REQUIRES TWO-THIRDS MAJORITY VOTE (§ 2) EXEMPT

(Reprinted with amendments adopted on April 9, 2003)

SECOND REPRINT **A.B. 79**

ASSEMBLY BILL NO. 79–ASSEMBLYMEN BUCKLEY, GIBBONS, ANDERSON, MANENDO, GIUNCHIGLIANI, ANDONOV, ANGLE, ARBERRY, ATKINSON, BEERS, BROWN, CARPENTER, CHOWNING, CHRISTENSEN, CLABORN, COLLINS, CONKLIN, GEDDES, GOICOECHEA, GOLDWATER, GRADY, GUSTAVSON, HARDY, HETTRICK, HORNE, KNECHT, KOIVISTO, LESLIE, MABEY, MARVEL, MCCLAIN, MCCLEARY, MORTENSON, OCEGUERA, OHRENSCHALL, PARKS, PERKINS, PIERCE, SHERER, WEBER AND WILLIAMS

FEBRUARY 11, 2003

JOINT SPONSOR: SENATOR TITUS

Referred to Committee on Commerce and Labor

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

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~[omitted material]~~ is material to be omitted.

AN ACT relating to health care; requiring an external review organization to be certified by the Commissioner of Insurance before conducting an external review of a final adverse determination of a managed care organization, health maintenance organization or certain insurers; authorizing an insured under certain health care plans to submit to a managed care organization, health maintenance organization or certain insurers a request for such a review under certain circumstances; requiring an external review organization to approve, modify or reverse a final adverse determination within a certain period; providing that an external review organization is not liable in a civil action for damages relating to a

determination issued by the external review organization under certain circumstances; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 **Section 1.** Chapter 683A of NRS is hereby amended by
2 adding thereto the provisions set forth as sections 2 and 3 of this act.
3 **Sec. 2.** ***1. An external review organization shall not***
4 ***conduct an external review of a final adverse determination***
5 ***pursuant to sections 16 to 28, inclusive, of this act unless the***
6 ***external review organization is certified in accordance with***
7 ***regulations adopted by the Commissioner. The regulations must***
8 ***include, without limitation, provisions setting forth:***
9 ***(a) The manner in which an external review organization may***
10 ***apply for a certificate and the requirements for the issuance and***
11 ***renewal of the certificate pursuant to this section;***
12 ***(b) The grounds for which the Commissioner may refuse to***
13 ***issue, suspend, revoke or refuse to renew a certificate issued***
14 ***pursuant to this section; and***
15 ***(c) The manner and circumstances under which an external***
16 ***review organization is required to conduct its business.***
17 ***2. A certificate issued pursuant to this section expires 1 year***
18 ***after it is issued and may be renewed in accordance with***
19 ***regulations adopted by the Commissioner.***
20 ***3. Except as otherwise provided in subsection 6, before the***
21 ***Commissioner may certify an external review organization, the***
22 ***external review organization must:***
23 ***(a) Demonstrate to the satisfaction of the Commissioner that it***
24 ***is able to carry out, in a timely manner, the duties of an external***
25 ***review organization set forth in this section and sections 16 to 28,***
26 ***inclusive, of this act. The demonstration must include, without***
27 ***limitation, proof that the external review organization employs,***
28 ***contracts with or otherwise retains only persons who are qualified***
29 ***because of their education, training, professional licensing and***
30 ***experience to perform the duties assigned to those persons; and***
31 ***(b) Provide assurances satisfactory to the Commissioner that***
32 ***the external review organization will:***
33 ***(1) Conduct its external review activities in accordance with***
34 ***the provisions of this section and sections 16 to 28, inclusive, of***
35 ***this act;***
36 ***(2) Provide its determinations in a clear, consistent,***
37 ***thorough and timely manner; and***
38 ***(3) Avoid conflicts of interest.***

4. For the purposes of this section, an external review organization has a conflict of interest if the external review organization or any employee, agent or contractor of the external review organization who conducts an external review has a material professional, familial or financial interest in any person who has a substantial interest in the outcome of the external review, including, without limitation:

(a) The insured;

(b) The insurer or any officer, director or management employee of the insurer;

(c) The provider of health care services that are provided or proposed to be provided, his partner or any other member of his medical group or practice;

(d) The hospital or other licensed health care facility where the health care service or treatment that is subject to external review has been or will be provided; or

(e) A developer, manufacturer or other person who has a substantial interest in the principal procedure, equipment, drug, device or other instrumentality that is the subject of the external review.

