PROPOSED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R132-98

August 18, 1998

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; §§19-24, NRS 679B.130, 695G.200, 695G.220 and 695G.230; §25 and 26, 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 regualtion.

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 695G of NAC is hereby amended by adding thereto the provisions set forth as sections 19 to 24, inclusive, of this regulation.

Sec. 19. *As used in this chapter, unless the context otherwise requires, the words and terms defined sections 20, 21 and 22 of this regulation have the meanings ascribed to them in those sections.*

Sec. 20. *"Commissioner" means the commissioner of insurance.*

Sec. 21. *"Division" means the division of insurance of the department of business and industry.*

Sec. 22. *"Managed care organization" has the meaning ascribed to it in NRS 695G.050.*

Sec. 23. *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. 24. *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. 25. NAC 695C.020 is hereby repealed.

Sec. 26. Notwithstanding the provisions of sections 3, 6, 12, 15 and 24 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" 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.