SENATE BILL NO. 23–SENATOR NEAL

PREFILED JANUARY 24, 2003

Referred to Committee on Commerce and Labor

SUMMARY—Provides for independent review of certain final adverse determinations made by health maintenance organizations and managed care organizations. (BDR 57-209)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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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 a health maintenance organization or managed care organization to establish a procedure for the independent review of certain final adverse determinations relating to the health care of an insured; requiring the Commissioner of Insurance to prepare and maintain a list of physicians to conduct independent reviews of certain final adverse determinations of health maintenance organizations and managed care organizations; and providing other matters properly relating thereto.

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

Section 1. Chapter 679B of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Commissioner shall prepare and maintain a list of physicians who are eligible to conduct independent reviews of final adverse determinations pursuant to sections 9 to 13, inclusive, of this act.

2. To be eligible to conduct independent reviews of final adverse determinations pursuant to sections 9 to 13, inclusive, of this act, a physician must be:

(a) Licensed pursuant to chapter 630 or 633 of NRS; and

(b) Actively engaged in the practice of medicine.

Sec. 2. NRS 695C.070 is hereby amended to read as follows:

695C.070 Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall 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 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 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, location of facilities at which health care services will be regularly available to enrollees, 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 projection of the initial operating results anticipated and the sources of working capital as well as 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 to]~~ ***system and the procedure for conducting independent reviews of final adverse determinations which will*** be utilized 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. 3. NRS 695C.260 is hereby amended to read as follows:

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

1. A complaint system which complies with the provisions of NRS 695G.200 to 695G.230, inclusive ~~[.]~~ ***; and***

2. A procedure for conducting independent reviews of final adverse determinations which complies with the provisions of sections 9 to 13, inclusive, of this act.

Sec. 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 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 ***complaint*** system ~~[for complaints]~~ required by NRS 695C.260 in a manner reasonably to dispose of valid complaints;

(h) ***The health maintenance organization has failed to put into effect the procedure for conducting independent reviews of final adverse determinations required by NRS 695C.260 or has failed to comply with that procedure;***

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

~~[(j)]~~ ***(k)*** 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. 5. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 6 to 13, inclusive, of this act.

Sec. 6. ***"Authorized representative" means a person who has obtained the consent of an insured to represent him in an independent review of a final adverse determination conducted pursuant to sections 9 to 13, inclusive, of this act.***

Sec. 7. *"Final adverse determination" means a final decision of a managed care organization to deny coverage for health care services or to deny payment for those services because the health care services were determined to be medically unnecessary. The term does not include a determination relating to a claim for workers' compensation pursuant to chapters 616A to 617, inclusive, of NRS.*

Sec. 8. *"Life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or medical condition is interrupted.*

Sec. 9. *A managed care organization shall establish a procedure for conducting independent reviews of final adverse determinations which complies with the provisions of sections 9 to 13, inclusive, of this act.*

Sec. 10. *If an insured or a primary care physician of an insured receives notice of a final adverse determination from a managed care organization concerning the insured, the insured, the primary care physician of the insured or an authorized representative may, within 30 days after receiving notice of the final adverse determination, submit a written request to the managed care organization for an independent review of the final adverse determination.*

Sec. 11. *1. A managed care organization shall:*

(a) Within 3 days after it receives a request pursuant to section 10 of this act, notify the insured, his authorized representative or his primary care physician and the Commissioner that the request has been filed with the managed care organization;

(b) Within 5 days after providing notice pursuant to paragraph (a), choose, with the approval of the insured and the primary care physician of the insured, a physician from the list of physicians maintained by the Commissioner pursuant to section 1 of this act to conduct independent review; and

(c) Within 5 days after choosing the physician pursuant to paragraph (b), notify the Commissioner and the physician who has been chosen to conduct the independent review and provide to the physician all documents and materials relating to the final adverse determination, including, without limitation:

(1) Any medical records of the insured relating to the independent review;

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

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

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

(5) 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 independent review.

