**[Nev. Rev. Stat. §§ 439B.700 through 439B.760.]**

# §§ 439B.700 through 439B.760: Restraining Costs of Health Care-- Payment for Medically Necessary Emergency Services Provided Out-of-Network

**§ 439B.700. Definitions.**

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

**§ 439B.703. "Covered person" defined.**

"Covered person" means a policyholder, subscriber, enrollee or other person covered by a third party.

**§ 439B.706. "Independent center for emergency medical care" defined.**

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

**§ 439B.709. "In-network emergency facility" defined.**

"In-network emergency facility" means a hospital or independent center for emergency medical care that is an in-network provider.

**§ 439B.712. "In-network provider" defined.**

"In-network provider" means, for a particular covered person, a provider of health care that has entered into a provider contract with a third party for the provision of health care to the covered person.

**§ 439B.715. "Medically necessary emergency services" defined.**

"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 person would believe that the absence of immediate medical attention could result in:

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

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

3. Serious impairment of a bodily function of the covered person; or

4. Serious dysfunction of any bodily organ or part of the covered person.

**§ 439B.718. "Out-of-network emergency facility" defined.**

"Out-of-network emergency facility" means a hospital or independent center for emergency medical care that is an out-of-network provider.

**§ 439B.721. "Out-of-network provider" defined.**

"Out-of-network provider" means, for a particular covered person, a provider of health care that has not entered into a provider contract with a third party for the provision of health care to the covered person.

**§ 439B.724. "Provider contract" defined.**

"Provider contract" means a contract between a third party and an in-network provider to provide health care services to a covered person.

**§ 439B.727. "Provider of health care" defined.**

"Provider of health care" has the meaning ascribed to it in NRS 695G.070.

**§ 439B.730. "Prudent person" defined.**

"Prudent person" means a person who:

1. Is not a provider of health care;

2. Possesses an average knowledge of health and medicine; and

3. Is acting reasonably under the circumstances.

**§ 439B.733. "Screen" defined.**

"Screen" means to conduct the medical screening examination required to be provided to a patient in the emergency department of a hospital pursuant to 42 U.S.C. § 1395dd.

**§ 439B.736. "Third party" defined.**

1. "Third party" includes, without limitation:

(a) The issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary emergency services;

(b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; and

(c) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760, inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.

**§ 439B.739. "To stabilize" and "stabilized" defined.**

"To stabilize" and "stabilized" have the meanings ascribed to them in 42 U.S.C. § 1395dd(e)(3).

**§ 439B.742. Inapplicability of provisions to certain hospitals, persons and health care services.**

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 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.

**§ 439B.745. Limitation on amount out-of-network provider may collect from covered person; duties of out-of-network emergency facility upon providing services.**

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.

**§ 439B.748. Payment to out-of-network emergency facility by third party.**

1. If an out-of-network emergency facility had a provider contract as an in-network emergency facility 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 emergency facility for those services, and the out-of-network emergency facility 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 emergency facility:

(a) If the out-of-network emergency facility was an in-network emergency facility 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 provider contract between the third party and the out-of-network emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) If the out-of-network emergency facility was an in-network emergency facility within the 24 months immediately preceding the provision of medically necessary emergency services, but not within the 12 months immediately preceding the provision of those services, 115 percent of 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 emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network emergency facility did not have a provider contract as an in-network emergency facility 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 to the covered person shall pay to the out-of-network emergency facility 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 emergency facility.

**§ 439B.751. Payment to out-of-network provider, other than emergency facility, by third party.**

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.

**§ 439B.754. Determination of amount owed when no recent contract exists between out-of-network provider and third party; arbitration to resolve dispute; no interest pending resolution of dispute; confidentiality of arbitration.**

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.

**§ 439B.757. Election by certain entities and organizations not otherwise covered to submit to provisions; regulations.**

Any entity or organization, not otherwise subject to the provisions of NRS 439B.700 to 439B.760, inclusive, 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, 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.

**§ 439B.760. Reports; confidentiality of information.**

1. On or before December 31 of each year, an arbitrator who arbitrated a matter pursuant to NRS 439B.754 during the immediately preceding 12 months shall report to the Department of Health and Human Services in the form prescribed by the Department:

(a) The number of cases arbitrated by the arbitrator;

(b) The types of providers of health care and third parties involved in those cases;

(c) The prevailing party in each such arbitration;

(d) Information concerning the geographic location of the provider of health care that provided medically necessary emergency services; and

(e) Any other information requested by the Department.

2. A provider of health care or third party:

(a) Shall provide to the Department any information requested by the Department to complete the report required by subsection 3; and

(b) May provide to the Department any other information relevant to that report.

3. On or before January 31 of each year, the Department shall:

(a) Compile a report which consists of:

(1) Aggregated information provided to the Department pursuant to subsections 1 and 2, presented in a manner that does not reveal the identity of any provider of health care, third party or patient;

(2) An analysis of any identifiable trends in the information described in subparagraph (1); and

(3) An analysis of the impact of actions taken pursuant to NRS 439B.700 to 439B.760, inclusive, on provider contracts and the provision of health care in this State;

(b) Post the report on an Internet website maintained by the Department; and

(c) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

4. Any information disclosed to the Department pursuant to this section is confidential.