

ASSEMBLY BILL NO. 491—ASSEMBLYMEN FREEMAN, MORTENSON, SEGERBLOM, GIBBONS, PARNELL, THOMAS, NEIGHBORS, BACHE, LEE, TIFFANY, WILLIAMS, OHRENSCHALL, MANENDO, KOIVISTO, ARBERRY, BUCKLEY, GOLDWATER, NOLAN, EVANS, CLABORN, MCCLAIN, DE BRAGA AND ANGLE

MARCH 11, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Establishes external review panel to hear appeals of denials of benefits or treatment under health care plans. (BDR 57-724)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: 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 insurance; providing in skeleton form for the creation of an external review panel in the division of insurance of the department of business and industry to review denials of benefits or treatment under health care plans; providing in skeleton form a procedure for the appeal of such denials to the review panel; authorizing the division of insurance to establish a schedule of fees to pay for the cost of such appeals; 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 679B of NRS is hereby amended by adding
2 thereto the provisions set forth as sections 2 to 19, inclusive, of this act.
3 **Sec. 2.** *As used in sections 2 to 19, inclusive, of this act, unless the*
4 *context otherwise requires, the words and terms defined in sections 3 to*
5 *9, inclusive, of this act have the meanings ascribed to them in those*
6 *sections.*
7 **Sec. 3.** *“Health care plan” means a policy, contract, certificate or*
8 *agreement offered or issued by an insurer to provide, deliver, arrange*
9 *for, pay for, or reimburse any of the costs of, health care services.*
10 **Sec. 4.** *“Insured” means an individual who receives benefits under a*
11 *health care plan.*

1 **Sec. 5.** *“Insurer” means any insurer or organization authorized*
2 *pursuant to this Title to conduct business in this state that provides or*
3 *arranges for the provision of health care services, including, without*
4 *limitation, an insurer that issues a policy of health insurance, an insurer*
5 *that issues a policy of group health insurance, a carrier serving small*
6 *employers, a fraternal benefit society, a hospital or medical service*
7 *corporation, a health maintenance organization, a plan for dental care, a*
8 *prepaid limited health service organization and a managed care*
9 *organization.*

10 **Sec. 6.** *“Managed care organization” has the meaning ascribed to it*
11 *in NRS 695G.050.*

12 **Sec. 7.** *“Primary care physician” means a physician who:*

- 13 1. *Provides initial and primary health care services to an insured;*
- 14 2. *Maintains the continuity of care for the insured; and*
- 15 3. *May refer the insured to a specialized provider of health care.*

16 **Sec. 8.** *“Provider of health care” has the meaning ascribed to it in*
17 *NRS 629.031.*

18 **Sec. 9.** *“Review panel” means the external panel for the review of*
19 *denials of benefits or treatment under a health care plan.*

20 **Sec. 10.** 1. *The commissioner shall appoint an external panel for*
21 *the review of denials of benefits or treatment under a health care plan.*
22 *The review panel consists of three members, who must be employees of*
23 *the division or other interested persons.*

24 2. *The review panel shall hear appeals of denials by insurers of*
25 *benefits or treatment under health care plans. For each such appeal, the*
26 *division may enter into a contract with:*

27 (a) *A medical director of a managed care organization in this state;*
28 *and*

29 (b) *A primary care physician who is licensed pursuant to chapter 630*
30 *of NRS to practice medicine in this state,*
31 *to advise the review panel concerning the appeal.*

32 3. *As a condition of membership on the review panel, and as a*
33 *condition of any contract entered into with a medical director or primary*
34 *care physician to advise the review panel, the member, medical director*
35 *or primary care physician must not have any conflict of interest or*
36 *appear to have any conflict of interest in the performance of his duties as*
37 *a member of, or an adviser to, the review panel.*

38 **Sec. 11.** 1. *An insured may, pursuant to sections 2 to 19, inclusive,*
39 *of this act, appeal the denial by an insurer of benefits or treatment under*
40 *a health care plan to the review panel if:*

41 (a) *The cost of the benefits or treatment denied is \$100 or more; and*

42 (b) *Except as otherwise provided in this paragraph, the insured has*
43 *exhausted the grievance procedures established by the insurer to*

