§ 108A-55.4. Requirements related to insurers and the Department of Health and Human Services.

(a) As used in this section, the terms:

(1) "Applicant" means an applicant or former applicant of medical assistance benefits.

(1a) "Department" means the Department of Health and Human Services.

(2) "Division" means the Division of Health Benefits of the Department of Health and Human Services.

(3) "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 USC Section 1167(1)]), service benefit plans, managed care organizations, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service as a condition of doing business in the State.

(4) "Medical assistance" means medical assistance benefits provided under the State Medical Assistance Plan.

(5), (6) Reserved for future codification.

(7) "Recipient" means a present or former recipient of medical assistance benefits.

(8) "Request" means any inquiry by the Department or Division for the purpose of determining the existence of insurance where the Department or Division may have expended public assistance benefits.

(9) "Subscriber" means the policyholder or covered person under the insurance policy.

(b) Health insurers, and pharmacy benefit managers regulated as third-party administrators under Article 56 of Chapter 58 of the General Statutes, shall provide, with respect to a subscriber upon request of the Division or its authorized contractor, information 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 subscriber's name, address, identification number, social security number, date of birth and identifying number of the insurance policy, in a manner prescribed by the Division or its authorized contractor. Notwithstanding any other provision of law, every health insurer shall provide, not more frequently than twelve times in a year and at no cost, to the Department of Health and Human Services, Division of Health Benefits, or the Department's or Division's authorized contractor, upon its request, information as necessary so that the Division may (i) identify applicants or recipients who may also be subscribers covered under the benefit plans of the health insurer; (ii) determine the period during which the individual, the individual's spouse, or the individual's dependents may be or may have been covered by the health benefit plan; and (iii) determine the nature of the coverage. To facilitate the Division or its authorized contractor in obtaining this and other related information, every health insurer shall do all of the following:

(1) Cooperate with the Division to determine whether a named individual who is a recipient of medical assistance may be covered under the insurer's health benefit plan and eligible to receive benefits under the health benefit plan for services provided under the State Medical Assistance Plan.

(2) Respond to the request for payment within 90 working 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 benefit plan of the health insurer.

(3) Accept the Division's right of recovery and the assignment to the Division of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State Medical Assistance Plan.

(4) With regard to any inquiry by the Division or its authorized contractor 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, respond within 60 days of receipt of the inquiry.

(5) Notwithstanding subsection (d) of this section, agree not to deny a claim submitted by the Division 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:

a. The claim is submitted by the Division within the three-year period beginning on the date on which the item or service was furnished; and

b. Any action by the Division to enforce its rights with respect to such claim is commenced within six years of the Division's submission of the claim.

(c) A health insurer that complies with this section shall not be liable on that account in any civil or criminal actions or proceedings.

(d) A health insurer is obligated to reimburse the Department only if the insurer has a contractual obligation to make payment for the covered service or item.

(e) All third parties, as defined under 42 U.S.C. § 1396a(a)(25), requiring prior authorization of an item or service furnished to an individual eligible to receive medical assistance shall accept an authorization provided by the Department that the item or service for which third-party reimbursement is being sought is a covered service or item for that individual under the North Carolina Medicaid State Plan, or under a relevant waiver of the State Plan, as if that authorization is the prior authorization made by the third party for the item or service. (2006-66, s. 10.8; 2006-221, ss. 9(a)-(c); 2007-442, s. 2; 2019-81, s. 15(a); 2023-134, s. 9E.23(d1).)