

SENATE BILL NO. 9—COMMITTEE ON COMMERCE AND LABOR

(ON BEHALF OF THE DIVISION OF HEALTH CARE
FINANCING AND POLICY OF THE DEPARTMENT
OF HEALTH AND HUMAN SERVICES)

PREFILED OCTOBER 29, 2024

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to Medicaid.
(BDR 57-290)

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 insurance; revising provisions governing certain duties of insurers and certain other providers of health coverage 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:

Under existing law, if a state agency is assigned any rights of a person who is eligible for medical assistance under Medicaid, insurers and certain other providers of health coverage are subject to certain requirements. Among other requirements, existing law requires the insurer or other provider to: (1) 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 (2) agree not to deny a claim submitted by the state agency for certain reasons. (NRS 689A.430, 689B.300, 695A.151, 695B.340, 695C.163, 695F.440)

Section 202 of the federal Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, revised certain requirements for a state plan for medical assistance concerning the liability of third parties for payment of a claim for a health care item or service. (42 U.S.C. § 1396a) **Sections 1-6** of this bill revise existing law to comply with those requirements. **Sections 1-6** require insurers and certain other providers of health coverage that the state agency reasonably believes cover the person who is eligible for medical assistance under Medicaid to respond to an inquiry regarding a claim for payment for the provision of any medical item or service not later than 60 days after receiving the inquiry. **Sections 1-6** also require



19 insurers and certain other providers of health coverage to agree not to deny a claim
20 submitted by the state agency solely on the basis of lack of prior authorization if the
21 state agency authorized the medical item or service.

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

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

3 689A.430 1. An insurer shall not, when considering
4 eligibility for coverage or making payments under a policy of health
5 insurance, consider the availability of, or eligibility of a person for,
6 medical assistance under Medicaid.

7 2. To the extent that payment has been made by Medicaid for
8 health care, an insurer:

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

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

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

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

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

21 (a) Eligible for medical assistance under Medicaid; and

22 (b) Covered by a policy of health insurance,

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

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

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

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

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

37 (b) ~~[Respond to]~~ *Not later than 60 days after receiving* any
38 inquiry by the state agency regarding a claim for payment for the



1 provision of any medical item or service *to the person who is*
2 *eligible for medical assistance under Medicaid and who the state*
3 *agency reasonably believes is covered by the insurer that is*
4 *submitted* not later than 3 years after the date of the provision of the
5 medical item or service ~~};~~, *respond to such inquiry;* and

6 (c) Agree not to deny a claim submitted by the state agency
7 solely on the basis of ~~the~~;

8 *(1) Lack of prior authorization if the state agency*
9 *authorized the medical item or service; or*

10 *(2) The* date of submission of the claim, the type or format of
11 the claim form or failure to present proper documentation at the
12 point of sale that is the basis for the claim if:

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

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

19 5. As used in this section, “insurer” includes, without
20 limitation, a self-insured plan, group health plan as defined in
21 section 607(1) of the Employee Retirement Income Security Act of
22 1974, 29 U.S.C. § 1167(1), service benefit plan or other
23 organization that has issued a policy of health insurance or any other
24 party described in section 1902(a)(25)(A), (G) or (I) of the Social
25 Security Act, 42 U.S.C. § 1396a(a)(25)(A), (G) or (I), as being
26 legally responsible for payment of a claim for a health care item or
27 service.

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

29 689B.300 1. An insurer shall not, when considering
30 eligibility for coverage or making payments under a group health
31 policy, consider the availability of, or eligibility of a person for,
32 medical assistance under Medicaid.

33 2. To the extent that payment has been made by Medicaid for
34 health care, an insurer:

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

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

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

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



1 3. If a state agency is assigned any rights of a person who is:
2 (a) Eligible for medical assistance under Medicaid; and
3 (b) Covered by a group health policy,
4 ↪ the insurer that issued the policy shall not impose any
5 requirements upon the state agency except requirements it imposes
6 upon the agents or assignees of other persons covered by the policy.
7 4. If a state agency is assigned any rights of an insured who is
8 eligible for medical assistance under Medicaid, an insurer shall:
9 (a) Upon request of the state agency, provide to the state agency
10 information regarding the insured to determine:
11 (1) Any period during which the insured or the spouse or
12 dependent of the insured may be or may have been covered by the
13 insurer; and
14 (2) The nature of the coverage that is or was provided by the
15 insurer, including, without limitation, the name and address of the
16 insured and the identifying number of the policy;
17 (b) ~~Respond to~~ *Not later than 60 days after receiving* any
18 inquiry by the state agency regarding a claim for payment for the
19 provision of any medical item or service *to the person who is*
20 *eligible for medical assistance under Medicaid and who the state*
21 *agency reasonably believes is covered by the insurer that is*
22 *submitted* not later than 3 years after the date of the provision of the
23 medical item or service ~~;~~, *respond to such inquiry*; and
24 (c) Agree not to deny a claim submitted by the state agency
25 solely on the basis of ~~the~~ :
26 (1) *Lack of prior authorization if the state agency*
27 *authorized the medical item or service; or*
28 (2) *The* date of submission of the claim, the type or format of
29 the claim form or failure to present proper documentation at the
30 point of sale that is the basis for the claim if:
31 ~~(1)~~ (I) The claim is submitted by the state agency not later
32 than 3 years after the date of the provision of the medical item or
33 service; and
34 ~~(2)~~ (II) Any action by the state agency to enforce its rights
35 with respect to such claim is commenced not later than 6 years after
36 the submission of the claim.
37 5. As used in this section, “insurer” includes, without
38 limitation, a self-insured plan, group health plan as defined in
39 section 607(1) of the Employee Retirement Income Security Act of
40 1974, 29 U.S.C. § 1167(1), service benefit plan or other
41 organization that has issued a group health policy or any other party
42 described in section 1902(a)(25)(A), (G) or (I) of the Social Security
43 Act, 42 U.S.C. § 1396a(a)(25)(A), (G) or (I), as being legally
44 responsible for payment of a claim for a health care item or service.



