Assembly Bill No. 87–Committee on
Commerce and Labor

CHAPTER.....

AN ACT relating to insurance; revising provisions governing certain duties of insurers with regard to coverage and claims for persons who are eligible for or provided medical assistance under Medicaid; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Federal law requires a state to place certain requirements upon health insurers with regard to the state plan for medical assistance. (42 U.S.C. § 1396a) Consistent with one of these requirements, existing state law: (1) prohibits an insurer from taking into account the fact that a person is eligible for medical assistance under Medicaid when considering the person's eligibility for coverage or when making payments under a policy of health insurance or group health policy; (2) requires an insurer to treat Medicaid as having a valid and enforceable assignment of the recipient of Medicaid's right to payment by the insurer or other specified entity; (3) prohibits an insurer from imposing additional requirements on a state agency that is assigned any rights of an insured who is eligible for medical assistance under Medicaid; (4) requires an insurer to provide, upon request, certain information concerning an insured who is eligible for medical assistance under Medicaid to a state agency that is assigned any rights of the insured; (5) requires an insurer to respond to inquiries by such a state agency concerning a claim for payment for any medical item or service not later than 3 years after the date of provision of the medical item or service; and (6) requires an insurer to agree not to deny a claim by such a state agency solely on the basis of certain procedural reasons if the state agency submits the claim not later than 3 years after the date of the provision of medical item or service and the state agency commences any action to enforce its rights with respect to the claim not later than 6 years after submission of the claim. (42 U.S.C. § 1396a(25)(I); NRS 689A.430, 689B.300) Existing state law also defines the term "insurer" for the purposes of the Nevada Insurance Code to include "every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance." (NRS 679A.100)

Sections 1 and 2 of this bill expressly provide, consistent with federal law, that all of the provisions of existing state law described above relating to Medicaid apply to insurers, including, without limitation, self-insured plans, group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1167(1), service benefit plans, other organizations that have issued a policy of health insurance or a group health policy and any other parties described in the Social Security Act as being legally responsible for payment of a claim for a health care item or service.

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

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

Section 1. NRS 689A.430 is hereby amended to read as follows:

689A.430 1. An insurer shall not, when considering eligibility for coverage or making payments under a policy of health insurance, consider the availability of, or eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care, an insurer ***:*** ~~[, self-insured plan, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C.A. § 1167(1), service benefit plan or other organization that has issued a policy of health insurance:]~~

(a) Shall treat Medicaid as having a valid and enforceable assignment of an insured's benefits regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by the policy, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any right of a recipient of Medicaid to reimbursement against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its insured.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by a policy of health insurance,

➥ the insurer that issued the policy shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by the policy.

4. If a state agency is assigned any rights of an insured who is eligible for medical assistance under Medicaid, an insurer shall:

(a) Upon request of the state agency, provide to the state agency information regarding the insured to determine:

(1) Any period during which the insured or the insured's spouse or dependent may be or may have been covered by the insurer; and

(2) The nature of the coverage that is or was provided by the insurer, including, without limitation, the name and address of the insured and the identifying number of the policy, evidence of coverage or contract;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

5. As used in this section, "insurer" includes, without limitation, a self-insured plan, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1167(1), service benefit plan or other organization that has issued a policy of health insurance or any other party described in section 1902(a)(25)(A), (G) or (I) of the Social Security Act, 42 U.S.C. § 1396a(a)(25)(A), (G) or (I), as being legally responsible for payment of a claim for a health care item or service.

Sec. 2. NRS 689B.300 is hereby amended to read as follows:

689B.300 1. An insurer shall not, when considering eligibility for coverage or making payments under a group health policy, consider the availability of, or eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care, an insurer ***:*** ~~[, self-insured plan, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C.A. § 1167(1), or other organization that has issued a group health policy:]~~

(a) Shall treat Medicaid as having a valid and enforceable assignment of an insured's benefits regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by the policy, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any rights of a recipient of Medicaid to reimbursement against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its insured.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by a group health policy,

➥ the insurer that issued the policy shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by the policy.

4. If a state agency is assigned any rights of an insured who is eligible for medical assistance under Medicaid, an insurer shall:

(a) Upon request of the state agency, provide to the state agency information regarding the insured to determine:

(1) Any period during which the insured or the spouse or dependent of the insured may be or may have been covered by the insurer; and

(2) The nature of the coverage that is or was provided by the insurer, including, without limitation, the name and address of the insured and the identifying number of the policy;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

5. As used in this section, "insurer" includes, without limitation, a self-insured plan, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1167(1), service benefit plan or other organization that has issued a group health policy or any other party described in section 1902(a)(25)(A), (G) or (I) of the Social Security Act, 42 U.S.C. § 1396a(a)(25)(A), (G) or (I), as being legally responsible for payment of a claim for a health care item or service.

Sec. 3. This act becomes effective upon passage and approval.