5. The Commissioner shall not certify an external review organization that is affiliated with:

(a) A health care plan; or

(b) A national, state or local trade association.

6. 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.

7. The Commissioner may charge and collect a fee for issuing or renewing a certificate of an external review organization pursuant to this section. The fee must not exceed the cost of issuing or renewing the certificate.

8. The Commissioner shall annually prepare and make available to the general public a list that includes the name of each external review organization which is issued a certificate or whose certificate is renewed pursuant to this section during the year immediately preceding the year in which the Commissioner prepares the list.

9. As used in this section:

(a) "Adverse determination" has the meaning ascribed to it in section 16 of this act.

(b) "External review organization" has the meaning ascribed to it in section 19 of this act.

(c) "Provider of health care" means any physician or other person who is licensed in this state or is licensed, certified or

otherwise authorized by any other state to provide any health care service.

Sec. 3. ***As soon as practicable after preparing an annual list of external review organizations pursuant to subsection 8 of section 2 of this act, the Commissioner shall submit a copy of the list to the Office for Consumer Health Assistance. If a change occurs in the list, the Commissioner shall notify the Office for Consumer Health Assistance of the change.***

Sec. 4. NRS 689A.745 is hereby amended to read as follows:

689A.745 1. [~~Each~~] ***Except as otherwise provided in subsection 4, each*** insurer that issues a policy of health insurance in this state shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner in consultation with the State Board of Health.

2. A system for resolving complaints ***established*** pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a policy of health insurance issued by the insurer.

3. The Commissioner or the State Board of Health may examine the system for resolving complaints established pursuant to [~~this section~~] ***subsection 1*** at such times as either deems necessary or appropriate.

4. Each insurer that issues a policy of health insurance in this state that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an insured concerning those health care services that complies with the provisions of sections 16 to 28, inclusive, of this act and NRS 695G.200 to 695G.230, inclusive.

Sec. 5. NRS 689A.750 is hereby amended to read as follows:

689A.750 1. Each insurer that issues a policy of health insurance in this state shall submit to the Commissioner and the State Board of Health an annual report regarding its system for resolving complaints established pursuant to ***subsection 1 of*** NRS 689A.745 on a form prescribed by the Commissioner in consultation with the State Board of Health which includes, without limitation:

(a) A description of the procedures used for resolving any complaints of an insured;

(b) The total number of complaints and appeals handled through the system for resolving complaints since the last report and a compilation of the causes underlying the complaints filed;

(c) The current status of each complaint and appeal filed; and

(d) The average amount of time that was needed to resolve a complaint and an appeal, if any.

2. Each insurer shall maintain records of complaints filed with it which concern something other than health care services and shall submit to the Commissioner a report summarizing such complaints at such times and in such format as the Commissioner may require.

Sec. 6. NRS 689B.0285 is hereby amended to read as follows:

689B.0285 1. ~~[Each]~~ ***Except as otherwise provided in subsection 4, each*** insurer that issues a policy of group health insurance in this state shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner in consultation with the State Board of Health.

2. A system for resolving complaints ***established*** pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a policy of group health insurance issued by the insurer.

3. The Commissioner or the State Board of Health may examine the system for resolving complaints established pursuant to ~~[this section]~~ ***subsection 1*** at such times as either deems necessary or appropriate.

4. Each insurer that issues a policy of group health insurance in this state that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an insured concerning the health care services that complies with the provisions of sections 16 to 28, inclusive, of this act and NRS 695G.200 to 695G.230, inclusive.

Sec. 7. NRS 689B.029 is hereby amended to read as follows:

689B.029 1. Each insurer that issues a policy of group health insurance in this state shall submit to the Commissioner and the State Board of Health an annual report regarding its system for resolving complaints established pursuant to ***subsection 1 of*** NRS 689B.0285 on a form prescribed by the Commissioner in consultation with the State Board of Health which includes, without limitation:

(a) A description of the procedures used for resolving any complaints of an insured;

(b) The total number of complaints and appeals handled through the system for resolving complaints since the last report and a compilation of the causes underlying the complaints filed;

(c) The current status of each complaint and appeal filed; and

(d) The average amount of time that was needed to resolve a complaint and an appeal, if any.

