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

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

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:

(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]~~ ***Not later than 60 days after receiving*** any inquiry by the state agency regarding a claim for payment for the

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

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

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

(2) 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)]~~ ***(I)*** 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)]~~ ***(II)*** 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:

(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]~~ ***Not later than 60 days after receiving*** any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service ***to the person who is eligible for medical assistance under Medicaid and who the state agency reasonably believes is covered by the insurer that is submitted*** not later than 3 years after the date of the provision of the medical item or service ~~[.]~~ ***, respond to such inquiry;*** and

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

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

(2) 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)]~~ ***(I)*** 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)]~~ ***(II)*** 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. NRS 695A.151 is hereby amended to read as follows:

695A.151 1. A society shall not, when considering eligibility for coverage or making payments under a certificate for health benefits, 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, a society:

(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 its certificate for health benefits, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any reimbursement rights of a recipient of Medicaid 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 certificate for health benefits,

➥ the society that issued the health 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 certificate.

4. If a state agency is assigned any rights of an insured who is eligible for medical assistance under Medicaid, a society that issues a certificate for health benefits, evidence of coverage or contract 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, a spouse or dependent of the insured may be or may have been covered by the society; and

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

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

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

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

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

(2) 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)]~~ ***(I)*** 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)]~~ ***(II)*** 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.

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

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

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

(a) Shall treat Medicaid as having a valid and enforceable assignment of benefits of a subscriber or policyholder or claimant under the subscriber or policyholder 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 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 subscriber or policyholder.

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 contract,

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

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

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

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

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

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

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

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

(2) 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)]~~ ***(I)*** 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)]~~ ***(II)*** 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.

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

695C.163 1. A health maintenance organization shall not, when considering eligibility for coverage or making payments under a health care plan, 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, a health maintenance organization:

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

(b) May, as otherwise allowed by its plan, 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 enrollee.

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 health care plan,

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

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

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

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

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

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

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

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

(2) 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)]~~ ***(I)*** 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)]~~ ***(II)*** 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.

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

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

coverage, 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, a prepaid limited health service organization:

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

(b) May, as otherwise allowed by its evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any rights of a recipient of Medicaid 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 subscriber.

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 any evidence of coverage,

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

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

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

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

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

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

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

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

(2) 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)~~]~~ ***(I)*** 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)~~]~~ ***(II)*** 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.

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

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