2. The physician chosen pursuant to paragraph (b) of subsection 1 to conduct the independent review must:

(a) Be certified by the Board of Medical Examiners in the same or similar area of practice as is the health care service that is the subject of the final adverse determination; and

(b) Not have a financial interest in the managed care organization of the insured who requested the independent review.

Sec. 12. *1. Not later than 5 days after the receipt of the notice, documents and materials from the managed care organization pursuant to section 11 of this act, the physician shall:*

(a) Review the documents and materials submitted pursuant to section 11 of this act and make a determination whether the health care services are medically necessary; and

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

2. Except as otherwise provided in subsection 3, the physician shall submit his determination within 15 days after he receives the information required to make that determination pursuant to this section. The physician shall submit a copy of his determination, including the reasons therefor, to:

(a) The insured;

(b) The primary care physician of the insured;

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

(d) The managed care organization; and

(e) The Commissioner.

3. If the insured who submitted the request for an independent review has a life-threatening condition, the physician shall make his determination as soon as practicable, but not later than 72 hours after he receives the notice, documents and materials from the managed care organization pursuant to section 11 of this act.

4. In making a determination whether the health care services are medically necessary, the physician who conducts an independent review of a final adverse determination for a managed care organization shall consider, without limitation:

(a) The medical records of the insured;

(b) Any recommendations of the primary care 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.

Sec. 13. ***1. A determination made by a physician who conducts an independent review of a final adverse determination pursuant to sections 9 to 13, inclusive, of this act is final and binding upon the managed care organization and the insured.***

2. A physician who conducts an independent review of a final adverse determination pursuant to sections 9 to 13, inclusive, of this act is not liable in a civil action for damages relating to his determination if the determination is made in good faith and without gross negligence.

3. The cost of conducting an independent review of a final adverse determination pursuant to sections 9 to 13, inclusive, of this act must be paid by the managed care organization which made the final adverse determination.

Sec. 14. 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 6, 7 and 8 of this act*** have the meanings ascribed to them in those sections.

Sec. 15. 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 independent review of a final adverse determination conducted pursuant to sections 9 to 13, inclusive, of this act.

Sec. 16. NRS 695G.210 is hereby amended to read as follows:

695G.210 1. ~~[A]~~ ***Except as otherwise provided in sections 9 to 13, inclusive, of this act, a*** system for resolving complaints created pursuant to NRS 695G.200 ***to 695G.230, inclusive,*** 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. 17. NRS 695G.220 is hereby amended to read as follows:

695G.220 1. Each managed care organization shall submit to the Commissioner and the State Board of Health an annual report regarding its system for resolving complaints established pursuant to NRS 695G.200 ***to 695G.230, inclusive, and the procedure established to conduct independent reviews of final adverse determinations pursuant to sections 9 to 13, inclusive, of this act. The report must be*** 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 complaints of an insured;

(b) The total number of complaints ***,*** ~~[and]~~ appeals ***and requests for independent reviews*** 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 ***and request for independent review*** filed; and

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

2. Each managed care organization 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. 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 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 9 to 13, inclusive, of this act;

(3) Receive an expedited independent review of a final adverse determination if he has a life-threatening condition, including notification of the procedure for requesting the expedited independent review; and

(4) Receive assistance from any person, including an attorney, for an independent review of a final adverse determination.

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. 19. NRS 287.04335 is hereby amended to read as follows:

287.04335 ~~[If]~~

1. Except as otherwise provided in this section, if the board provides health insurance through a plan of self-insurance, it shall comply with the provisions of 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.

2. The board is not required to comply with the provisions of NRS 695G.200 to 695G.230, inclusive, which relate to independent reviews of final adverse determinations.

Sec. 20. The amendatory provisions of this act apply to policies, contracts and plans for health insurance, managed care or the provision of health care services entered into or renewed on or after October 1, 2003.

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