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ASSEMBLY BILL NO. 87—COMMITTEE  
ON COMMERCE AND LABOR

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

PREFILED DECEMBER 20, 2014

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Referred to Committee on Commerce and Labor

SUMMARY—Revises certain provisions governing the duties of insurers with regard to Medicaid. (BDR 57-326)

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.

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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:**

1 Federal law requires a state to place certain requirements upon health insurers  
2 with regard to the state plan for medical assistance. (42 U.S.C. § 1396a) Consistent  
3 with one of these requirements, existing state law: (1) prohibits an insurer from  
4 taking into account the fact that a person is eligible for medical assistance under  
5 Medicaid when considering the person’s eligibility for coverage or when making  
6 payments under a policy of health insurance or group health policy; (2) requires an  
7 insurer to treat Medicaid as having a valid and enforceable assignment of the  
8 recipient of Medicaid’s right to payment by the insurer or other specified entity; (3)  
9 prohibits an insurer from imposing additional requirements on a state agency that is  
10 assigned any rights of an insured who is eligible for medical assistance under  
11 Medicaid; (4) requires an insurer to provide, upon request, certain information  
12 concerning an insured who is eligible for medical assistance under Medicaid to a  
13 state agency that is assigned any rights of the insured; (5) requires an insurer to  
14 respond to inquiries by such a state agency concerning a claim for payment for any  
15 medical item or service not later than 3 years after the date of provision of the  
16 medical item or service; and (6) requires an insurer to agree not to deny a claim by  
17 such a state agency solely on the basis of certain procedural reasons if the state  
18 agency submits the claim not later than 3 years after the date of the provision of  
19 medical item or service and the state agency commences any action to enforce its



20 rights with respect to the claim not later than 6 years after submission of the claim.  
21 (42 U.S.C. § 1396a(25)(I); NRS 689A.430, 689B.300) Existing state law also  
22 defines the term “insurer” for the purposes of the Nevada Insurance Code to include  
23 “every person engaged as principal and as indemnitor, surety or contractor in the  
24 business of entering into contracts of insurance.” (NRS 679A.100)

25 **Sections 1 and 2** of this bill expressly provide, consistent with federal law, that  
26 all of the provisions of existing state law described above relating to Medicaid  
27 apply to insurers, including, without limitation, self-insured plans, group health  
28 plans as defined in section 607(1) of the Employee Retirement Income Security Act  
29 of 1974, 29 U.S.C. § 1167(1), service benefit plans, pharmacy benefit managers  
30 and other organizations that have issued a policy of health insurance or a group  
31 health policy.

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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 : ~~[ self-insured plan, group health plan as  
9 defined in section 607(1) of the Employee Retirement Income  
10 Security Act of 1974, 29 U.S.C.A. § 1167(1), service benefit plan or  
11 other organization that has issued a policy of health insurance.]~~

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

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

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

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

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

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

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

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

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



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

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

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

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

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

18 (1) The claim is submitted by the state agency not later than  
19 3 years after the date of the provision of the medical item or service;  
20 and

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

24 *5. As used in this section, "insurer" includes, without*  
25 *limitation, a self-insured plan, group health plan as defined in*  
26 *section 607(1) of the Employee Retirement Income Security Act of*  
27 *1974, 29 U.S.C. § 1167(1), service benefit plan, pharmacy benefit*  
28 *manager or other organization that has issued a policy of health*  
29 *insurance.*

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

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

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

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

43 (b) May, as otherwise allowed by the policy, evidence of  
44 coverage or contract and applicable law or regulation concerning



1 subrogation, seek to enforce any rights of a recipient of Medicaid to  
2 reimbursement against any other liable party if:

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

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

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

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

9 (b) Covered by a group health policy,

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

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

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

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

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

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

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

31 (1) The claim is submitted by the state agency not later than  
32 3 years after the date of the provision of the medical item or service;  
33 and

34 (2) Any action by the state agency to enforce its rights with  
35 respect to such claim is commenced not later than 6 years after the  
36 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, pharmacy benefit*  
41 *manager or other organization that has issued a group health*  
42 *policy.*

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

