Minutes for the Hearing for the Amendment of Regulation of the Office for Consumer Health Assistance

The public hearing was conducted virtually via TEAMS Meeting beginning at 1:00 p.m. until adjournment at 1:17pm, Thursday, August 18, 2022.

The purpose of the hearing is to receive comments from all interested persons regarding the amendment of regulation that pertain to chapter 439B of the Nevada Administrative Code (NAC), relating to disputes between third party insurers and out-of-network providers over payment of medically necessary emergency services in LCB File No. R101-19 (NRS 439B.700-NRS439B.760).

1. Introduction of hearing process

Carrie Embree, Governor's Consumer Health Advocate with the Office for Consumer Health Assistance (OCHA) introduced the item informing the stakeholders the purpose of the hearing is to receive comments and no discussion or questions would be entertained. The purpose of the hearing is to receive comments from all interested persons regarding the amendment of regulation that pertain to Chapter 439 B of the Nevada Administrative Code relating to disputes between third party insurers and out of network providers, overpayment of medically necessary emergency services, and LCB File R-101-19, Authority NRS 439B.700 - NRS439B.760. Questions can be emailed to OCHA at govcha@adsd.nv.gov

2. Public comment

Stacy Sasso with the Health Services Coalition commented we do want to thank you for your time today regarding the revised proposed regulations, the Health Services coalition represents 25 employer and union sponsored self-funded plans in Southern Nevada, including Culinary Health Fund, Teamsters Board gaming and numerous construction trades and public safety groups representing about 280,000 lives. We reviewed the proposed revisions for 439 B and we do have a few concerns. So do we just wanted to bring to your attention today.
It appears the intent of section 19, subsection two, is to provide information to help prepare the report that's noted in subsection three, and since subsection one seems like it can accomplish the reporting of subsection three, we're failing to see why subsection two is necessary.

What additional information does the department expect to gain from providers and third parties to prepare the report defined in subsection three, that the department cannot get in the arbitrators from the arbitrators in subsection one, we would ask that subsection two of section 19 be removed in its entirety. In addition, subsection five, I'm sorry, Section 5, subsection 3, the edit 220 days to withdraw participation of a plan is workable and appreciated by our plans. We would, however, ask that D the reason for requesting to withdraw the election be struck from regulations. Finally, in Section 6, subsection two, we're reviewing the ability of our plans to provide requested information in a

timely manner. Many of our plans are complying with the federal No Surprises Act and this addition may be additional burden to the individual self-funded plans. We would appreciate the removal of this requirement. Again, we do appreciate your time and we look forward to working with you on these regulations.

3. Adoption of proposed amendments to Nevada Administrative Code (NAC) Chapter 439B relating to disputes between third-party insurers and out-of-network providers over payment of medically necessary emergency services in LCB File No. R101-19 (NRS 439B.700-NRS 439B.760).

Carrie Embree introduced the Office for Consumer Health Assistance's hearing for adoption of proposed amendments to Nevada Administrative Code (NAC) Chapter 439B relating to disputes between third-party insurers and out-of-network providers over payment of medically necessary emergency services in LCB File No. R101-19, authority NRS 439B.754, NRS 439B.757 and NRS 439B.760. There are no substantial changes or revisions to the proposed regulation LCB File No. R101-19, dated September 9, 2021.

1) Existing law requires a third-party insurer and an out-of-network provider of health care that have a dispute regarding the payment for medically necessary emergency services rendered to a covered person to participate in arbitration to resolve the dispute. If such a dispute arises, existing law requires the out-of-network provider to request a list of five randomly selected arbitrators from an entity authorized by regulations of the Director of the Department of Health and Human Services to provide such arbitrators. (NRS 439B.754) For a dispute over a claim of less than $5,000, **section 2** of this regulation requires the request to be submitted to the Department. **Section 2** also: (1) prescribes the required contents of the request; (2) provides for the review and approval of the request by the Department; and (3) requires the Department to provide the out-of-network provider and third party with a written list of five randomly selected employees of the State who are qualified to arbitrate the dispute and who are determined not to have a conflict of interest. **Section 3** of this regulation provides for the selection of an arbitrator and prescribes the procedure for the arbitration. For a dispute about a claim in the amount of $5,000 or more, **section 4** of this regulation requires the out-of-network provider to request a list of five randomly selected arbitrators from the American Arbitration Association or JAMS.
2) Existing law authorizes an entity or organization not otherwise subject to provisions of law governing the resolution of disputes between a third-party insurer and an out-of-network provider of health care over payment for medically necessary emergency services to elect to have those provisions to apply to the entity or organization. Existing law requires the Director to adopt regulations governing such an election. (NRS 439B.757) **Section 5** of this regulation prescribes the procedure for making and withdrawing such an election.
3) Existing law requires the Department to compile a report which consists of certain information concerning the resolution of disputes regarding the payment of medically necessary emergency services. Existing law requires a provider of health care or third party to provide to the Department any information requested by the Department to complete that report. (NRS 439B.760) **Section 6** of this regulation requires a third party that provides coverage to residents of this State and a provider of health care who provides medically necessary emergency medical services in this State to annually submit to the Department certain information for the purpose of compiling that report.

4. Public Comment

Jack Kim with the Nevada Association Health Plans provided written comments and commented I think as our as our health plans have been working through the Surprise Billing Nevada, they have some suggestions they think would be helpful as this process continues. First, to comment to really direct it towards claims under five 5,000. One of the things we've noticed as arbitrators are making their decisions, we're not getting a lot of detail on why the decisions are being made. We think it would be helpful for the health plans and providers to get rationale of what the decisions are and the reason behind it. We think this would be helpful as you know there's additional type of additional arbitrations, it'll help and hopefully make the process smoother for both parties. The second piece on the

5,000 and under is that often when these arbitrations going on are some other health plans have noticed that we don't get a lot of information that the providers are disclosing to the arbitrators, we think it would be helpful to have that information disclosed to the third parties and we think this will also help for future arbitrations. It may lead to quicker decisions from both parties. The last piece is really related to any of the arbitrations, especially the ones where the carriers are being asked to certify that a claim is subject to the arbitration rules. You know the providers because they submit arbitrations and often OCHA then just sends it to the carriers and ask them some information, and we often have to figure out if some of these parties are actually subject to the Nevada Surprise Billing. In one case, one of our carriers indicated of the 900 requests they've gotten, 200 hundred of them were outside the scope. There was ERISA, self-funded they hadn't elected and so that's had a lot of burden on both OCHA and the carriers. Oftentimes the carriers are asked to provide documents that support that these are versus self-funded plans. Representations that these was a self-funded plan that's enough. Our suggestion would be that the providers determine whether these are even subject to Nevada Surprise Billing before they submit to OCHA. That would reduce amount of claims or arbitration to process. Then if some of them are still questioned. Carries could also just indicate you know through representation that, hey, this is self-funded claim and that's outside the scope is of this process. I'd be glad to answer any questions you have.

Karen Massey with Northern Nevada Emergency Physicians, Reno and the Medical Group Management Association commented she has a perspective across practices and I agree. I think one of the challenges we have and I put this in my comments, was providers being able to determine if they're in the state process or the federal process. The federal law did contemplate this and identified some codes that they have encouraged insurers to pass at the time of claim. That would be a tremendous help to us. They're specifically in NA58 for state and NA895 for federal.
And I don't know if there are barriers, but I think considering that as part of the state legislation might expedite that and reduce the workload for providers, insurers and certainly OCHA. So I just wanted to share that the rest of my comments are submitted for the record. Thank you.

5. Adjournment
Carrie Embree adjourned the hearing at 1:17 PM.