ASSEMBLY BILL NO. 399–ASSEMBLYMEN GANSERT; GRADY, HAMBRICK, HARDY, SETTELMEYER AND WOODBURY

MARCH 16, 2009

Referred to Committee on Commerce and Labor

SUMMARY—Establishes provisions for the primacy of health care plans. (BDR 57-964)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

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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; requiring the Commissioner of Insurance to establish and maintain a centralized database for the electronic interchange of certain information; requiring persons administering a publicly sponsored health plan to establish primacy before paying any claim for benefits; requiring the Division of Health Care Financing and Policy of the Department of Health and Human Services to respond to certain inquiries from the Commissioner of Insurance; providing civil penalties; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Section 2 of this bill requires the Commissioner of Insurance to establish a centralized database for the electronic interchange of data relating to coverage under a health care plan to determine the primacy of a publicly sponsored health plan. **Section 3** of this bill requires the person administering a publicly sponsored health plan to not pay any claim for benefits under that plan until a determination regarding the primacy of the publicly sponsored health plan has been determined in relation to any other health plan under which a person submitting a claim for benefits may also be covered. **Section 4** of this bill requires the Commissioner to impose a penalty of not more than $1,000 for each occurrence of an insurer's failure or refusal to respond to an inquiry made by a publicly sponsored health plan regarding the enrollment status of any person. **Section 4** also requires the Commissioner to permanently revoke an insurer's certificate of authority to transact business in this State for a second violation. **Section 4** further requires the Attorney General to commence civil actions under both state and federal law for an insurer's failure or refusal to comply with requirements concerning the electronic interchange of information using the centralized database. **Section 7** of this bill requires the Division of Health Care Financing and Policy of the Department of

Health and Human Services to respond to inquiries from the Commissioner relating to a person's employment or income for purposes of determining the primacy of coverage under the State Plan for Medicaid in relation to the person's coverage under any other health plan.

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

Section 1. Chapter 680A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 4, inclusive, of this act.

Sec. 2. ***1. The Commissioner shall establish and maintain a centralized database to allow:***

(a) Persons responsible for the administration of any publicly sponsored health plan, including, without limitation, the State Plan for Medicaid, the Public Employees' Benefits Program, the Children's Health Insurance Program or any governmental health plan of a political subdivision, to submit electronic inquiries to every insurer issued a certificate of authority in this State regarding the enrollment record of any person with respect to particular coverage of that person; and

(b) Every insurer receiving inquiries made pursuant to paragraph (a) to respond to such inquiries or, in the alternative, to transmit to the database responsive information concerning coverage and benefits for viewing by the person making the inquiry.

2. The centralized database described in subsection 1 must:

(a) Allow for the secure submission of personal identifying information of a person for purposes of checking coverage, including name, gender and date of birth; and

(b) Function in such a manner as to meet the minimum standards of quality for the interchange of electronic data as approved by the American National Standards Institute.

3. The Commissioner shall adopt regulations as are necessary to carry out the provisions of this section, including, without limitation, procedures to register into the database every insurer issued a certificate of authority in this State, requirements for access to the database and the transmittal of electronic data and procedures to provide assistance to persons for compliance with this section.

4. Any information concerning eligibility or coverage that is interchanged pursuant to this section is deemed an element of data and is exempt from the privacy and confidentiality provisions of 42 U.S.C. §§ 1320d to 1320d-9, inclusive, and any applicable state

law, except that no person shall use such information for any purpose other than as described in this section.

Sec. 3. *1. A person administering a publicly sponsored health plan described in section 2 of this act:*

(a) Shall presume that persons eligible for benefits under its plan may also be currently covered by another health plan provided by an insurer;

(b) Shall submit inquiries to the centralized database for transmittal to each insurer issued a certificate of authority regarding coverage of any person who submits a claim for benefits; and

(c) Shall not pay any claim made by a person or otherwise expend any public money relating to such a claim until it has received a response to an inquiry from each insurer to determine the primacy of its coverage in relation to the coverage of the person who submitted a claim for benefits, if any, under any other health plan.

2. An insurer shall respond to any inquiry made pursuant to subsection 1 within 24 hours.

Sec. 4. *1. The Commissioner shall impose a penalty of not more than $1,000 for each failure or refusal to comply with subsection 2 of section 3 of this act, to be recovered by the Commissioner in a civil action in a court of competent jurisdiction. For purposes of this subsection, an attempt by an insurer to impose data elements or other burdens not expressly authorized by 42 U.S.C. §§ 1320d to 1320d-9, inclusive, and the Commissioner or related regulations shall be deemed a refusal to comply with subsection 2 of section 3 of this act.*

2. Upon a showing by the Commissioner that a violation has occurred, the Attorney General shall:

(a) Subpoena the enrollment record for coverage from the insurer;

(b) Commence an action under 42 U.S.C. §§ 1320d to 1320d-9, inclusive, for administrative sanctions pursuant to the federal Health Insurance Portability and Accountability Act;

(c) Commence an action under 18 U.S.C. § 1035; and

(d) Commence an action in a court of competent jurisdiction to enjoin an insurer from noncompliance.

