"[CHAPTER 431L]
MEDICAID-RELATED MANDATES

Section

Cross References

Federally qualified health centers; rural health clinics; reimbursement, see §346-53.6.

" **§431L-1 Insurers prohibited from taking medicaid status into account.** Any health insurer (including a self-insured plan, a group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a health service benefit plan, a mutual benefit society, a fraternal benefit society, a health maintenance organization, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) is prohibited, in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under title 42 United States Code section 1396a (section 1902 of the Social Security Act) herein referred to as medicaid, for this State, or any other state. [L 1995, c 83, pt of §2; am L 2009, c 103, §3]

" **§431L-2 State's right to third party payments.** To the extent that payment has been made under the state plan for medical assistance for health care items or services furnished to an individual in any case where another party has a legal liability to make payment for such assistance, the State is considered to have acquired the rights of the individual to payment by the other party for those health care items or services. [L 1995, c 83, pt of §2; am L 2009, c 103, §4]

" **§431L-2.5 Insurer requirements.** Any health insurer as identified in section 431L-1 shall:

(1) Provide upon the request of the State, information for all of its members to 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 that is or was provided by the health insurer, including the name, address, and identifying number of the plan in a manner prescribed by the State;

(2) Beginning in 2014, provide to an independent, third party entity, no more than quarterly, a report listing its members. The third party entity shall match this report with one provided by the department of human

services and provide the department of human services with third party liability information for medical assistance recipients. The department of human services shall determine the minimum data required to ensure the validity of matches, which may include name, date of birth, and social security number, as available. The information provided by the health insurers to the third party entity shall not be used for any purpose other than that specified in this chapter. The department of human services shall provide for representation by private health insurers in evaluating the qualifications of potential third party entities and determining the minimum data fields for matching;

(3) Accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for a health care item or service for which payment has been made for medical assistance under title 42 United States Code section 1396a (section 1902 of the Social Security Act);

(4) Respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service; and

(5) Agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or 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:

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

(B) Any action by the State to enforce its rights with respect to the claim is commenced within six years of the State's submission of the claim. [L 2009, c 103, §2; am L 2012, c 95, §2]

" **§431L-3 Coverage of children.** (a) No insurer shall deny enrollment of a child under the health plan of the child's parent for the following grounds:

(1) The child was born out of wedlock;

(2) The child is not claimed as a dependent on the parent's federal tax return; or

(3) The child does not reside with the parent or in the insurer's service area.

(b) Where a child has health coverage through an insurer of a noncustodial parent the insurer shall:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) Permit the custodial parent (or the provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

(3) Make payments on claims submitted in accordance with paragraph (2) directly to the custodial parent, the provider, or the state medicaid agency.

(c) Where a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family coverage, as defined in section 431:10A-103, and reciprocal beneficiary family coverage, as defined in section 431:10A-601, the insurer shall be required:

(1) To permit the parent to enroll, under the family coverage or reciprocal beneficiary family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) If the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage or reciprocal beneficiary family coverage upon application of the child's other parent, the state agency administering the medicaid program, or the state agency administering the child support enforcement program; and

(3) Not to disenroll (or eliminate coverage of) the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

(d) An insurer may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under medicaid and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other

individual so covered. [L 1995, c 83, pt of §2; am L 1997, c 383, §8; am L 2004, c 122, §81]

" **§431L-4 Employer obligations.** Where a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this State, the employer is required:

(1) To permit the parent to enroll under family coverage, as defined in section 431:10A-103 or reciprocal beneficiary family coverage, as defined in section 431:10A-601, any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(2) If the parent is enrolled but fails to make application to obtain coverage of the child, to enroll the child under family coverage or reciprocal beneficiary family coverage upon application by the child's other parent, by the state agency administering the medicaid program, or by the state agency administering the child support enforcement program;

(3) Not to disenroll (or eliminate coverage of) any such child unless the employer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect;

(B) The child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(C) The employer has eliminated family health coverage or reciprocal beneficiary family coverage for all of its employees; and

(4) To withhold from the employee's compensation the employee's share (if any) of premiums for health coverage and to pay this amount to the insurer. [L 1995, c 83, pt of §2; am L 1997, c 383, §9]

" **[§431L-5] Recoupment of amounts spent on child medical care.** The department of the attorney general may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds to, any person who:

(1) Is required by court or administrative order to provide coverage of the cost of health services to a child eligible for medical assistance under medicaid; and

(2) Has received payment from a third party for the costs of such services but has not used the payments to

reimburse either the other parent or guardian of the child or the provider of the services,

to the extent necessary to reimburse the department of human services for its costs, but claims for current and past due child support shall take priority over these claims. [L 1995, c 83, pt of §2]

" **[§431L-6] Requirements for coverage of an adopted child.** (a) In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.

(b) A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(c) As used in this section:

"Child" means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained the age of eighteen as of the date of such adoption or placement for adoption.

"Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligation. [L 1995, c 83, pt of §2]