US ANESTHESIA PARTNERS

January 16, 2020

Ms. Carrie Embree
Governor's Consumer Health Advocate
State of Nevada Office of Consumer Health Assistance
clembree@adsd.nv.gov
cha@govcha.nv.gov

Re: Comments on Proposed Regulations of the Office of Consumer Health Assistance of the Department of Health and Human Services, LCB File No. R101-19

Dear Ms. Embree:

US Anesthesia Partners (USAP) is a single-specialty physician group focused on delivering superior anesthesia services through a commitment to quality, excellence, safety, innovation, satisfaction, and leadership. We sincerely appreciate the opportunity to provide comments to the Office for Consumer Health Assistance for the State of Nevada regarding the Revised Draft of Permanent Regulations Regarding AB 469, NRS 439, LCB File No. R101-19 (dated December 9, 2019) and the Proposed Regulation of the Director of the Department of Health and Human Services, LCB File No. R101-19 (dated January 6, 2020), as posted at http://dhhs.nv.gov/Programs/CHA/.

We thank the State of Nevada for taking important action to protect patients from surprise medical bills in emergency contexts, and we appreciate your leadership and efforts to ensure that the rulemaking process supports continued progress to protect patients while treating medical providers and insurance carriers fairly. As an organization that has always had an in-network strategy, USAP applauds the efforts taken to date, and we hope our feedback is helpful in furthering seamless implementation of AB 469 in 2020.

Our comments below are organized in response to the proposed regulations referenced above and where possible we have offered potential revised language for your consideration. Where applicable, we have provided section references to the December 9, 2019 draft, with cross-references noted to the January 6, 2020 document.

Sec. 17 – Submission, contents and review of requests for arbitration (…). (December 9, 2019 draft)

Section 2 (January 6, 2020 draft)

Subsections 17.2 and 17.3 – Timeframe for Arbitration Requests. We appreciate the drafters' revisions to Subsection 17.2 and Subsection 17.3 to extend the timeframe for submitting requests for arbitration from 10 business days to 30 business days (an update from the previous November 2019 draft). We suggest an additional clarification to the current draft as outlined below.

For added clarity, we propose that Subsections 17.2 and 17.3 be revised as follows, with the underlined language added to the current draft:

2. *The request must be submitted to the Department within 30 business days from the later of the time the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec. 17.3.*
3. *The Department will not accept applications requesting arbitration past 30 business days from the later of the date the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec. 17.3 and payment received will be considered payment in full.*

For Section 2 of the January 6, 2020 draft, we suggest that Section 2.1(a) be revised to read *"the out-of-network provider must submit the request by the later of: (a) (...) or (b) (...)."*

Subsection 17.4 – Online Filing of Arbitration Requests and Contents. We recommend considering revising Subsection 17.4 to clarify that arbitration request forms shall be submitted through an online process. It is important for the submission process to be efficient and simple. To that end, any potential for arbitration request forms to be submitted by hard copy through the postal service or otherwise could hinder the efficiency of the process.

In addition, we recommend the drafters consider deleting Subsection 17.4(h)e in its entirety which, as proposed, would require out-of-network providers to disclose in all arbitration requests a "representative sample of at least 3 fees received by the provider in the last 24 months for the same service, in the same region, from health plans in which the provider does not participate." For providers with a strong history of in-network contracting, this information regarding out-of-network payments might not even exist. Further, over time, this information could simply reflect a pattern and practice of underpayments by carriers who know that their out-of-network payments might be considered in this context. If adopted, this requirement could incentivize commercial payors to offer lower reimbursement rates for out-of-network emergency claims on a global level given their knowledge that such information might be used by an arbitrator as a benchmark in future arbitrations.

For Section 2 of the January 6, 2020 draft, we suggest that Section 2(e)(3) be deleted to remove the requirement that this information be submitted for the reasons noted as to 17.4 above: *"A representative sample of at least three payments received by the out-of-network provider as compensation for the same medically necessary emergency services provided in the same region of this state from third parties with which the out-of-network provider has not entered into a provider contract."*

Additional Proposed Revision – Regulation on Bundling Claims for Arbitration. We recommend adding a regulation which specifies that a single arbitration can address multiple disputed out-of-network emergency claims. The text of AB 469 is silent on this issue, but the general spirit of the new law is to facilitate fair and efficient dispute resolution. There could be a multitude of scenarios where conducting a single arbitration covering disputes associated with multiple claims would further this purpose, especially to the extent these claims involve substantially similar issues and parties.

However, we also recognize that there must be some limitations on bundling of claims in a single arbitration. Accordingly, we recommend considering a regulation which provides:

> *Multiple claims may be heard and determined in a single arbitration proceeding if the following three conditions are met: (1) the claims involve the identical carrier and the same provider or medical group; (2) the claims involve the same or related services; and (3) the claims occur within a period of three months of each other.*

Additional Proposed Revision – Clarification as to Arbitrator's Award. AB 469 provides a specific and detailed procedure for the arbitration process for out-of-network billing disputes as to emergency claims. In short, the arbitrator's decision is to be final and not subject to any appeals or future litigation. Accordingly, in order to avoid inviting potential litigation and further disputes over an arbitrator's decision, we recommend the addition of a regulation which provides:

> *The arbitrator shall render a decision in accordance with the procedures outlined in Sec. 17 of AB 469 without any reference to any other statutes addressing arbitration, such as the Nevada Uniform Arbitration Act and the Federal Arbitration Act, or any other rules of procedure governing arbitration in other private contexts, such as the American Arbitration Association Rules of Arbitration and the Rules of Procedure for Commercial Arbitration of the American Health Lawyer's Association.*

Additional Proposed Revision – Identifying Conflicts of Interest. We recommend a regulation regarding Sec. 17.4 which allows both the commercial payor and the out-of-network provider an opportunity to identify and disclose any personal, professional, or financial conflicts of interest with any of the five arbitrators randomly selected for the parties' consideration. Qualified arbitrators should be non-conflicted in accordance with the goals of AB 469, and it would be helpful to allow the parties an opportunity to identify and disclose potential conflicts between the arbitrator and any other party to the arbitration before undertaking the task of selecting an arbitrator to preside over an arbitration. This would ensure that the parties have the opportunity to consider five truly "qualified arbitrators" without the inclusion of arbitrators with conflicts of interest, which AB 469 clearly intends.

Other Qualifications of Arbitrators. AB 469/N.R.S. 439B.754(3) permits "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." The proposed regulations dated December 9, 2019 and January 6, 2020 both state that the arbitrators must be selected from the American Arbitration Association, JAMS, or their successor organizations. We suggest that the language of the statute be preserved so that arbitrators from other nationally recognized providers *may* be selected if appropriate.

Thank you again for the opportunity to share our comments for the foregoing proposed regulations related to the implementation of AB 469, and we appreciate your leadership on this important issue.

Sincerely,

US Anesthesia Partners