Sixty-eighth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1047

Introduced by

Human Services Committee

(At the request of the Department of Health and Human Services)

A BILL for an Act to amend and reenact section 50-24.1-29 of the North Dakota Century Code, relating to the requirement that health insurers provide certain information to the department of health and human services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 50-24.1-29 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-29. Insurers to provide certain information to the department.

1. For purposes of this section:
   a. "Department" means the department of health and 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.
2. a. 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, and duration of the health insurance coverage. 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.~~ (1) Identify individuals covered under the insurer's health benefit plans who are also recipients of medical assistance;

~~b.~~ (2) Determine the period during which the individual or the individual's spouse or the individual's dependents may be or may have been covered by the health benefit plan; and

~~c.~~ (3) Determine the nature of the coverage.

b. 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, entitlement to payment, 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 within sixty days 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.

f. Accept Medicaid's authorization that the item or service is covered under the state plan as if the authorization were the prior authorization made by the third party for the item or service.

g. Agree to not deny a claim submitted by the department for failure to obtain prior authorization for an item or service.

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.