2. Each insurer shall maintain records of complaints filed with it which concern something other than health care services and shall submit to the Commissioner a report summarizing such complaints at such times and in such format as the Commissioner may require.

Sec. 8. NRS 689C.156 is hereby amended to read as follows:

689C.156 1. As a condition of transacting business in this state with small employers, a carrier shall actively market to a small employer each health benefit plan which is actively marketed in this state by the carrier to any small employer in this state. The health insurance plans marketed pursuant to this section by the carrier must include, without limitation, a basic health benefit plan and a standard health benefit plan. A carrier shall be deemed to be actively marketing a health benefit plan when it makes available any of its plans to a small employer that is not currently receiving coverage under a health benefit plan issued by that carrier.

2. A carrier shall issue to a small employer any health benefit plan marketed in accordance with this section if the eligible small employer applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with NRS 689C.015 to 689C.355, inclusive, and 689C.610 to 689C.980, inclusive, except that a carrier is not required to issue a health benefit plan to a self-employed person who is covered by, or is eligible for coverage under, a health benefit plan offered by another employer.

3. If a health benefit plan marketed pursuant to this section provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, the carrier shall provide a system for resolving any complaints of an employee concerning those health care services that complies with the provisions of sections 16 to 28, inclusive, of this act and NRS 695G.200 to 695G.230, inclusive.

Sec. 9. NRS 695B.380 is hereby amended to read as follows:

695B.380 1. ~~[Each]~~ ***Except as otherwise provided in subsection 4, each*** insurer that issues a contract for hospital or medical services in this state shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner in consultation with the State Board of Health.

2. A system for resolving complaints ***established*** pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services

pursuant to a contract for hospital or medical services issued by the insurer.

3. The Commissioner or the State Board of Health may examine the system for resolving complaints established pursuant to ~~[this section]~~ ***subsection 1*** at such times as either deems necessary or appropriate.

4. Each insurer that issues a contract specified in subsection 1 shall, if the contract provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, provide a system for resolving any complaints of an insured concerning those health care services that complies with the provisions of sections 16 to 28, inclusive, of this act and NRS 695G.200 to 695G.230, inclusive.

Sec. 10. NRS 695B.390 is hereby amended to read as follows:

695B.390 1. Each insurer that issues a contract for hospital or medical services in this state shall submit to the Commissioner and the State Board of Health an annual report regarding its system for resolving complaints established pursuant to ***subsection 1 of*** NRS 695B.380 on a form prescribed by the Commissioner in consultation with the State Board of Health which includes, without limitation:

(a) A description of the procedures used for resolving any complaints of an insured;

(b) The total number of complaints and appeals handled through the system for resolving complaints since the last report and a compilation of the causes underlying the complaints filed;

(c) The current status of each complaint and appeal filed; and

(d) The average amount of time that was needed to resolve a complaint and an appeal, if any.

2. Each insurer shall maintain records of complaints filed with it which concern something other than health care services and shall submit to the Commissioner a report summarizing such complaints at such times and in such format as the Commissioner may require.

Sec. 11. NRS 695C.070 is hereby amended to read as follows:

695C.070 Each application for a certificate of authority ~~[shall]~~ ***must*** be verified by an officer or authorized representative of the applicant, ~~[shall]~~ ***must*** be in a form prescribed by the Commissioner, and ~~[shall]~~ ***must*** set forth or be accompanied by the following:

1. A copy of the basic organizational document, if any, of the applicant, and all amendments thereto;

2. A copy of the bylaws, rules or regulations, or ***a*** similar document, if any, regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses ~~[,]~~ and official positions of the persons who ~~[are to]~~ ***will*** be responsible for the conduct of the

