DISCLAIMER

Electronic versions of the exhibits in these minutes may not be complete.

This information is supplied as an informational service only and should not be relied upon as an official record.

Original exhibits are on file at the Legislative Counsel Bureau Research Library in Carson City.

Contact the Library at (775) 684-6827 or library@lcb.state.nv.us.

ASSEMBLY BILL NO. 79– AMENDMENT

Section 1. Chapter 683A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An external review organization shall not conduct an external review of a final adverse determination pursuant to sections 7 to 19 ~~6 to 14~~, inclusive, of this act unless the external review organization is certified in accordance with regulations adopted by the Commissioner. The regulations must include, without limitation, provisions setting forth:

(a) The manner in which an external review organization may apply for a certificate and the requirements for the issuance and renewal of the certificate pursuant to this section;

(b) The grounds for which the Commissioner may refuse to issue, suspend, revoke or refuse to renew a certificate issued pursuant to this section; and

(c) The manner and circumstances under which an external review organization is required to conduct its business.

2. A certificate issued pursuant to this section expires 1 year after it is issued and may be renewed in accordance with regulations adopted by the Commissioner.

3. Except as otherwise provided in subsection 6, before the Commissioner may certify an external review organization, the external review organization must:

(a) Demonstrate to the satisfaction of the Commissioner that it is able to carry out, in a timely manner, the duties of an external review organization set forth in this section and sections 6 to 14, inclusive, of this act. The demonstration must include, without limitation, proof that the external review organization employs, contracts with or otherwise retains only persons who are qualified because of their education, training, professional licensing and experience to perform the duties assigned to those persons; and

(b) Provide assurances satisfactory to the Commissioner that the external review organization will:

(1) Conduct its external review activities in accordance with the provisions of this section and sections 7 to 19 ~~6 to 14~~, inclusive, of this act;

(2) Provide its determinations in a clear, consistent, thorough and timely manner; and

(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

ASSEMBLY COMMERCE & LABOR 1 & 16
DATE: 3/03/03 ROOM: 4100 EXHIBIT D
SUBMITTED BY: Assemblywoman B. Buckley

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) "External review organization" has the meaning ascribed to it in section 9 8 of this act.

(b) "Final adverse determination" has the meaning ascribed to it in section 10 9 of this act.

(c) "Provider of health care" means any physician or other person who is licensed, ~~certified or otherwise authorized~~ in this state or is licensed, certified or otherwise authorized by any other state to provide any health care service.

Sec 2. The Commissioner shall transmit to the Office of Consumer Health Assistance, a list of organizations that have been certified pursuant to Section 1 to conduct external review. The Commissioner shall notify the Office of Consumer Health Assistance whenever there is a change to the list of organizations that have been certified pursuant to Section 1.

Sec. 3 ~~2~~. 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:

D 2816

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 affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers in the case of a corporation, and the partners or members in the case of a partnership or association;

4. A copy of any contract made or to be made between any providers or persons listed in subsection 3 and the applicant;

5. A statement generally describing the health maintenance organization, its health care plan or plans, ***the*** location of facilities at which health care services will be regularly available to enrollees~~[,]~~ ***and*** the type of health care personnel who will provide the health care services;

6. A copy of the form of evidence of coverage to be issued to the enrollees;

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

8. Certified financial statements showing the applicant's assets, liabilities and sources of financial support;

9. The proposed method of marketing the plan, a financial plan which includes a ~~[three-year]~~ ***3-year*** projection of the initial operating results anticipated and the sources of working capital ~~[as well as]~~ ***and*** any other sources of funding;

10. A power of attorney, ~~[duly]~~ executed by the applicant, appointing the Commissioner and his ~~[duly]~~ authorized deputies~~[,]~~ as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

11. A statement reasonably describing the geographic area to be served;

12. A description of the ~~[complaint]~~ procedures ***for resolving complaints and procedures for external reviews*** to be ~~[utilized]~~ ***used*** as required under NRS 695C.260;

13. A description of the procedures and programs to be implemented to meet the quality of health care requirements in NRS 695C.080;

14. A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of program content under subsection 2 of NRS 695C.110; and

15. Such other information as the Commissioner may require to make the determinations required in NRS 695C.080.

Sec. ~~4~~ **3.** NRS 695C.260 is hereby amended to read as follows:

695C.260 ~~[Every]~~ ***Each*** health maintenance organization shall establish ~~[a complaint]~~ ***:***

D 3 of 16

1. A system *for resolving complaints* which complies with the 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 6 to 14, inclusive, of this act.

