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ASSEMBLY BILL 79 (2nd Reprint)
SECTION-BY-SECTION SUMMARY

Assemblywoman Buckley

Prepared by the Research Division of the Legislative Counsel Bureau
May 6, 2003

SUMMARY—Provides for external review of final adverse determinations made by managed care organizations, health maintenance organizations, and certain insurers. (BDR 57-955)

Note: Chapter 695C of *Nevada Revised Statutes* (NRS) governs health maintenance organizations (HMOs) and Chapter 695G of NRS governs managed care organizations (MCOs).

Section 1 of the bill adds two new sections to Chapter 683A of *Nevada Revised Statutes* (NRS).

Section 2 adds a requirement to Chapter 683A of NRS that the Commissioner of Insurance adopt regulations concerning certification of organizations that will conduct external reviews of final adverse determinations of MCOs and HMOs. A certificate issued by the Commissioner expires 1 year after it is issued and may be renewed.

An external review organization must demonstrate to the Commissioner its ability to carry out the duties required by this bill and do so with qualified and experienced personnel. An external review organization must not have a conflict of interest with the insured, the insurer, the provider of health care services, the health care facility where the care is given, or certain other interests.

An external review organization that is certified or accredited by an accrediting body that is nationally recognized shall be deemed to have satisfied all the conditions and qualifications required for certification pursuant to this section.

The Commissioner may charge a reasonable fee for issuing or renewing the certificate. The Commissioner must prepare and make available for public inspection a list that includes the name of each external review organization that is issued a certificate or whose certificate is renewed.

Section 3 adds to Chapter 683A of NRS a requirement that the Commissioner annually submit to the Office for Consumer Health Assistance an updated list of external review organizations.

Sections 4 through 10 require certain insurers that issue health insurance policies that cover the cost of health care services through managed care to establish systems for resolving complaints concerning those services as provided for in this bill. These sections also make conforming changes concerning reports required to be filed with the Commissioner and the State Board of Health by certain health insurers.

Section 11 amends NRS 695C.070 to require that an applicant for a certificate of authority to operate an HMO must provide a description of its procedures for conducting external reviews.

Section 12 amends NRS 695C.260 to require HMOs to establish a system for conducting external reviews.

Section 13 amends NRS 695C.330 to allow the Commissioner to suspend the certificate of an HMO that has failed to establish a system for conducting external reviews that meets the requirements of this bill.
Section 14 provides that each prepaid limited health service organization that issues any evidence of coverage for health care services through managed care must provide a system for resolving any

complaints of an enrollee or subscriber concerning those health care services that meets the requirements of this bill.

Section 15 adds to Chapter 695G of NRS provisions in the following 13 sections of the bill (Sections 16 through 28).

Section 16 defines "adverse determination."

Section 17 defines "authorized representative."

Section 18 defines "clinical peer."

Section 19 defines "external review organization."

Section 20 defines "medically necessary."

Section 21 defines "final adverse determination" of an MCO.

Section 22 provides the circumstances under which a request for an external review can be made. The amount required to be paid for the provided health care services must be at least $500 and the request must be made within 60 days after receiving a notice of the final adverse determination. This section also specifies certain timeframes for acknowledging that a request for an external review has been made and requires that the Office for Consumer Health Assistance, as soon as practicable, select on a rotating basis an organization to perform the external review and notify the respective parties of the selection.

Section 23 gives an external review organization 5 days within which to (1) review a request for an external review, and (2) request any additional information needed to conduct the review. This section also requires that the external review organization approve, modify, or reverse the final adverse determination within 15 days after it receives the information required to make a determination.

Section 24 provides that an MCO must approve or deny a request for an external review within 72 hours after it receives proof that failure to proceed in an expedited manner may jeopardize the life or health of the insured, and specifies certain timeframes for assigning and completing external reviews.

Section 25 requires that an external review organization consider various factors when making its determination.

Section 26 provides that the determination of the external review organization is binding on the MCO if the determination is in favor of the insured. In addition, it provides that an external review organization or any clinical peer who participates in an external review is not liable in a civil action for damages if the determination is made in good faith and without gross negligence. In addition, this section requires that the MCO pay the cost of the external review.

Section 27 allows an MCO to submit a complaint to an external review organization in lieu of resolving a complaint in accordance with a system for resolving complaints pursuant to NRS 695G.200. It also allows an MCO to submit a complaint for resolution in accordance with federal law or regulation if the federal law or regulation provides a procedure that is substantially similar to the procedure for submitting a complaint to an external review organization as provided for in this bill.

Section 28 requires that each MCO file with the Office for Consumer Health Assistance an annual report setting forth the number of external reviews received by the MCO during the preceding year and the number of final adverse determinations that were upheld and reversed.

Section 29 makes a conforming change to NRS 695G.010 concerning definitions.

Section 30 clarifies that the term "utilization review" as defined in NRS 695G.080 does not include an external review of a final adverse determination.

Section 31 specifies that an organization that provides health care services through managed care to recipients of Medicaid or the Children's Health Insurance Program under a contract with the Division of Health Care Financing and Policy is not required to establish a system for resolving complaints pursuant to Chapter 695G of NRS. However, this exemption does not apply to any other contract of an MCO.

Section 32 makes a conforming change to ensure that existing provisions in NRS 695G.210 regarding a system for resolving complaints of an insured are not in conflict with the requirements of Section 27 of this bill.

Section 33 grants to an insured a right to appeal a final adverse determination and to receive an expedited external review of the adverse determination if the MCO receives proof from the insured's provider of health care that failure to proceed in an expedited manner may jeopardize the life or health of the insured. It also gives the insured a right to receive assistance from any person, including an attorney, for an external review. Finally, it gives the insured a right to the telephone number of the Office for Consumer Health Assistance.

Section 34 adds a requirement to NRS 223.580 that the annual report from the Director of the Office for Consumer Health Assistance to the Governor and the Director of the Legislative Counsel Bureau include a statement setting forth the number of external reviews conducted and the disposition of each of those reviews.

Section 35 amends NRS 287.04335 to make the provisions of this bill applicable to employees who receive health insurance through a plan of self-insurance provided by the Board of the Public Employees' Benefits Program.

Section 36 clarifies that an MCO or an HMO that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing is not required to establish an external review system with respect to that contract. However, this exemption does not apply to an MCO or and HMO for services provided pursuant to any other contract.

Section 37 specifies effective dates for various sections of this bill.

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