1 affairs of the applicant, including all members of the board of
2 directors, board of trustees, executive committee, or other governing
3 board or committee, the officers in the case of a corporation, and the
4 partners or members in the case of a partnership or association;
5 4. A copy of any contract made or to be made between any
6 providers or persons listed in subsection 3 and the applicant;
7 5. A statement generally describing the health maintenance
8 organization, its health care plan or plans, ***the*** location of facilities at
9 which health care services will be regularly available to enrollees [,]
10 ***and*** the type of health care personnel who will provide the health
11 care services;
12 6. A copy of the form of evidence of coverage to be issued to
13 the enrollees;
14 7. A copy of the form of the group contract, if any, which is to
15 be issued to employers, unions, trustees or other organizations;
16 8. Certified financial statements showing the applicant's assets,
17 liabilities and sources of financial support;
18 9. The proposed method of marketing the plan, a financial plan
19 which includes a [three-year] ***3-year*** projection of the initial
20 operating results anticipated and the sources of working capital [as
21 well as] ***and*** any other sources of funding;
22 10. A power of attorney ***,*** [duly] executed by the applicant,
23 appointing the Commissioner and his [duly] authorized deputies [,]
24 as the true and lawful attorney of such applicant in and for this state
25 upon whom all lawful process in any legal action or proceeding
26 against the health maintenance organization on a cause of action
27 arising in this state may be served;
28 11. A statement reasonably describing the geographic area to
29 be served;
30 12. A description of the [complaint] procedures ***for resolving***
31 ***complaints and procedures for external reviews*** to be [utilized]
32 ***used*** as required under NRS 695C.260;
33 13. A description of the procedures and programs to be
34 implemented to meet the quality of health care requirements in
35 NRS 695C.080;
36 14. A description of the mechanism by which enrollees will be
37 afforded an opportunity to participate in matters of program content
38 under subsection 2 of NRS 695C.110; and
39 15. Such other information as the Commissioner may require
40 to make the determinations required in NRS 695C.080.
41 **Sec. 12.** NRS 695C.260 is hereby amended to read as follows:
42 695C.260 [Every] ***Each*** health maintenance organization shall
43 establish [a complaint] ***:***
44 ***1. A*** system ***for resolving complaints*** which complies with the
45 provisions of NRS 695G.200 to 695G.230, inclusive [.] ***; and***

2. A system for conducting external reviews of final adverse determinations that complies with the provisions of sections 16 to 28, inclusive, of this act.

Sec. 13. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS ~~[695C.170 to 695C.200, inclusive, or 695C.1694, 695C.1695]~~ ***695C.1694 to 695C.200, inclusive,*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The State Board of Health certifies to the Commissioner that the health maintenance organization:

(1) Does not meet the requirements of subsection 2 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system ~~[for complaints]~~ required by NRS 695C.260 ***for:***

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; ***and***

(2) Conducting external reviews of final adverse determinations that comply with the provisions of sections 16 to 28, inclusive, of this act;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(j) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may by written order permit such further operation of the organization as he may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 14. NRS 695F.230 is hereby amended to read as follows:

695F.230 1. Each prepaid limited health service organization shall establish a system for the resolution of written complaints submitted by enrollees and providers.

2. The provisions of subsection 1 do not prohibit an enrollee or provider from filing a complaint with the Commissioner or limit the Commissioner's authority to investigate such a complaint.

3. Each prepaid limited health service organization that issues any evidence of coverage that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an enrollee or subscriber concerning those health care services that complies with the provisions of sections 16 to 28, inclusive, of this act and NRS 695G.200 to 695G.230, inclusive.

Sec. 15. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 16 to 28, inclusive, of this act.

Sec. 16. ***"Adverse determination" means a determination of a managed care organization to deny all or part of a service or procedure that is proposed or being provided to an insured on the basis that it is not medically necessary or appropriate or is experimental or investigational. The term does not include a determination of a managed care organization that such an allocation is not a covered benefit.***

Sec. 17. ***"Authorized representative" means a person who has obtained the consent of an insured to represent him in an external review of a final adverse determination conducted pursuant to sections 16 to 28, inclusive, of this act.***

Sec. 18. ***"Clinical peer" means a physician who is:***

1. Engaged in the practice of medicine; and

2. Certified or is eligible for certification by a member board of the American Board of Medical Specialties in the same or similar area of practice as is the health care service that is the subject of a final adverse determination.