Sec. 5. ~~4.~~ 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 7 to 19 ~~6 to 14~~, 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. 6. ~~5.~~ Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections *7 to 19* ~~6 to 14~~, inclusive, of this act.

Sec. 7. ~~6.~~ *"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 7 to 19* ~~6 to 14~~*, inclusive, of this act.*

Sec. 8. ~~7.~~ *"Clinical peer" means a physician who is:*

1. Engaged in the practice of medicine; and

2. Certified or is eligible for certification by ~~*the Board of Medical Examiners*~~ *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. 9. ~~8.~~ *"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 1 of this act.~~*; and*~~

~~*3. Has contracted with the Director of the Office for Consumer Health Assistance to conduct external reviews of final adverse determinations pursuant to subsection 8 of NRS 223.560.*~~

~~Sec. 9. *"Final adverse determination" means a final decision of a managed care organization to deny, reduce or terminate coverage for health care services or to deny payment for those services concerning a complaint filed pursuant to NRS 695G.200 because the health care services were determined to be:*~~

~~*1. Not medically necessary; or*~~

D 5 of 16

~~*2. Experimental or investigational.*~~
~~*The term does not include a determination relating to a claim for workers' compensation pursuant to chapters 616A to 617, inclusive, of NRS.*~~

Sec. 10. *"Adverse determination" means the decision of a managed care organization that an allocation of health care resources and services which is provided or proposed to be provided to an insured is not medically necessary and appropriate, or is experimental or investigational. The term does not include the decision of a managed care organization that such an allocation is not a covered benefit.*

Sec. 10a. *1. For the purposes of NRS 695G.200 to 695G.230, inclusive, and sections 7-19, inclusive, of this act, an adverse determination is final if the insured has exhausted all procedures provided in the health care plan for reviewing the determination within the managed care organization.*
2. A final adverse determination shall be deemed to exist for the purpose of assigning it to an independent review organization for external review if:
(a) An insured has exhausted all procedures provided in the health care plan for reviewing a determination within a managed care organization, but the managed care organization has failed to render a decision within the time allotted by the plan for it to do so; or
(b) A managed care organization assigns a matter concerning an insured to an independent review organization for external review without requiring the insured to exhaust all procedures provided in the health care plan for reviewing the determination within the managed care organization.

Sec. 11. ~~10.~~ *"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; ~~and~~

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

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

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

Sec. 12. ~~11.~~ *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. The Office for Consumer Health Assistance shall immediately assign an external review organization from the list of organization that have been certified pursuant to Section 1 to conduct an independent review. The Office for Consumer Health Assistance shall assign a request for external review on a rotating basis.

~~*3. Within 5 days after receiving a notification pursuant to subsection 2, the Office for Consumer Health Assistance shall:*~~

~~*(a) Randomly select an external review organization to conduct an external review of the final adverse determination;*~~

~~*(b) Notify the external review organization that it has been*~~

D 7 of 16

~~*selected to conduct the external review; and*~~

~~*(c) Notify the insured, his authorized representative or his physician, the agent who performed utilization review for the managed care organization, if any, and the managed care organization of the external review organization selected to conduct the external review.*~~

4. Upon notification by the Office for Consumer Health Assistance of the external review organization selected pursuant to subsection 3, the managed care organization shall within 5 days 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. 13. ~~12.~~ *1. Upon receipt of a request for an external review pursuant to section 12* ~~11~~ *of this act, the external review organization shall, except as provided in section 14, within 5 days after receiving the request:*

(a) Review the request and the documents and materials submitted pursuant to section 12 ~~11~~ *of this act; and*

(b) Notify the insured, his physician and the managed care organization if any additional information is required to conduct a review of the final adverse determination.

2. ~~*Except as otherwise provided in subsection 3, t*~~*The external review organization shall approve, modify or reverse the final adverse determination within 15 days after it receives the information required to make that determination pursuant to this section. The external review organization shall submit a copy of its determination, including the reasons therefor, to:*

(a) The insured;

(b) The physician of the insured;

(c) The authorized representative of the insured, if any; and

(d) The managed care organization.~~*; and*~~

~~*(e) The Director of the Office for Consumer Health Assistance.*~~

Sec. 14. ~~*3.*~~ *A managed care organization shall approve or deny a request for an external review of a final adverse determination in an expedited manner not later than 72 hours after it 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.*

D 8 9 16

(1) If the managed care organization approves a request for external review on an expedited basis, it shall:

(a) Assign the request to an external review organization not later than 1 working day ~~thereafter~~thereafter pursuant to Section 15; and

(b) Provide that external review organization with all relevant documents in its possession at the time it assigns the request pursuant to Section 12(4).

