ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R132-98

Effective March 30, 1999

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

AUTHORITY: §§2 and 3, NRS 679B.130, 689A.745, 689A.750 and 689A.755; §§5 and 6, NRS 679B.130, 689B.0285, 689B.029 and 689B.0295; §§8-12, NRS 679B.130, 695B.380, 695B.390 and 695B.400; §§14-17, NRS 679B.130, 695C.260; §§19-26, NRS 679B.130; §§28-32, NRS 679B.130; §§34-39, NRS 679B.130, 695G.200, 695G.220 and 695G.230; §40 and 41, NRS 679B.130.

Section 1. Chapter 689A of NAC is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this regulation.

Sec. 2. ***To obtain approval of a system for resolving complaints of insureds concerning health care services covered by an insurer from the commissioner as required pursuant to NRS 689A.745, an insurer must:***

1. Demonstrate that the system will resolve oral and written complaints concerning:

(a) Payment or reimbursement for covered health care services;

(b) The availability, delivery or quality of covered health care services, including, without limitation, adverse determinations made pursuant to utilization review; and

(c) The terms and conditions of the health care plans of insureds.

2. Submit to the division:

(a) The name and title of the employee responsible for the system;

(b) A description of the procedure used to notify an insured of the decision regarding his complaint; and

(c) A copy of the explanation of rights and procedures which is to be provided to insureds pursuant to NRS 689A.755.

Sec. 3. *1. An insurer shall submit its annual report regarding its system for resolving complaints as required pursuant to NRS 689A.750 on or before June 1 of each year. The insurer shall retain a copy of the annual report for at least 3 years or until the next examination conducted by the division, whichever is longer.*

2. The insurer is not required to include in the annual report information concerning an oral inquiry by an insured relating to a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the insurer shall report it as a complaint in the annual report.

Sec. 4. Chapter 689B of NAC is hereby amended by adding thereto the provisions set forth as sections 5 and 6 of this regulation.

Sec. 5. *To obtain approval of a system for resolving complaints of insureds concerning health care services covered by an insurer from the commissioner as required pursuant to NRS 689B.0285, an insurer must:*

1. Demonstrate that the system will resolve oral and written complaints concerning:

(a) Payment or reimbursement for covered health care services;

(b) The availability, delivery or quality of covered health care services, including, without limitation, an adverse determination made pursuant to utilization review; and

(c) The terms and conditions of the health care plans of insureds.

2. Submit to the division:

(a) The name and title of the employee responsible for the system;

(b) A description of the procedure used to notify an insured of the decision regarding his complaint; and

(c) A copy of the explanation of rights and procedures which is to be provided to insureds pursuant to NRS 689B.0295.

Sec. 6. *1. An insurer shall submit its annual report regarding its system for resolving complaints as required pursuant to NRS 689B.029 on or before June 1 of each year. The insurer shall retain a copy of the annual report for at least 3 years or until the next examination conducted by the division, whichever is longer.*

2. The insurer is not required to include in the annual report information concerning an oral inquiry by an insured relating a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the insurer shall report it as a complaint in the annual report.

Sec. 7. Chapter 695B of NAC is hereby amended by adding thereto the provisions set forth as sections 8 to 12, inclusive, of this regulation.

Sec. 8. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 9 and 10, of this regulation, have the meanings ascribed to them in those sections.***

Sec. 9. ***"Commissioner" means the commissioner of insurance.***

Sec. 10. ***"Division" means the division of insurance of the department of business and industry.***

Sec. 11. ***To obtain approval of a system for resolving complaints of insureds concerning health care services covered by an insurer from the commissioner as required pursuant to NRS 695B.380, an insurer must:***

1. Demonstrate that the system will resolve oral and written complaints concerning:

(a) Payment or reimbursement for covered health care services;

(b) The availability, delivery or quality of covered health care services, including, without limitation, an adverse determination made pursuant to utilization review; and

(c) The terms and conditions of the health care plan of insureds.

2. Submit to the division:

(a) The name and title of the employee responsible for the system;

(b) A description of the procedure used to notify an insured of the decision regarding his complaint; and

(c) A copy of the explanation of rights and procedures which is to be provided to insureds pursuant to NRS 695B.400.

Sec. 12. *1. An insurer shall submit its annual report regarding its system for resolving complaints as required pursuant to NRS 695B.390 on or before June 1 of each year. The insurer shall retain a copy of the annual report for at least 3 years or until the next examination conducted by the division, whichever is longer.*

2. The insurer is not required to include in the annual report information concerning an oral inquiry by an insured relating to a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the insurer shall report it as a complaint in the annual report.

Sec. 13. Chapter 695C of NAC is hereby amended by adding thereto the provisions set forth as sections 14 and 15 of this regulation.