1 **Sec. 3.** NRS 695A.151 is hereby amended to read as follows:

2 695A.151 1. A society shall not, when considering eligibility
3 for coverage or making payments under a certificate for health
4 benefits, consider the availability of, or eligibility of a person for,
5 medical assistance under Medicaid.

6 2. To the extent that payment has been made by Medicaid for
7 health care, a society:

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

11 (b) May, as otherwise allowed by its certificate for health
12 benefits, evidence of coverage or contract and applicable law or
13 regulation concerning subrogation, seek to enforce any
14 reimbursement rights of a recipient of Medicaid against any other
15 liable party if:

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

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

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

21 (a) Eligible for medical assistance under Medicaid; and

22 (b) Covered by a certificate for health benefits,
23 ➤ the society that issued the health policy shall not impose any
24 requirements upon the state agency except requirements it imposes
25 upon the agents or assignees of other persons covered by the
26 certificate.

27 4. If a state agency is assigned any rights of an insured who is
28 eligible for medical assistance under Medicaid, a society that issues
29 a certificate for health benefits, evidence of coverage or contract
30 shall:

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

33 (1) Any period during which the insured, a spouse or
34 dependent of the insured may be or may have been covered by the
35 society; and

36 (2) The nature of the coverage that is or was provided by the
37 society, including, without limitation, the name and address of the
38 insured and the identifying number of the certificate for health
39 benefits, evidence of coverage or contract;

40 (b) ~~[Respond to]~~ *Not later than 60 days after receiving* any
41 inquiry by the state agency regarding a claim for payment for the
42 provision of any medical item or service *to the person who is*
43 *eligible for medical assistance under Medicaid and who the state*
44 *agency reasonably believes is covered by the society that is*



1 *submitted* not later than 3 years after the date of the provision of the
2 medical item or service ~~};~~, *respond to such inquiry*; and

3 (c) Agree not to deny a claim submitted by the state agency
4 solely on the basis of ~~the~~:

5 *(1) Lack of prior authorization if the state agency*
6 *authorized the medical item or service; or*

7 *(2) The* date of submission of the claim, the type or format of
8 the claim form or failure to present proper documentation at the
9 point of sale that is the basis for the claim if:

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

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

16 **Sec. 4.** NRS 695B.340 is hereby amended to read as follows:

17 695B.340 1. A corporation shall not, when considering
18 eligibility for coverage or making payments under a contract,
19 consider the availability of, or any eligibility of a person for,
20 medical assistance under Medicaid.

21 2. To the extent that payment has been made by Medicaid for
22 health care, a corporation:

23 (a) Shall treat Medicaid as having a valid and enforceable
24 assignment of benefits of a subscriber or policyholder or claimant
25 under the subscriber or policyholder regardless of any exclusion of
26 Medicaid or the absence of a written assignment; and

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

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

33 (2) It has reimbursed Medicaid in full for the health care
34 provided by Medicaid to its subscriber or policyholder.

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

36 (a) Eligible for medical assistance under Medicaid; and

37 (b) Covered by a contract,

38 ↪ the corporation that issued the contract shall not impose any
39 requirements upon the state agency except requirements it imposes
40 upon the agents or assignees of other persons covered by the same
41 contract.