(2). An external review organization that accepts an assignment for external review on an expedited basis shall:

(a) Compete its external review not later than 2 working days after the external review organization receives the assignment unless the insured and the managed care organization consent to the a longer period of time;

(b) Provide notification of its decision by telephone to the insured, the physician of the insured, the authorized representative of the insured, if any; and the managed care organization not later than 1 working day after the external review is completed; and

(c) Provide its decision in writing not later than 5 working days after the external review is completed.

Section 15. On a monthly basis, the Office of Consumer Health Assistance will designate two external review organizations to conduct expedited external reviews.

(a) The managed care organization will assign an external review organization on a rotating basis from this list.

(b) The managed care organization shall notify the Office for Consumer Health Assistance when it has assigned an external review organization to conduct an expedited external review organization from this list.

~~*4. In making a determination pursuant to this section, 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 shall consider, without limitation:*~~

~~*(a) The medical records of the insured;*~~

~~*(b) Any recommendations of the physician of the insured;*~~

~~*(c) Any generally accepted medical guidelines, including guidelines established by the Federal Government or any national or professional society, board or association that establishes such guidelines approved by the Commissioner; and*~~

~~*(d) Any applicable criteria relating to adverse final determinations established and used by the managed care organization or the agent it designates to perform utilization review.*~~

Sec 16. The decision of an external review organization on a request for external review must be based on:

1. Documentary evidence including any recommendations of the physician provided by the parties pursuant to section 12 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) Reports in peer-reviewed literature;

(c) Evidence-based medicine, including, without limitation, reports

D 9 & 16

and guidelines published by nationally recognized professional organizations that include supporting scientific data; and
(d) Opinions of independent physicians who are experts in the health specialty involved.
3. The terms and conditions regarding benefits set forth in the evidence of coverage issued by the managed care organization to the insured.

Sec. 17. ~~13.~~ *1. The determination of an external review organization concerning an external review of a final adverse determination is final 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 7 to 19 ~~6 to 14~~, inclusive, of this act ~~must~~ shall be paid ~~to the Office for Consumer Health Assistance~~ by the managed care organization that made the final adverse determination.

Sec. 18. ~~14.~~ *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 7 to 19 ~~6 to 14~~, 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 7 to 19 ~~6 to 14~~, inclusive, of this act, submit the complaint for resolution in accordance with the federal law or regulation.

Sec 19 . On January 31, the managed care organization shall file a report with the Office for Consumer Health Assistance that outlines the following:
1. The number of external review requests that were received,
2. The number of final adverse determinations that were upheld;
3. The number of final adverse determinations that were overturned; and
4. The number of final adverse determinations that were partially upheld.

Sec. 20. ~~15.~~ 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 7 to 11 ~~6 to 10~~, inclusive, of this act* have the meanings ascribed to them in those sections.

Sec. 21 ~~1.~~ 6. NRS 695G.080 is hereby amended to read as follows:

D 10 of 16

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 7 to 19 ~~6 to 14~~, inclusive, of this act.

Sec. 22 ~~17.~~ NRS 695G.210 is hereby amended to read as follows:

695G.210 1. ~~[A]~~ ***Except as otherwise provided in section 18 ~~14~~ 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. 23. ~~18.~~ 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

D 11 of 16

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 7 to 19 ~~6 to 14~~, 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 24. NRS 695G.090 is hereby amended to read as follows:

NRS 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, 695G.210, 695G.220, and 695G.230 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. 25. Chapter 422.273 of NRS is hereby amended by adding thereto a new subsection to read as follows:

This subsection applies to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the state plans 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 an organization shall not be required to establish a system for

D 12 8 16

conducting external reviews of final determinations as otherwise required by Chapters 695B, 695C, or 695G of the NRS. This subsection does not exempt an organization for services provided pursuant to any other contract.

Sec. 26. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

No policy of health insurance that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care may be delivered or issued for delivery in this state unless it provides a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 7 to 19, inclusive, of this act.

Sec. 27. NRS 689B.0285 is hereby amended to read as follows:

689B.0285 1. 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 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 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 must provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 7 to 19, inclusive, of this act.