Sec. 14. *"Commissioner" means the commissioner of insurance.*

Sec. 15. *1. An organization shall submit its annual report regarding it system for resolving complaints as required pursuant to NRS 695C.260 and 695G.220 on or before June 1 of each year. The organization shall retain a copy of the annual report for at least 3 years or until the next examination conducted by the division, whichever is longer.*

2. The organization is not required to include in the annual report information concerning an oral inquiry by an enrollee relating to a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the organization shall report it as a complaint in the annual report.

Sec. 16. NAC 695C.010 is hereby amended to read as follows:

695C.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in:

1. NAC 695C.020 to 695C.090, inclusive, ~~[and]~~ sections 2 to 5, inclusive, of ~~[this regulation,]~~ ***LCB File No. R129-96 and section 14 of this regulation,*** have the meanings ascribed to them in those sections; and

2. NRS 695C.030 have the meanings ascribed to them in that section.

Sec. 17. NAC 695C.230 is hereby amended to read as follows:

695C.230 ~~[1.]~~ To obtain approval of ~~[its system to resolve complaints, an]~~ ***a system for resolving complaints of enrollees concerning health care services covered by an organization as required pursuant to NRS 695C.260 and 695G.200, the*** organization must submit to the division:

~~[(a)]~~ ***1.*** The name and title of the employee responsible for the system;

~~[(b)]~~ ***2.*** A description of the procedure used to notify an enrollee of the decision regarding his complaint; and

~~[(c)]~~ ***3.*** A copy of the explanation of rights and procedures ~~[for an appeal]~~ which is to be ~~[given]~~ ***provided*** to an enrollee ~~[.~~

~~2. Each organization shall maintain a summary of the complaints received by it, including those complaints which do not result in any action by the organization. The summary must be retained 3 years or until the next examination conducted by the division and may be transferred to microfilm or otherwise maintained electronically.~~

~~3. Each organization, on or before March 1 of each year, shall submit to the:~~

~~(a) Division; and~~

~~(b) State board of health,~~

~~a copy of the report required in subsection 2 of NRS 695C.260 for the complaints received during the preceding year.]~~ ***pursuant to NRS 695C.260 and 695G.230.***

Sec. 18. Chapter 695D of NAC is hereby amended by adding thereto the provisions set forth as sections 19 to 25, inclusive, of this regulation.

Sec. 19. ***"Member" has the meaning ascribed to it in NRS 695D.050.***

Sec. 20. ***"Policy" has the meaning ascribed to it in NRS 695D.080.***

Sec. 21. ***1. Each organization that issues a policy in this state shall establish with the approval of the commissioner a system for resolving any complaints of a member concerning services covered under the policy. In determining whether to approve a system for resolving complaints, the commissioner will consult 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 persons on a review board must be members who receive services pursuant to a policy issued by the organization.

3. Each organization shall allow the commissioner or the state board of health to examine the system for resolving complaints established pursuant to this section at such times as either deems necessary or appropriate.

Sec. 22. *1. Each organization that issues a policy 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 section 21 of this regulation 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 a member;

(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 organization shall maintain records of complaints filed with it which concern something other than 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. 23. *1. Following approval by the commissioner, each organization that issues a policy in this state shall provide written notice to a member, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the member to file a written complaint. Such notice must be provided to a member:*

(a) At the time he receives his policy;

(b) Any time that the organization denies coverage of a service or limits coverage of a service to a member; and

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

2. Any time that an organization denies coverage of a service to a member it shall notify the member in writing of:

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

(b) The criteria by which the organization determines whether to authorize or deny coverage of the service; and

(c) His right to file a written complaint.

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. *To obtain approval of a system for resolving complaints of members concerning services covered by an organization from the commissioner as required pursuant to section 21 of this regulation, an organization must:*

1. Demonstrate that the system will resolve oral and written complaints concerning:

(a) Payment or reimbursement for covered services;

(b) The availability, delivery or quality of covered services, including, without limitation, adverse determinations made pursuant to utilization review; and

(c) The terms and conditions of the policies of member.

2. Submit to the division:

(a) The name and title of the employee responsible for the system;

(b) A description of the procedure used to notify a member of the decision regarding his complaint; and

(c) A copy of the explanation of rights and procedures which is to be provided to members pursuant to section 23 of this regulation.

Sec. 25. *1. An organization shall submit its annual report regarding its system for resolving complaints as required pursuant to section 22 of this regulation on or before June 1 of each year. The organization shall retain a copy of the annual report for at least 3 years or until the next examination conducted by the division, whichever is longer.*

2. The organization is not required to include in the annual report information concerning an oral inquiry by a member relating to a misunderstanding or

miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the organization shall report it as a complaint in the annual report.

