029 to 449.2428, inclusive, upon any of the following grounds:

(a) Violation by the applicant or the licensee of any of the provisions of NRS 439B.410 or 449.029 to 449.245, inclusive, or of any other law of this State or of the standards, rules and regulations adopted thereunder.

(b) Aiding, abetting or permitting the commission of any illegal act.

(c) Conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a license is issued.

(d) Conduct or practice detrimental to the health or safety of the occupants or employees of the facility.

(e) Failure of the applicant to obtain written approval from the Director of the Department of Health and Human Services as required by NRS 439A.100 or as provided in any regulation adopted pursuant to NRS 449.001 to 449.430, inclusive, and 449.435 to 449.531, inclusive, and chapter 449A of NRS if such approval is required.

(f) Failure to comply with the provisions of NRS 441A.315 and any regulations adopted pursuant thereto or NRS 449.2486.

(g) Violation of the provisions of NRS 458.112.

(h) Failure to comply with the provisions of sections 2 to 13, inclusive, of this act, any regulations adopted pursuant thereto or any order issued pursuant thereto.

2. In addition to the provisions of subsection 1, the Division may revoke a license to operate a facility for the dependent if, with respect to that facility, the licensee that operates the facility, or an agent or employee of the licensee:

(a) Is convicted of violating any of the provisions of NRS 202.470;

(b) Is ordered to but fails to abate a nuisance pursuant to NRS 244.360, 244.3603 or 268.4124; or

(c) Is ordered by the appropriate governmental agency to correct a violation of a building, safety or health code or regulation but fails to correct the violation.

3. The Division shall maintain a log of any complaints that it receives relating to activities for which the Division may revoke the license to operate a facility for the dependent pursuant to subsection 2. The Division shall provide to a facility for the care of adults during the day:

(a) A summary of a complaint against the facility if the investigation of the complaint by the Division either substantiates the complaint or is inconclusive;

(b) A report of any investigation conducted with respect to the complaint; and

(c) A report of any disciplinary action taken against the facility.

➥ The facility shall make the information available to the public pursuant to NRS 449.2486.

4. On or before February 1 of each odd-numbered year, the Division shall submit to the Director of the Legislative Counsel Bureau a written report setting forth, for the previous biennium:

(a) Any complaints included in the log maintained by the Division pursuant to subsection 3; and

(b) Any disciplinary actions taken by the Division pursuant to subsection 2.

Sec. 22. NRS 449A.118 is hereby amended to read as follows:

449A.118 1. Every medical facility and facility for the dependent shall inform each patient or the patient's legal representative, upon the admission of the patient to the facility, of the patient's rights as listed in NRS 449A.100 and 449A.106 to 449A.115, inclusive.

2. In addition to the requirements of subsection 1, if a person with a disability is a patient at a facility, as that term is defined in NRS 449A.218, the facility shall inform the patient of his or her rights pursuant to NRS 449A.200 to 449A.263, inclusive.

3. In addition to the requirements of subsections 1 and 2, every hospital shall, upon the admission of a patient to the hospital, provide to the patient or the patient's legal representative:

(a) Notice of the right of the patient to:

(1) Designate a caregiver pursuant to NRS 449A.300 to 449A.330, inclusive; and

(2) Express complaints and grievances as described in paragraphs (b) to (f), inclusive;

(b) The name and contact information for persons to whom such complaints and grievances may be expressed, including, without limitation, a patient representative or hospital social worker;

(c) Instructions for filing a complaint with the Division;

(d) The name and contact information of any entity responsible for accrediting the hospital;

(e) A written disclosure approved by the Director of the Department of Health and Human Services, which written disclosure must set forth:

(1) Notice of the existence of the Bureau for Hospital Patients created pursuant to NRS 232.462;

(2) The address and telephone number of the Bureau; and

(3) An explanation of the services provided by the Bureau, including, without limitation, the services for dispute resolution described in subsection 3 of NRS 232.462; and

(f) Contact information for any other state or local entity that investigates complaints concerning the abuse or neglect of patients.

4. In addition to the requirements of subsections 1, 2 and 3, every hospital shall, upon the discharge of a patient from the hospital, provide to the patient or the patient's legal representative a written disclosure approved by the Director, which written disclosure must set forth:

(a) If the hospital is a major hospital:

(1) Notice of ~~[the]~~ ***any*** reduction or discount available pursuant to NRS 439B.260, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount under that section; and

(2) Notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide ~~[discounted]~~ ***discounts for*** services ***that are not subject to the provisions of sections 2 to 13, inclusive, of this act*** to persons, which policies and procedures are in addition to any reduction or discount required to be provided pursuant to NRS 439B.260. The notice required by this subparagraph must describe the criteria a patient must satisfy to qualify for the additional reduction or discount, including, without limitation, any relevant

limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment.

(b) If the hospital is not a major hospital, notice of any policies and procedures the hospital may have adopted to reduce charges for services ***that are not subject to the provisions of sections 2 to 13, inclusive, of this act*** provided to persons or to provide ~~[discounted]~~ ***discounts on such*** services to persons. The notice required by this paragraph must describe the criteria a patient must satisfy to qualify for the reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment.