1 *challenge the denial of benefits or treatment. The commissioner may*
2 *waive this requirement if the life of the insured is in imminent or*
3 *emergent jeopardy.*

4 2. *An appeal of a denial of benefits or treatment may be brought by:*

5 (a) *The insured;*

6 (b) *His legal guardian or legal representative; or*

7 (c) *His provider of health care.*

8 3. *Except as otherwise provided in this subsection, an appeal of a*
9 *denial of benefits or treatment must include a nonrefundable filing fee of*
10 *\$25 payable to the division. The commissioner shall waive the filing fee if*
11 *he determines that the person filing the request is indigent or otherwise*
12 *cannot afford the fee.*

13 **Sec. 12.** *An insurer shall, as a part of its grievance procedures*
14 *established to challenge the denial of benefits or treatment, provide*
15 *notification to the insured of his right to appeal a denial of benefits or*
16 *treatment to the review panel. The notification must include information*
17 *on the procedure for making such an appeal.*

18 **Sec. 13.** 1. *The review panel shall conduct a full review of each*
19 *appeal of a denial of benefits or treatment by an insurer to determine*
20 *whether, as a result of the denial of benefits or treatment, the insured*
21 *was deprived of any service or treatment that was medically necessary.*
22 *The insured and the insurer may present evidence, and the review panel*
23 *may examine witnesses. The review panel may consider any pertinent*
24 *information submitted to it, including, without limitation, medical*
25 *records, practice guidelines and clinical protocols.*

26 2. *Except as otherwise provided in subsection 3, the review panel*
27 *shall approve, modify or reverse the decision of the insurer to deny the*
28 *benefits or treatment within 30 days after the date on which the appeal*
29 *was filed.*

30 3. *If the life of the insured is in imminent or emergent jeopardy, the*
31 *commissioner shall convene the review panel within 24 hours after*
32 *receiving the request for the appeal and the review panel shall approve,*
33 *modify or reverse the decision of the insurer to deny the benefits or*
34 *treatment as expeditiously as possible.*

35 4. *The decision of the review panel is a final decision that is binding*
36 *on the insured and the insurer.*

37 **Sec. 14.** *If the review panel finds in favor of the insured, the insurer*
38 *shall pay to the division the cost of the appeal not later than 45 days after*
39 *the date on which the review panel issues its finding. The division shall,*
40 *by regulation, establish a reasonable fee to be charged pursuant to this*
41 *section to pay for the cost of an appeal before the review panel.*

1 **Sec. 15.** *In an appeal before the review panel, an insured or insurer*
2 *may be represented by legal counsel or any other person whom the*
3 *insured or insurer, as appropriate, chooses. An insured or insurer who*
4 *uses an attorney or other person to represent the insured or insurer, as*
5 *appropriate, before the review panel is responsible for any attorney's fees*
6 *or other fees charged by his attorney or representative. The insured and*
7 *insurer are not required to attend any hearing held by the review panel*
8 *on the appeal.*

9 **Sec. 16.** *The review panel, and any medical director and primary*
10 *care physician advising the review panel, shall, to the extent required by*
11 *law, preserve the confidentiality of medical records that are submitted to*
12 *the review panel, unless the insured, or his legal guardian or legal*
13 *representative gives written consent to the disclosure of the records.*

14 **Sec. 17.** *A member of the review panel, and any medical director*
15 *and primary care physician advising the review panel, is not liable in a*
16 *civil action for any act that he performs in good faith in the execution of*
17 *his duties pursuant to sections 2 to 19, inclusive, of this act.*

18 **Sec. 18.** *On or before January 1 of each year, the commissioner*
19 *shall:*

20 1. *Compile a report of the number of appeals made to the review*
21 *panel during the previous calendar year and the outcomes of those*
22 *appeals; and*

23 2. *Submit the report to:*

24 (a) *The governor; and*

25 (b) *The director of the legislative counsel bureau for transmittal to the*
26 *appropriate legislative committees.*

27 **Sec. 19.** *The division shall adopt such regulations as are necessary*
28 *to carry out the provisions of sections 2 to 19, inclusive, of this act.*