Sec. 26. NAC 695D.010 is hereby amended to read as follows:

695D.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NAC ~~[695D.020]~~ ***695D.015*** to 695D.060, inclusive, ***and sections 19 and 20 of this regulation,*** have the meanings ascribed to them in those sections.

Sec. 27. Chapter 695F of NAC is hereby amended by adding thereto the provisions set forth as sections 28 to 32, inclusive, of this regulation.

Sec. 28. ***1. Each organization that issues an evidence of coverage in this state shall establish with the approval of the commissioner a system for resolving any complaints of an enrollee concerning limited health services covered under the evidence of coverage. In determining whether to approve a system for resolving complaints, the commissioner will consult 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 enrollees who receive limited health services pursuant to an evidence of coverage issued by the organization.

3. Each organization shall allow the commissioner or the state board of health to examine the system for resolving complaints established pursuant to this section at such times as either deems necessary or appropriate.

Sec. 29. *1. Each organization that issues an evidence of coverage 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 section 28 of this regulation 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 resoling any complaints of an enrollee;

(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 organization shall maintain records of complaints filed with it which concern something other than limited health 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. 30. *1. Following approval by the commissioner, each organization that issues an evidence of coverage in this state shall provide written notice to an enrollee, in*

clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the enrollee to file a written complaint. Such notice must be provided to an enrollee:

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

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

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

2. Any time that an organization denies coverage of a limited health service to an enrollee it shall notify the enrollee in writing of:

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

(b) The criteria by which the organization determines whether to authorize or deny coverage of the limited health service; and

(c) His right to file a written complaint.

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. 31. *To obtain approval of a system for resolving complaints of enrollees concerning limited health services covered by an organization from the commissioner as required pursuant to section 28 of this regulation, an organization must:*

1. Demonstrate that the system will resolve oral and written complaints concerning:

(a) Payment or reimbursement for covered limited health services;

(b) The availability, delivery or quality of covered limited health services, including, without limitation, adverse determinations made pursuant to utilization review; and

(c) The terms and conditions of the evidences of coverage of enrollees.

2. Submit to the division:

(a) The name and title of the employee responsible for the system;

(b) A description of the procedure used to notify an enrollee of the decision regarding his complaint; and

(c) A copy of the explanation of rights and procedures which is to be provided to enrollees pursuant to section 30 of this regulation.

Sec. 32. *1. An organization shall submit its annual report regarding its system for resolving complaints as required pursuant to section 29 of this regulation on or before June 1 of each year. The organization shall retain a copy of the annual report for at least 3 years or until the next examination conducted by the division, whichever is longer.*

2. The organization is not required to include in the annual report information concerning an oral inquiry by an enrollee relating to a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the organization shall report it as a complaint in the annual report.

Sec. 33. Chapter 695G of NAC is hereby amended by adding thereto the provisions set forth as sections 34 to 39, inclusive, of this regulation.

Sec. 34. ***As used in this chapter, unless the context otherwise requires, the words and terms defined sections 35, 36 and 37 of this regulation have the meanings ascribed to them in those sections.***

Sec. 35. ***"Commissioner" means the commissioner of insurance.***

Sec. 36. ***"Division" means the division of insurance of the department of business and industry.***

Sec. 37. ***"Managed care organization" has the meaning ascribed to it in NRS 695G.050.***

Sec. 38. ***To obtain approval of a system for resolving complaints of insureds from the commissioner as required pursuant to NRS 695G.200, a managed care organization must submit to the division:***

1. The name and title of the employee responsible for the system;

2. A description of the procedure used to notify an insured of the decision regarding his complaint; and

3. A copy of the explanation of rights and procedures which is to be provided to insureds pursuant to NRS 695G.230.

Sec. 39. ***1. A managed care organization shall submit its annual report regarding its system for resolving complaints as required pursuant to NRS 695G.220 on or before June 1 of each year. The managed care organization shall retain a copy of the annual***

report for at least 3 years or until the next examination conducted by the division, whichever is longer.

2. The managed care organization is not required to include in the annual report information concerning an oral inquiry by an insured relating to a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the managed care organization shall report it as a complaint in the annual report.

Sec. 40. NAC 695C.020 is hereby repealed.

Sec. 41. Notwithstanding the provisions of sections 3, 6, 12, 15, 25, 32 and 39 of this regulation, the annual report required to be submitted pursuant to those sections must be submitted on or before March 1, 1999, and on or before June 1 for each year thereafter.

TEXT OF REPEALED SECTION

695C.020 "Complaint" defined. "Complaint" means any grievance of an enrollee against an organization or provider arising out of the performance of health care services, when the grievance has been reduced to writing and filed with the organization in accordance with the system required to be established under NRS 695C.260, and is not yet the cause or subject of a suit filed by the enrollee.