Sec. 19. ***"External review organization" means an organization that:***

1. Conducts an external review of a final adverse determination; and

2. Is certified by the Commissioner in accordance with section 2 of this act.

Sec. 20. ***"Medically necessary" means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and:***

1. Provided in accordance with generally accepted standards of medical practice;

2. Clinically appropriate with regard to type, frequency, extent, location and duration;

3. Not primarily provided for the convenience of the patient, physician or other provider of health care;

4. Required to improve a specific health condition of an insured or to preserve his existing state of health; and

5. The most clinically appropriate level of health care that may be safely provided to the insured.

Sec. 21. ***1. For the purposes of sections 16 to 28, inclusive, of this act and NRS 695G.200 to 695G.230, inclusive, an adverse determination is final if the insured has exhausted all procedures set forth in the health care plan for reviewing the adverse determination within the managed care organization.***

2. An adverse determination shall be deemed final for the purpose of submitting the adverse determination to an external review organization for an external review:

(a) If an insured exhausts all procedures set forth in the health care plan for reviewing the adverse determination within the managed care organization and the managed care organization fails to render a decision within the period required to render that decision set forth in the health care plan; or

(b) If the managed care organization submits the adverse determination to the external review organization without

requiring the insured to exhaust all procedures set forth in the health care plan for reviewing the adverse determination within the managed care organization.

Sec. 22. *1. If an insured or a physician of an insured receives notice of a final adverse determination from a managed care organization concerning the insured, and if the insured is required to pay $500 or more for the health care services that are the subject of the final adverse determination, the insured, the physician of the insured or an authorized representative may, within 60 days after receiving notice of the final adverse determination, submit a request to the managed care organization for an external review of the final adverse determination.*

2. Within 5 days after receiving a request pursuant to subsection 1, the managed care organization shall notify the insured, his authorized representative or his physician, the agent who performed utilization review for the managed care organization, if any, and the Office for Consumer Health Assistance that the request has been filed with the managed care organization.

3. As soon as practicable after receiving a notice pursuant to subsection 2, the Office for Consumer Health Assistance shall assign an external review organization from the list maintained pursuant to section 2 of this act. Each assignment made pursuant to this subsection must be completed on a rotating basis.

4. Within 5 days after receiving notification from the Office for Consumer Health Assistance specifying the external review organization assigned pursuant to subsection 3, the managed care organization shall provide to the external review organization all documents and materials relating to the final adverse determination, including, without limitation:

(a) Any medical records of the insured relating to the external review;

(b) A copy of the provisions of the health care plan upon which the final adverse determination was based;

(c) Any documents used by the managed care organization to make the final adverse determination;

(d) The reasons for the final adverse determination; and

(e) Insofar as practicable, a list that specifies each provider of health care who has provided health care to the insured and the medical records of the provider of health care relating to the external review.

Sec. 23. *1. Except as otherwise provided in section 24 of this act, upon receipt of a request for an external review pursuant to section 22 of this act, the external review organization shall, within 5 days after receiving the request:*

1 ***(a) Review the request and the documents and materials***
2 ***submitted pursuant to section 22 of this act; and***
3 ***(b) Notify the insured, his physician and the managed care***
4 ***organization if any additional information is required to conduct a***
5 ***review of the final adverse determination.***
6 ***2. Except as otherwise provided in section 24 of this act, the***
7 ***external review organization shall approve, modify or reverse***
8 ***the final adverse determination within 15 days after it receives the***
9 ***information required to make that determination pursuant to this***
10 ***section. The external review organization shall submit a copy of its***
11 ***determination, including the reasons therefor, to:***
12 ***(a) The insured;***
13 ***(b) The physician of the insured;***
14 ***(c) The authorized representative of the insured, if any; and***
15 ***(d) The managed care organization.***
16 **Sec. 24.** ***1. A managed care organization shall approve or***
17 ***deny a request for an external review of a final adverse***
18 ***determination in an expedited manner not later than 72 hours***
19 ***after it receives proof from the insured's provider of health care***
20 ***that failure to proceed in an expedited manner may jeopardize the***
21 ***life or health of the insured.***
22 ***2. If a managed care organization approves a request for an***
23 ***external review pursuant to subsection 1, the managed care***
24 ***organization shall:***
25 ***(a) In accordance with subsections 4 and 5, assign the request***
26 ***to an external review organization not later than 1 working day***
27 ***after approving the request; and***
28 ***(b) At the time of assigning the request, provide to the external***
29 ***review organization all documents and materials specified in***
30 ***subsection 4 of section 22 of this act.***
31 ***3. An external review organization that is assigned to conduct***
32 ***an external review pursuant to subsection 2 shall, if it accepts the***
33 ***assignment:***
34 ***(a) Complete its external review not later than 2 working days***
35 ***after receiving the assignment, unless the insured and the***
36 ***managed care organization agree to a longer period;***
37 ***(b) Not later than 1 working day after completing its external***
38 ***review, notify the insured, the physician of the insured, the***
39 ***authorized representative of the insured, if any, and the managed***
40 ***care organization by telephone of its determination; and***
41 ***(c) Not later than 5 working days after completing its external***
42 ***review, submit a written decision of its external review to the***
43 ***insured, the physician of the insured, the authorized representative***
44 ***of the insured, if any, and the managed care organization.***