42 4. If a state agency is assigned any rights of a subscriber or
43 policyholder who is eligible for medical assistance under Medicaid,
44 a corporation shall:



1 (a) Upon request of the state agency, provide to the state agency
2 information regarding the subscriber or policyholder to determine:

3 (1) Any period during which the subscriber or policyholder,
4 the spouse or a dependent of the subscriber or policyholder may be
5 or may have been covered by a contract; and

6 (2) The nature of the coverage that is or was provided by the
7 corporation, including, without limitation, the name and address of
8 the subscriber or policyholder and the identifying number of the
9 contract;

10 (b) ~~Respond to~~ *Not later than 60 days after receiving* any
11 inquiry by the state agency regarding a claim for payment for the
12 provision of any medical item or service *to the person who is*
13 *eligible for medical assistance under Medicaid and who the state*
14 *agency reasonably believes is covered by a contract that is*
15 *submitted* not later than 3 years after the date of the provision of the
16 medical item or service ~~;~~, *respond to such inquiry*; and

17 (c) Agree not to deny a claim submitted by the state agency
18 solely on the basis of ~~the~~:

19 (1) *Lack of prior authorization if the state agency*
20 *authorized the medical item or service; or*

21 (2) *The* date of submission of the claim, the type or format of
22 the claim form or failure to present proper documentation at the
23 point of sale that is the basis for the claim if:

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

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

30 **Sec. 5.** NRS 695C.163 is hereby amended to read as follows:

31 695C.163 1. A health maintenance organization shall not,
32 when considering eligibility for coverage or making payments under
33 a health care plan, consider the availability of, or eligibility of a
34 person for, medical assistance under Medicaid.

35 2. To the extent that payment has been made by Medicaid for
36 health care, a health maintenance organization:

37 (a) Shall treat Medicaid as having a valid and enforceable
38 assignment of benefits due an enrollee or claimant under the
39 enrollee regardless of any exclusion of Medicaid or the absence of a
40 written assignment; and

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



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

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

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

6 (a) Eligible for medical assistance under Medicaid; and

7 (b) Covered by a health care plan,

8 ↪ the organization responsible for the health care plan shall not
9 impose any requirements upon the state agency except requirements
10 it imposes upon the agents or assignees of other persons covered by
11 the same plan.

12 4. If a state agency is assigned any rights of an enrollee who is
13 eligible for medical assistance under Medicaid, a health
14 maintenance organization shall:

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

17 (1) Any period during which the enrollee, the spouse or a
18 dependent of the enrollee may be or may have been covered by the
19 health care plan; and

20 (2) The nature of the coverage that is or was provided by the
21 organization, including, without limitation, the name and address of
22 the enrollee and the identifying number of the health care plan;

23 (b) ~~Respond to~~ *Not later than 60 days after receiving* any
24 inquiry by the state agency regarding a claim for payment for the
25 provision of any medical item or service *to the person who is*
26 *eligible for assistance under Medicaid and who the state agency*
27 *reasonably believes is covered by the health care plan that is*
28 *submitted* not later than 3 years after the date of the provision of the
29 medical item or service ~~;~~, *respond to such inquiry*; and

30 (c) Agree not to deny a claim submitted by the state agency
31 solely on the basis of ~~the~~:

32 *(1) Lack of prior authorization if the state agency*
33 *authorized the medical item or service; or*

34 *(2) The date of submission of the claim, the type or format of*
35 *the claim form or failure to present proper documentation at the*
36 *point of sale that is the basis for the claim if:*

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

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

43 **Sec. 6.** NRS 695F.440 is hereby amended to read as follows:

44 695F.440 1. An organization shall not, when considering
45 eligibility for coverage or making payments under any evidence of



1 coverage, consider the availability of, or eligibility of a person for,
2 medical assistance under Medicaid.

3 2. To the extent that payment has been made by Medicaid for
4 health care, a prepaid limited health service organization:

5 (a) Shall treat Medicaid as having a valid and enforceable
6 assignment of benefits due a subscriber or claimant under the
7 subscriber regardless of any exclusion of Medicaid or the absence of
8 a written assignment; and

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

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

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

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

18 (a) Eligible for medical assistance under Medicaid; and

19 (b) Covered by any evidence of coverage,

20 ↪ the prepaid limited health service organization that issued the
21 evidence of coverage shall not impose any requirements upon the
22 state agency except requirements it imposes upon the agents or
23 assignees of other persons covered by any evidence of coverage.

24 4. If a state agency is assigned any rights of a subscriber who is
25 eligible for medical assistance under Medicaid, a prepaid limited
26 health service organization shall:

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

29 (1) Any period during which the subscriber, the spouse or a
30 dependent of the subscriber may be or may have been covered by
31 the organization; and

32 (2) The nature of the coverage that is or was provided by the
33 organization, including, without limitation, the name and address of
34 the subscriber and the identifying number of the evidence of
35 coverage;

36 (b) ~~Respond to~~ *Not later than 60 days after receiving* any
37 inquiry by the state agency regarding a claim for payment for the
38 provision of any medical item or service *to the person who is*
39 *eligible for medical assistance under Medicaid and who the state*
40 *agency reasonably believes is covered by the organization that is*
41 *submitted* not later than 3 years after the date of the provision of the
42 medical item or service ~~;~~, *respond to such inquiry*; and

43 (c) Agree not to deny a claim submitted by the state agency
44 solely on the basis of ~~the~~ :



1 *(1) Lack of prior authorization if the state agency*
2 *authorized the medical item or service; or*

3 *(2) The* date of submission of the claim, the type or format of
4 the claim form or failure to present proper documentation at the
5 point of sale that is the basis for the claim if:

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

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

12 **Sec. 7.** This act becomes effective upon passage and approval.



