SENATE BILL NO. 372–SENATOR DONATE

MARCH 23, 2023

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to emergency medical services. (BDR 40-992)

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; prescribing procedures for determining the amount that certain third parties are required to pay to an out-of-network private ambulance service for medically necessary emergency services provided to a covered person; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prohibits an out-of-network provider of health care from collecting from a person covered by insurance an amount for medically necessary emergency services that exceeds the copayment, coinsurance or deductible required by that insurance. (NRS 439B.745) Existing law establishes various amounts which a third party that provides such coverage must pay an out-of-network provider for such services, and an out-of-network provider must accept as payment in full. Under existing law, those amounts are based on the amount that would have been paid under the most recent applicable contract between the third party and the provider. If the provider was not a recent participant in the network of the third party or if the third party terminated the most recent contract between the third party and the provider for cause and the provider is not a facility, existing law requires the third party to pay the provider an amount that the third party determines to be fair and reasonable for the medically necessary emergency services. (NRS 439B.748, 439B.751) If the out-of-network provider rejects an amount determined by the third party to be fair and reasonable under such circumstances, existing law requires the provider to 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. If the third party refuses to pay the additional amount requested by the provider, existing law requires the third party and the provider to submit the dispute to binding arbitration. (NRS 439B.754)

This bill creates a similar system for determining the amount that a third party is required to pay an out-of-network private ambulance service for medically

necessary emergency services provided to a covered person. **Sections 2 and 3** of this bill define the terms "out-of-network private ambulance service" and "private ambulance service," respectively. **Section 4** of this bill requires a third party to pay an out-of-network private ambulance service for medically necessary emergency services the greater of: (1) the amount that the third party would pay an in-network private ambulance service for similar services, except for any copayment, coinsurance or deductible required; (2) an amount calculated using the same method the third party generally uses to determine payments for out-of-network private ambulance services; or (3) the amount that would be paid for such services under Medicare Part B. If the out-of-network private ambulance service rejects that amount as payment in full for the medically necessary emergency services, **section 8** of this bill requires the out-of-network private ambulance service to request from the third party an additional amount which, when combined with the amount previously paid, the out-of-network private ambulance service is willing to accept as payment in full. If the third party refuses to pay the additional amount requested by the out-of-network private ambulance service, **section 8** requires the third party and the out-of-network private ambulance service to submit the dispute to binding arbitration.

Sections 5 and 9 of this bill make conforming changes to indicate the proper placement of **sections 2-4** in the Nevada Revised Statutes. **Section 7** of this bill makes conforming changes to clarify that certain provisions governing payment for medically necessary emergency services do not apply to such services provided by an out-of-network private ambulance service.

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, 3 and 4 of this act.

Sec. 2. ***"Out-of-network private ambulance service" means a private ambulance service that is an out-of-network provider.***

Sec. 3. ***"Private ambulance service" means an ambulance service that is not operated by a governmental entity.***

Sec. 4. ***1. A third party that provides coverage to a covered person who receives medically necessary emergency services from an out-of-network private ambulance service shall pay the out-of-network private ambulance service as payment for the medically necessary emergency services the greater of:***

(a) The amount that would be paid pursuant to a provider contract with an in-network private ambulance service for the relevant medically necessary emergency services when provided in the same geographic region where the medically necessary emergency services were rendered to the covered person, 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 private ambulance service. If there is more than one such amount, the relevant amount is the median of those amounts. In determining the median amount, the amount that

would be paid pursuant to each provider contract with an in-network private ambulance service must be treated as a separate amount, including, without limitation, where the same amount is paid to more than one in-network private ambulance service. If there is no provider contract with an in-network private ambulance service which prescribes an amount to be paid on a per-service basis for the relevant medically necessary emergency services when provided in the same geographic region, including, without limitation, because any relevant provider contract which covers such services provides for capitation payments or other similar payments, the amount described in this paragraph may not be applied.

(b) An amount calculated using the same method the third party generally uses to determine payments for an out-of-network private ambulance service, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an out-of-network private ambulance service.

(c) The amount that would be paid under Medicare Part B provided pursuant to Part B of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395j et seq., 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 private ambulance service.

2. As used in this section, "in-network private ambulance service" means a private ambulance service that is an in-network provider.

Sec. 5. NRS 439B.700 is hereby amended to read as follows:

439B.700 As used in NRS 439B.700 to 439B.760, inclusive, ***and sections 2, 3 and 4 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 439B.703 to 439B.739, inclusive, ***and sections 2 and 3 of this act*** have the meanings ascribed to them in those sections.

Sec. 6. 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 ~~[.]~~ ***and includes a private ambulance service.***

Sec. 7. 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 ~~[,]~~ ***or an out-of-network private ambulance service,*** 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 ~~[,]~~ ***or an out-of-network private ambulance service,*** 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. 8. 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 ***or section 4 of this act*** 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, ***or section 4 of this act,*** 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, ***or section 4 of this act,*** 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. 9. NRS 439B.757 is hereby amended to read as follows:

439B.757 Any entity or organization, not otherwise subject to the provisions of NRS 439B.700 to 439B.760, inclusive, ***and sections 2, 3 and 4 of this act*** that provides coverage for emergency medical services, including, without limitation, a participating public agency, as defined in NRS 287.04052, and any other local governmental agency 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, may elect for the provisions of NRS 439B.700 to 439B.760, inclusive, ***and sections 2, 3 and 4 of this act*** to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons. The Director of the Department of Health and Human Services shall:

1. Publish on an Internet website maintained by the Department a list of third parties that have made such an election; and

2. Adopt regulations governing such an election, which may include, without limitation, regulations that establish the procedure by which a third party may make such an election.

Sec. 10. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 9, inclusive, 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;

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