4. At least once each month, the Office for Consumer Health Assistance shall designate at least 2 external review organizations to conduct external reviews in an expedited manner pursuant to this section. As soon as practicable after designating an external review organization pursuant to this section, the Office for Consumer Health Assistance shall notify each managed care organization of the designation.

5. As soon as practicable after assigning an external review organization to conduct an external review pursuant to this section, the managed care organization shall notify the Office for Consumer Health Assistance of the assignment. Each assignment made by a managed care organization pursuant to this section must be completed on a rotating basis.

Sec. 25. *The decision of an external review organization concerning a request for an external review must be based on:*

1. Documentary evidence, including any recommendation of the physician of the insured submitted pursuant to section 22 of this act;

2. Medical evidence, including, without limitation:

(a) Professional standards of safety and effectiveness for diagnosis, care and treatment that are generally recognized in the United States;

(b) Any report published in literature that is peer-reviewed;

(c) Evidence-based medicine, including, without limitation, reports and guidelines that are published by professional organizations that are recognized nationally and that include supporting scientific data; and

(d) An opinion of an independent physician who, as determined by the external review organization, is an expert in the health specialty that is the subject of the external review; and

3. The terms and conditions for benefits set forth in the evidence of coverage issued to the insured by the managed care organization.

Sec. 26. *1. If the determination of an external review organization concerning an external review of a final adverse determination is in favor of the insured, the determination is final, conclusive and binding upon the managed care organization.*

2. An external review organization or any clinical peer who conducts or participates in an external review of a final adverse determination for the external review organization is not liable in a civil action for damages relating to a determination made by the external review organization if the determination is made in good faith and without gross negligence.

3. The cost of conducting an external review of a final adverse determination pursuant to sections 16 to 28, inclusive, of

this act must be paid by the managed care organization that made the final adverse determination.

Sec. 27. *In lieu of resolving a complaint of an insured in accordance with a system for resolving complaints established pursuant to the provisions of NRS 695G.200, a managed care organization may:*

1. Submit the complaint to an external review organization pursuant to the provisions of sections 16 to 28, inclusive, of this act; or

2. If a federal law or regulation provides a procedure for submitting the complaint for resolution that the Commissioner determines is substantially similar to the procedure for submitting the complaint to an external review organization pursuant to sections 16 to 28, inclusive, of this act, submit the complaint for resolution in accordance with the federal law or regulation.

Sec. 28. *On or before January 31 of each year, each managed care organization shall file a written report with the Office for Consumer Health Assistance setting forth the total number of:*

1. Requests for external review that were received by the managed care organization during the immediately preceding year; and

2. Final adverse determinations of the managed care organization that were:

(a) Upheld during the immediately preceding year.

(b) Reversed during the immediately preceding year.

Sec. 29. NRS 695G.010 is hereby amended to read as follows:

695G.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695G.020 to 695G.080, inclusive, *and sections 16 to 20, inclusive, of this act* have the meanings ascribed to them in those sections.

Sec. 30. NRS 695G.080 is hereby amended to read as follows:

695G.080 *1.* "Utilization review" means the various methods that may be used by a managed care organization to review the amount and appropriateness of the provision of a specific health care service to an insured.

2. The term does not include an external review of a final adverse determination conducted pursuant to sections 16 to 28, inclusive, of this act.

Sec. 31. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. The provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small

employers, a fraternal benefit society, a hospital or medical service corporation *,* and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with any other applicable provision of this title.

3. The provisions of NRS 695G.200 to 695G.230, inclusive, do not apply to an organization that provides 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 of Human Resources. This subsection does not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 32. NRS 695G.210 is hereby amended to read as follows:

695G.210 1. [A] ***Except as otherwise provided in section 27 of this act, a*** system for resolving complaints created pursuant to NRS 695G.200 must include, without limitation, an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members of the review board must be insureds who receive health care services from the managed care organization.