Sec. 28. 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. ***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, it must provide a system for resolving complaints of an insured concerning such services that***

D 13 8/16

complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 7 to 19, inclusive, of this act.

3. 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.

Sec. 29. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

Each contract that is authorized pursuant to this chapter must, if it provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 7 to 19, inclusive, of this act.

Sec. 30. NRS 695B.181 is hereby amended to read as follows:

695B.181 1. Except as otherwise provided in NRS 695B.182 ***and section 29 of this act*** and subject to the approval of the Commissioner, any contract which is authorized pursuant to this chapter may include a provision which requires the parties to the contract to submit for binding arbitration any dispute between the parties concerning any matter directly or indirectly related to, or associated with, the contract. If such a provision is included in the contract:

(a) A person who elects to be covered by the contract must be given the opportunity to decline to participate in binding arbitration at the time he elects to be covered by the contract.

(b) It must clearly state that the parties to the contract who have not declined to participate in binding arbitration agree to forego their right to resolve any such dispute in a court of law or equity.

2. Except as otherwise provided in subsection 3, the arbitration must be conducted pursuant to the rules for commercial arbitration established by the American Arbitration Association. The insurer is responsible for any administrative fees and expenses relating to the arbitration, except that the insurer is not responsible for attorney's fees and fees for expert witnesses unless those fees are awarded by the arbitrator.

3. If a dispute required to be submitted to binding arbitration requires an immediate resolution to protect the physical health of a person insured under the contract, any party to the dispute may waive arbitration and seek declaratory relief in a court of competent jurisdiction.

4. If a provision described in subsection 1 is included in a contract, the provision shall not be deemed unenforceable as an unreasonable contract of adhesion if the provision is included in compliance with the provisions of subsection 1.

Sec. ~~37~~ 38. NRS 695C.260 is hereby amended to read as follows:

695C.260 Every health maintenance organization shall establish a

D 14 08 16

complaint system which complies with the provisions of NRS 695G.200 to 695G.230, ~~inclusive.~~] , ***and sections 7 to 19, inclusive, of this act.***

Sec. ~~32.~~ 31 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 provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 7 to 19, inclusive, of this act

~~**Sec. 19.** NRS 223.560 is hereby amended to read as follows:~~

~~223.560 The Director shall:~~

~~1. Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;~~

~~2. Assist consumers and injured employees in understanding their rights and responsibilities under health care plans and policies of industrial insurance;~~

~~3. Identify and investigate complaints of consumers and injured employees regarding their health care plans and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:~~

~~(a) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and~~

~~(b) Providing counseling and assistance to consumers and injured employees concerning health care plans and policies of industrial insurance;~~

~~4. Provide information to consumers and injured employees concerning health care plans and policies of industrial insurance in this state;~~

~~5. Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the office;~~

~~6. Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Director pursuant to this section; [and]~~

~~7. In appropriate cases and pursuant to the direction of the Governor, refer a complaint or the results of an investigation to the Attorney General for further action[.] ; *and*~~

~~***8. On or before January 1 of each year, and in accordance with regulations adopted by the Commissioner of Insurance, contract with at least two external review organizations that are***~~

D 1598161

~~*certified by the Commissioner of Insurance pursuant to section 1 of this act to conduct external reviews of final adverse determinations in accordance with the provisions of sections 6 to 14, inclusive, of this act. A contract entered into pursuant to this subsection may be renewed by the Director.*~~

Sec. ~~33~~ 32**.** 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 *7 to* ~~*6 to 14,*~~ ***19, inclusive, of this act and the disposition of*** ~~*each*~~ ***of those reviews*** *as reported pursuant to section 19.* ~~,~~

Sec. ~~34.~~ 33~~21.~~ 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*** *7 to 19* ~~*6 to 14, inclusive, of this act and*~~ NRS 689B.255, 695G.150, 695G.160, 695G.170 and 695G.200 to 695G.230, ~~inclusive,in~~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. ~~35.~~ 34~~22.~~ 1. This section becomes effective upon passage and approval.

~~2. Section 19 of this act becomes effective upon passage and approval for the purpose of performing any preparatory administrative tasks that are necessary to carry out the provisions of section 19 of this act, and on January 1, 2004, for all other purposes.~~

2. ~~3.~~ Sections 1 to *23* ~~18~~, inclusive, *28* ~~20~~ and *29* ~~21~~ 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 1 of this act;

~~(b) On January 1, 2004, for the purposes of filing notice of and~~

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

D 160816