

By: Lucio III

H.B. No. 1436

A BILL TO BE ENTITLED

AN ACT

1
2 relating to provider reimbursements and enrollee cost-sharing
3 payments for services provided under a managed care plan by certain
4 out-of-network providers.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

6 SECTION 1. Subchapter A, Chapter 533, Government Code, is
7 amended by adding Section 533.01316 to read as follows:

8 Sec. 533.01316. REIMBURSEMENT FOR CERTAIN OUT-OF-NETWORK
9 SERVICES. (a) This section applies only to a Medicaid service
10 provided to a recipient by a provider who, on the date the recipient
11 was initially enrolled or was reenrolled for a subsequent
12 enrollment period in a managed care plan offered by a Medicaid
13 managed care organization, was included in the organization's
14 provider network directory but is no longer in the provider network
15 on the date the service is provided to the recipient.

16 (b) Except as provided by Subsection (c), the commission
17 shall require a Medicaid managed care organization to reimburse a
18 provider of a service to which this section applies at the
19 organization's in-network reimbursement rate if the service is
20 provided to the recipient during the enrollment period that began
21 on the date described by Subsection (a).

22 (c) Subsection (b) does not apply if the provider is no
23 longer in the Medicaid managed care organization's provider network
24 on the date the service is provided because:

1 (1) the provider's license to provide health care
2 services is expired, suspended, or revoked; or

3 (2) the provider unilaterally terminated
4 participation in the network for a reason other than the
5 organization's default or breach of the contract between the
6 provider and the organization.

7 SECTION 2. Subchapter K, Chapter 1451, Insurance Code, is
8 amended by adding Section 1451.506 to read as follows:

9 Sec. 1451.506. PAYMENT OR REIMBURSEMENT FOR CERTAIN
10 OUT-OF-NETWORK HEALTH CARE SERVICES. (a) If a provider is included
11 in a health benefit plan issuer's provider directory on the date an
12 enrollee enrolls in the plan, the issuer shall, until the
13 expiration of the health benefit plan contract year or other
14 contract period during which the enrollee enrolled:

15 (1) pay or reimburse the provider the in-network rate
16 for services provided to the enrollee; and

17 (2) ensure that the enrollee is not responsible for a
18 cost-sharing amount that is higher than the amount the enrollee
19 would have been required to pay if the service had been provided by
20 an in-network provider.

21 (b) This section does not apply if the provider is no longer
22 in the health benefit plan issuer's provider network on the date the
23 service is provided because:

24 (1) the provider's license to provide health care
25 services is expired, suspended, or revoked; or

26 (2) the provider unilaterally terminated
27 participation in the network for a reason other than the issuer's

1 default or breach of the contract between the provider and the
2 issuer.

3 SECTION 3. (a) The Health and Human Services Commission
4 shall, in a contract between the commission and a managed care
5 organization under Chapter 533, Government Code, that is entered
6 into or renewed on or after the effective date of this Act, require
7 that the managed care organization comply with Section 533.01316,
8 Government Code, as added by this Act.

9 (b) The Health and Human Services Commission shall seek to
10 amend contracts entered into with managed care organizations under
11 Chapter 533, Government Code, before the effective date of this Act
12 to require those managed care organizations to comply with Section
13 533.01316, Government Code, as added by this Act. To the extent of
14 a conflict between that section and a provision of a contract with a
15 managed care organization entered into before the effective date of
16 this Act, the contract provision prevails.

17 SECTION 4. Section 1451.506, Insurance Code, as added by
18 this Act, applies only to a health benefit plan that is delivered,
19 issued for delivery, or renewed on or after January 1, 2022. A
20 health benefit plan delivered, issued for delivery, or renewed
21 before January 1, 2022, is governed by the law as it existed
22 immediately before the effective date of this Act, and that law is
23 continued in effect for that purpose.

24 SECTION 5. If before implementing any provision of this Act
25 a state agency determines that a waiver or authorization from a
26 federal agency is necessary for implementation of that provision,
27 the agency affected by the provision shall request the waiver or

1 authorization and may delay implementing that provision until the
2 waiver or authorization is granted.

3 SECTION 6. This Act takes effect September 1, 2021.