August 12, 2022

RE: Input Opportunity: Hearing Regarding Proposed Regulation on AB 469 (Surprise Medical Billing)

Comments:

1. Identification of third-party insurer status - AB469 and subsequent regulation fail to require a third-party insurer to identify if they are subject to state or federal regulation on the claim. This continues to confound the efforts of providers to participate in the correct process for remedy. We request that regulation simply ask a third-party providing insurance to identify whether they are regulated at a state or federal level when making the initial payment on an out-of-network rate. This is easily accomplished in other states by passing a code as the out-of-network initial payment is made. The payment is rendered by the entity that has knowledge that they are out-of-network (absence of a contracted rate) and that knows whether or not the product in question is regulated at a state or federal level.

   The passage of federal No Surprises Act exacerbates this concern in terms of understanding which process to access.

   We thank the Nevada Office for Consumer Health Assistance for assistance when we have struggled to get this information directly. We recognize that there are efforts to update websites, but these can be out of date or incomplete (largely due to the complexity of multiple products by a third-party and the associated different structures) despite best efforts of all parties. To the intent of the legislation and regulation, passing a code in a routine fashion would allow us to reduce the expense associated with the manual aspects of this process – for all parties.

2. Expense of Arbitration - In Emergency Medicine, where disputed amounts are well, well below the $5,000 threshold, the newly defined charge adds expense to being paid at a market rate for services that have been rendered. Practically, we will need to arbitrate all claims that reimburse us below market to preserve market rates, so this will be a loss to us in terms of the existing administrative burden and now, new fees.

3. Unnecessary Duplication – The inability bundle like claims to the same provider continues for the same billing code requires redundant trips through the same process, each at an additional expense, to make the same argument with the same set of facts to the same set of arbitrators.

Thank you for accepting these comments for consideration.

Sincerely,

Karen Massey

Karen Massey, MHA, FAMPE
Executive Director, Northern Nevada Emergency Physicians
Legislative Liaison, Nevada Medical Group Management Association
Government Affairs Committee, Medical Group Management Association

August 12, 2022

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RE: Public Comment on Chapter 439B NAC relating to LCB File No. R101-19 (NRS §§ 439B.700-439B.760).

Ms. Francis:

The Nevada Association of Health Plans (the "NvAHP) is a statewide trade association representing ten member companies who provide commercial health insurance and government programs to Nevadans. Our mission is to ensure the growth and development of a high-quality and affordable health care delivery system throughout the state. The NvAHP appreciates the opportunity to provide comments on proposed changes to Nevada statute on non-participating emergency provider reimbursement disputes.

1. For arbitrations in which the amount sought is less than $5,000, the regulation does not require, and the arbitrators do not provide any rationale for their determination as to who is the prevailing party. Both providers and payors would benefit from the arbitrator providing a concise and informative explanation of their determination, because this would facilitate payors and providers' negotiations in future disputes over the amount of reimbursement for out-of-network emergency claims, thereby reducing the number of arbitration filings. Providing a rationale for the arbitrator's decision would likely result in fewer arbitrations being filed or, if filed, contested. Furthermore, including a rationale for the arbitrator's decision would.

2. For arbitrations in which the amount sought is less than $5,000, the regulation does not require the provider to disclose to the payor (referred to as the "third party" in the statute) the information or evidence submitted to the arbitrator in connection with a dispute. All that the provider typically only submits a UB-04 to the payor for emergency services furnished. At the time a claim is submitted and at the time that the provider submits an appeal to the payor, medical records or other documentation is not usually submitted in support of the provider's request for additional reimbursement. Therefore, the payor is unable to evaluate the basis for the provider's claim that it is entitled to additional reimbursement for out-of-network emergency services claims. A provider should be required to submit on appeal all documents and other evidence it relies upon for its claim for additional reimbursement, which would allow all parties to understand the full scope of information to be considered by an arbitrator. As a result, payors could be more prepared to address providers' specifical claims for arbitration, which could shorten the duration of arbitrations and encourage parties to settle matters earlier.

3. Under NRS § 439B.757, a "third party" must elect for the provisions of NRS §§ 439B.700 to 439B.760, inclusive, (the "Nevada surprise billing law") to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons (NRS § 439B.736(1)(c)). However, if a self-funded third party does not so elect, the provider may not avail itself of the arbitration process through the Office for Consumer Health Assistance (OCHA).

Currently, providers have been submitting arbitration requests even though the claim is not subject to the Nevada surprise billing law.

For example, one carrier to date has received over nine hundred arbitration requests.

- Over two hundred of them have been dismissed due to lack of eligibility of the member's self-funded group.
- In each of those instances, GovCHA had to send out 200 unnecessary arbitration requests even though the provider filing the arbitration has information in its possession, such as the patient's ID card, that allows it to know whether the member is in fact insured with the plan or not; and if not, whether the self-funded group at issue has opted into the arbitration process (based on information available on the Office of Consumer Health Assistance's website).
- If a provider does not check the state website, the carrier is required to prove that the group at issue is ineligible (that it is a self-funded group) and the standard of proof has been such that in some instances, it has not been able to establish the fact because it does not have the documentation for self-insured employer groups, i.e., their summary plan description or other plan documents. **If a carrier has determined that the employer is a self-funded plan after reviewing its records, we do not believe that a carrier should be required to provide any additional documents. OCHA should be able to rely on the representation from the carrier that the claim is from a Self-Funded plan.**
- And yet, the burden is being placed on the carrier to prove that the group is not eligible. In situations analogous to this, such as filing a demand for arbitration under American Arbitration Association rules, the burden is on the party filing the arbitration to show that the matter is eligible for the process. This seems logical as well, in that the filing party is seeking to avail itself of the process. Moving the burden to the party being "sued" is unfair. And, in the instance of this process, as it has been applied to carriers, the result is particularly unfair in that a significant percentage of the disputes filed have been determined to be ineligible. In effect, carriers expend time and money to defend itself in more than 25% of matters that are not even eligible for the process. If providers have not been informed on the process, we recommend that the state consider doing so.

This practice of filing arbitration request without reviewing whether a self-funded group has elected to avail themselves to the Nevada surprise billing law without checking the state website has created an unnecessary burden on both GovCHA and carriers. Additionally, because the federal surprise billing law applies to self-funded groups, the provider would need to resubmit the arbitration request under the Federal surprise billing framework. **We suggest that the regulation require that the party submitting the arbitration request determine whether the claims fall under the Nevada surprise billing law or the federal surprise billing requirements prior to submitting the request to GovCHA.**

We appreciate the opportunity to provide comments and look forward to answering any questions you may have.

Sincerely,

Helen A. Foley
Legislative Advocate
Nevada Association of Health Plans