3. Upon a showing that a second violation has occurred, the Commissioner shall permanently revoke the certificate of authority issued to the noncompliant insurer. For purposes of this subsection, the Commissioner may consider, if he has such knowledge, an insurer's noncompliance with similar requirements imposed by another jurisdiction in determining whether a

violation of section 3 of this act shall be deemed a first or second violation.

Sec. 5. NRS 680A.190 is hereby amended to read as follows:

680A.190 1. The Commissioner shall refuse to continue or shall suspend or revoke an insurer's certificate of authority:

(a) If such action is required by any provision of this Code;

(b) If it is a foreign insurer and it no longer meets the requirements for a certificate of authority, on account of deficiency of capital or surplus or otherwise;

(c) If it is a domestic insurer and it has failed to cure an impairment of capital or surplus within the time allowed therefor by the Commissioner under this Code or is otherwise no longer qualified for the certificate of authority;

(d) If the insurer's certificate of authority to transact insurance therein is suspended or revoked by its state of domicile, or state of entry into the United States of America if an alien insurer;

(e) For failure of the insurer to pay taxes on its premiums if required by this Code; ~~[or]~~

(f) For failure of the insurer to furnish information to the Commissioner relating to medical malpractice insurance issued by the insurer in this State or any other state ~~[.]~~ ***; or***

(g) For a second violation pursuant to subsection 3 of section 4 of this act.

2. Except in case of insolvency, impairment of required capital or surplus, or suspension or revocation by another state, the Commissioner shall give the insurer at least 20 days' notice in advance of any such refusal, suspension or revocation under this section, and of the particulars of the reasons therefor. If the insurer requests a hearing thereon within those 20 days, the Commissioner's proposed action is automatically stayed until his order is made after the hearing.

Sec. 6. NRS 680A.200 is hereby amended to read as follows:

680A.200 1. Except as otherwise provided in NRS 616B.472, the Commissioner may refuse to continue or may suspend, limit or revoke an insurer's certificate of authority if he finds after a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has:

(a) Violated or failed to comply with any lawful order of the Commissioner;

(b) Conducted his business in an unsuitable manner;

(c) Willfully violated or willfully failed to comply with any lawful regulation of the Commissioner; or

(d) Violated any provision of this Code other than one for violation of which suspension or revocation is mandatory.

➥ ~~[In]~~ ***Except as otherwise provided in subsection 3 of section 4 of this act, in*** lieu of such a suspension or revocation, the Commissioner may levy upon the insurer, and the insurer shall pay forthwith, an administrative fine of not more than $2,000 for each act or violation.

2. Except as otherwise provided in chapter 696B of NRS, the Commissioner shall suspend or revoke an insurer's certificate of authority on any of the following grounds if he finds after a hearing thereon that the insurer:

(a) Is in unsound condition, is being fraudulently conducted, or is in such a condition or is using such methods and practices in the conduct of its business as to render its further transaction of insurance in this State currently or prospectively hazardous or injurious to policyholders or to the public.

(b) With such frequency as to indicate its general business practice in this State:

(1) Has without just cause failed to pay, or delayed payment of, claims arising under its policies, whether the claims are in favor of an insured or in favor of a third person with respect to the liability of an insured to the third person; or

(2) Without just cause compels insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims.

(c) Refuses to be examined, or its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its books, papers, records, contracts, correspondence or other documents for examination by the Commissioner when required, or refuse to perform any legal obligation relative to the examination.

(d) Except as otherwise provided in NRS 681A.110, has reinsured all its risks in their entirety in another insurer.

(e) Has failed to pay any final judgment rendered against it in this State upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within 30 days after the judgment became final or within 30 days after dismissal of an appeal before final determination, whichever date is the later.

3. The Commissioner may, without advance notice or a hearing thereon, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation or other delinquency proceedings have been commenced in any state by the public officer who supervises insurance for that state.

4. No proceeding to suspend, limit or revoke a certificate of authority pursuant to this section may be maintained unless it is

commenced by the giving of notice to the insurer within 5 years after the occurrence of the charged act or omission. This limitation does not apply if the Commissioner finds fraudulent or willful evasion of taxes.

Sec. 7. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

The Division shall, within a reasonable time, respond to any inquiries submitted by the Commissioner of Insurance regarding information relating to the employment and income of any person for the purposes of determining the primacy of coverage under the State Plan for Medicaid in relation to the person's coverage under any other health plan.

Sec. 8. Every person administering a publicly sponsored health plan shall:

1. On or before November 1, 2009, commence an audit of the primacy of its payments on claims for benefits by checking the identities of every person enrolled for coverage against the enrollment of such persons under any other health plan; and

2. On or before July 1, 2010, prepare and submit to the Interim Finance Committee a report of the audit required pursuant to subsection 1.

Sec. 9. 1. This section and sections 1, 2, 7 and 8 of this act become effective on July 1, 2009.

2. Sections 3 to 6, inclusive, of this act become effective on July 1, 2010.

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