➥ As used in this subsection, "major hospital" has the meaning ascribed to it in NRS 439B.115.

5. In addition to the requirements of subsections 1 to 4, inclusive, every hospital shall post in a conspicuous place in each public waiting room in the hospital a legible sign or notice in 14-point type or larger, which sign or notice must:

(a) Provide a brief description of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, including, without limitation:

(1) Instructions for receiving additional information regarding such policies and procedures; and

(2) Instructions for arranging to make payment;

(b) Be written in language that is easy to understand; and

(c) Be written in English and Spanish.

Sec. 23. NRS 450.420 is hereby amended to read as follows:

450.420 1. The board of county commissioners of the county in which a public hospital is located may determine whether patients presented to the public hospital for treatment are subjects of charity. Except as otherwise provided in NRS 439B.330, the board of county commissioners shall establish by ordinance criteria and procedures to be used in the determination of eligibility for medical care as medical indigents or subjects of charity.

2. The board of hospital trustees shall fix the charges for ~~[treatment of]~~ ***the provision of goods and services that are not subject to the provisions of sections 2 to 13, inclusive, of this act to*** those persons able to pay for the charges, as the board deems just and proper. The board of hospital trustees may impose an interest charge of not more than 12 percent per annum on unpaid accounts. The receipts must be paid to the county treasurer and credited to the hospital fund. In fixing charges pursuant to this subsection the board of hospital trustees shall not include, or seek to recover from paying patients, any portion of the expense of the hospital which is properly attributable to the care of indigent patients.

3. Except as provided in subsection 4 of this section and subsection 3 of NRS 439B.320, the county is chargeable with the entire cost of services rendered by the hospital and any salaried staff physician or employee to any person admitted for emergency treatment, including all reasonably necessary recovery, convalescent and follow-up inpatient care required for any such person as determined by the board of trustees of the hospital, but the hospital shall use reasonable diligence to collect the charges from the emergency patient or any other person responsible for the support of the patient. Any amount collected must be reimbursed or credited to the county.

4. The county is not chargeable with the cost of services rendered by the hospital or any attending staff physician or surgeon to the extent the hospital is reimbursed for those services pursuant to NRS 428.115 to 428.255, inclusive.

Sec. 24. NRS 689A.041 is hereby amended to read as follows:

689A.041 1. A policy of health insurance which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

↪ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the

provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A]~~ ***Except as otherwise provided in section 8 of this act, a*** plan or issuer may negotiate rates of reimbursement with providers of care.

7. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal the amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

8. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

9. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 25. NRS 689B.0375 is hereby amended to read as follows:

689B.0375 1. A policy of group health insurance which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

➥ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A]~~ ***Except as otherwise provided in section 8 of this act, a*** plan or issuer may negotiate rates of reimbursement with providers of care.

7. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

8. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

9. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 26. NRS 695B.191 is hereby amended to read as follows:

695B.191 1. A policy of health insurance, issued by a medical service corporation, which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

➥ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A]~~ ***Except as otherwise provided in section 8 of this act, a*** plan or issuer may negotiate rates of reimbursement with providers of care.

7. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

8. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

9. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 27. NRS 695C.171 is hereby amended to read as follows:

695C.171 1. A health maintenance plan which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

➥ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A]~~ ***Except as otherwise provided in section 8 of this act, a*** plan or issuer may negotiate rates of reimbursement with providers of care.

7. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

8. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

9. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 28. 1. On or before January 1, 2024, the Governor shall appoint to the Independent Commission on Rates for Health Care Services created by section 6 of this act:

(a) Four members to initial terms that expire on January 1, 2026; and

(b) Five members to initial terms that expire on January 2, 2028.

2. Notwithstanding the amendatory provisions of this act, a health care facility is not required to comply with the provisions of sections 2 to 13, inclusive, of this act until the later of:

(a) January 1, 2025; or

(b) One year after the date on which the regulations adopted pursuant to section 12 of this act become effective.

3. The amendatory provisions of this act do not affect any contract or other agreement that establishes the rates paid to a health care facility which is entered into on or before the effective date of this section. A health care facility shall not enter into a contract or other agreement after the effective date of this section that provides for the payment of rates for services to which sections 2 to 13, inclusive, of this act apply that differ from the rates fixed pursuant to those sections after the later of:

(a) January 1, 2025; or

(b) One year after the date on which the regulations adopted pursuant to section 12 of this act become effective.

4. As used in this section, "health care facility" has the meaning ascribed to it in section 4 of this act.

Sec. 29. 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. 30. NRS 439B.706, 439B.709, 439B.718 and 439B.748 are hereby repealed.

Sec. 31. 1. This section and section 28 of this act become effective upon passage and approval.

2. Sections 1 to 12, inclusive, and 29 of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2024, for all other purposes.

3. Sections 13 to 27, inclusive, and 30 of this act become effective on the later of:

(a) January 1, 2025; or

(b) One year after the date on which the regulations adopted pursuant to section 12 of this act become effective.

LEADLINES OF REPEALED SECTIONS

439B.706 "Independent center for emergency medical care" defined.
439B.709 "In-network emergency facility" defined.
439B.718 "Out-of-network emergency facility" defined.
439B.748 Payment to out-of-network emergency facility by third party.

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