FIRST ENGROSSMENT

Sixtieth
Legislative Assembly
of North Dakota

ENGROSSED SENATE BILL NO. 2131

Introduced by

Industry, Business and Labor Committee

(At the request of the Department of Human Services)

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to information provided by health insurers to the department of human services; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Insurers to provide certain information to the department of human services.

1. For purposes of this section:
   a. "Department" means the department of human services or its agent.
   b. "Health insurer" includes 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, managed care organizations, pharmacy benefit managers, or other parties that legally are responsible by statute, contract, or agreement for payment of a claim for a health care item or service.
   c. "Medical assistance" means benefits paid under chapter 50-24.1 and title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].
2. As a condition of doing business in this state, health insurers shall provide to the department upon its request and in a manner prescribed by the department information about individuals who are eligible for medical assistance so the department may determine during what period the individual or the individual's spouse or dependents may be or may have been covered by a health insurer and the nature of the coverage provided by the health insurer, including the name, address, and identifying number of the plan. Notwithstanding any other provision

of law, every health insurer, not more frequently than twelve times in a year, shall provide to the department upon its request information, including automated data matches conducted under the direction of the department, as necessary, to:

a. Identify individuals covered under the insurer's health benefit plans who are also recipients of medical assistance;

b. Determine the period during which the individual or the individual's spouses or the individual's dependents may be or may have been covered by the health benefit plan; and

c. Determine the nature of the coverage.

The insurer must provide the information required in this subsection to the department at no cost if the information is in a readily available structure or format. If the department requests the information in a structure or format that is not readily available, the insurer may charge a reasonable fee for providing the information, not to exceed the actual cost of providing the information.

3. To facilitate the department in obtaining the information required by this section, a health insurer shall:

a. Cooperate with the department to determine whether a medical assistance recipient may be covered under the insurer's health benefit plan and is eligible to receive benefits under the health benefit plan for services provided under the medical assistance program.

b. Respond to the request for information within ninety days after receipt of written proof of loss or claim for payment for health care services provided to a recipient of medical assistance who is covered by the insurer's health benefit plan.

c. Accept the department's right of recovery and the assignment to the department of any right of an individual or other entity to payment from a liable third party for an item or service for which payment has been made under the state medical assistance plan.

d. Respond to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the health care item or service.

e. Agree not to deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type of format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(1) The claim is submitted by the department within the three-year period beginning on the date on which the item or service was furnished; and

(2) Any action by the department to enforce its rights with respect to such claim is commenced within six years of the department's submission of the claim.

4. A health insurer is prohibited, in enrolling an individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance.

5. The department may not use or disclose any information provided by the insurer other than as permitted or required by law. The insurer may not be held liable for the release of insurance information to the department or a department agent if the release is authorized under this section.

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.