2. Except as otherwise provided in subsection 3, a review board shall complete its review regarding a complaint or appeal and notify the insured of its determination not later than 30 days after the complaint or appeal is filed, unless the insured and the review board have agreed to a longer period ***.*** [of time.]

3. If a complaint involves an imminent and serious threat to the health of the insured, the managed care organization shall inform the insured immediately of his right to an expedited review of his complaint. If an expedited review is required, the review board shall notify the insured in writing of its determination within 72 hours after the complaint is filed.

4. Notice provided to an insured by a review board regarding a complaint must include, without limitation, an explanation of any further rights of the insured regarding the complaint that are available under his health care plan.

Sec. 33. NRS 695G.230 is hereby amended to read as follows:

695G.230 1. [Following] ***After*** approval by the Commissioner, each managed care organization shall provide ***a*** written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the insured to file a written complaint and to obtain an expedited

review pursuant to NRS 695G.210. Such ***a*** notice must be provided to an insured:

(a) At the time he receives his certificate of coverage or evidence of coverage;

(b) Any time that the managed care organization denies coverage of a health care service or limits coverage of a health care service to an insured; and

(c) Any other time deemed necessary by the Commissioner.

2. ~~[Any time that]~~ ***If*** a managed care organization denies coverage of a health care service to an insured, including, without limitation, a health maintenance organization that denies a claim related to a health care plan pursuant to NRS 695C.185, it shall notify the insured in writing within 10 working days after it denies coverage of the health care service of:

(a) The reason for denying coverage of the service;

(b) The criteria by which the managed care organization or insurer determines whether to authorize or deny coverage of the health care service; ~~[and]~~

(c) His right to ~~[file]~~ ***:***

(1) File a written complaint and the procedure for filing such a complaint ~~[.]~~ ***;***

(2) Appeal a final adverse determination pursuant to sections 16 to 28, inclusive, of this act;

(3) Receive an expedited external review of a final adverse determination if the managed care organization 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, including notification of the procedure for requesting the expedited external review; and

(4) Receive assistance from any person, including an attorney, for an external review of a final adverse determination; and

(d) The telephone number of the Office for Consumer Health Assistance.

3. A written notice which is approved by the Commissioner shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

Sec. 34. NRS 223.580 is hereby amended to read as follows:

223.580 On or before February 1 of each year, the Director shall submit a written report to the Governor, and to the Director of the Legislative Counsel Bureau for transmittal to the appropriate committee or committees of the Legislature. The report must include, without limitation:

1. A statement setting forth the number and geographic origin of the written and telephonic inquiries received by the office and the issues to which those inquiries were related;

2. A statement setting forth the type of assistance provided to each consumer and injured employee who sought assistance from the Director, including, without limitation, the number of referrals made to the Attorney General pursuant to subsection 7 of NRS 223.560; [and]

3. A statement setting forth the disposition of each inquiry and complaint received by the Director [.] ***; and***

4. A statement setting forth the number of external reviews conducted by external review organizations pursuant to sections 16 to 28, inclusive, of this act and the disposition of each of those reviews as reported pursuant to section 28 of this act.

Sec. 35. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of ***sections 16 to 28, inclusive, of this act and*** NRS 689B.255, 695G.150, 695G.160, 695G.170 and 695G.200 to 695G.230, inclusive, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 36. NRS 422.273 is hereby amended to read as follows:

422.273 1. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; and

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid.

Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

2. During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

3. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

4. For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

5. ***The provisions of this section apply to any managed care organization, including a health maintenance organization, 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 and Policy of the Department of Human Resources. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of final adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.***

6. As used in this section, unless the context otherwise requires:

(a) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(b) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(c) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

Sec. 37. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 36, inclusive, of this act become effective:

(a) Upon passage and approval for the purposes of:

(1) Adopting regulations by the Commissioner of Insurance to carry out the provisions of this act; and

(2) Certifying external review organizations pursuant to section 2 of this act;

(b) On January 1, 2004, for the purposes of filing notice of and approving any material modifications to operations as required pursuant to NRS 695C.140; and

(c) On July 1, 2004, for all other purposes.