BILL ANALYSIS

C.S.H.B. 3119
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Federal law was recently updated regarding third-party liability as it relates to Medicaid. Specifically, the law required that third parties other than Medicare accept the state's "authorization" that a health care item or service is covered under the state Medicaid plan as if such authorization were the prior authorization made by the third party for such item or service. This law also added a 60-day timeliness requirement in which the third party must respond to a state's inquiry about a claim and required that a third party must agree not to deny a state's claim for failure to obtain prior authorization for the item or service. C.S.H.B. 3119 seeks to update state statutes regarding third-party liability to reflect these changes in federal law.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3119 repeals Human Resources Code provisions relating to the requirement for health insurers to maintain and provide to the Health and Human Services Commission (HHSC) certain information pertaining to each individual covered by the insurer for the purpose of determining whether health benefits have been or should have been claimed and paid under a health insurance policy or plan for medical care or services received by an individual for whom Medicaid coverage would otherwise be available and the requirement for the state's Medicaid third-party recovery division to identify Medicaid recipients who have third-party health coverage or insurance.

C.S.H.B. 3119 amends the Government Code and the Human Resources Code to give HHSC the option to delegate to a designee the authority to request a third-party health insurer to provide the information necessary to determine the period during which an individual entitled to Medicaid, the individual's spouse, or the individual's dependents may be, or may have been, covered by coverage issued by the health insurer and certain related coverage information and to require an insurer to provide information in response to the designee's request. The bill authorizes HHSC, if it is cost-effective, to expand the scope of persons about whom information is collected to include recipients of services provided through other benefits programs administered by HHSC or a health and human services agency and authorizes HHSC to impose an administrative penalty against a person who does not comply with an information request in the same manner as HHSC is authorized to take such actions with respect to information collected or requested under provisions repealed by the bill.

C.S.H.B. 3119 requires a third-party health insurer that requires prior authorization for an item or service provided to an individual entitled to Medicaid to accept authorization provided by HHSC or HHSC's designee that the item or service is covered under Medicaid as if that authorization is a prior authorization made by the third-party health insurer for the item or service. The bill exempts from this requirement a third-party health insurer with respect to providing any of the following under the federal Social Security Act:

- hospital insurance benefits or supplementary insurance benefits;
- a health care prepayment plan;
- a Medicare Advantage plan;
- a prescription drug plan as a prescription drug plan sponsor; or
- a reasonable cost reimbursement plan.

C.S.H.B. 3119 prohibits a responsible third-party health insurer, other than one covered by that exemption, from denying a claim submitted by HHSC or HHSC's designee for which payment was made under Medicaid solely on the basis of a failure to obtain prior authorization for the item or service for which the claim is being submitted if the following conditions are satisfied:

- the claim is submitted by HHSC or HHSC's designee not later than the third anniversary of the date the item or service was provided; and
- any action by HHSC or HHSC's designee to enforce the state's rights with respect to the claim is commenced not later than the sixth anniversary of the date HHSC or HHSC's designee submits the claim.

C.S.H.B. 3119 replaces the requirement for a third party health insurer to respond to any inquiry by HHSC regarding a claim for payment for any health care item or service reimbursed by HHSC under Medicaid not later than the third anniversary of the date the health care item or service was provided with a requirement for a third-party health insurer to respond to an inquiry from HHSC or HHSC's designee regarding a claim for payment submitted to the insurer not later than the 60th day after receiving the inquiry, provided the inquiry was submitted not later than the third anniversary of the date the item or service was provided.

C.S.H.B. 3119 establishes that a "third-party health insurer" means a health insurer or other person that is legally responsible by state or federal law or private agreement to pay some or all claims for health care items or services provided to an individual. The term includes the following:

- a person providing a self-insured plan;
- a person providing a group health plan;
- a person providing a service benefit plan;
- a managed care organization; and
- a pharmacy benefit manager.

C.S.H.B. 3119 provides for the delayed implementation of any bill provision for which an applicable state agency determines a federal waiver or authorization is necessary for implementation until the waiver or authorization is requested and granted.

C.S.H.B. 3119 repeals Sections 32.042 and 32.0424(e), Human Resources Code.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 3119 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

Whereas the introduced excepted Medicare from the requirement imposed by the bill for a third-party health insurer to accept an authorization from HHSC or HHSC's designee for a particular item or service provided to an individual entitled to receive Medicaid as if the authorization is a prior authorization made by the insurer, the substitute instead exempts from that requirement a third-party health insurer with respect to providing any of the following under the federal Social Security Act:

- hospital insurance benefits or supplementary insurance benefits;
- a health care prepayment plan;
- a Medicare Advantage plan;
- a prescription drug plan as a prescription drug plan sponsor; or
- a reasonable cost reimbursement plan.

The substitute makes a corresponding update to the exemption provided by the introduced from the prohibition against denying a claim submitted by HHSC or HHSC's designee for which payment was made under Medicaid solely on the basis of a failure to obtain prior authorization for the item or service for which the claim is being submitted, provided certain conditions are satisfied.

Whereas the introduced required a third-party health insurer to respond to an inquiry from HHSC or HHSC's designee regarding a claim for payment not later than the 60th day after receiving the inquiry, provided the claim was submitted not later than the third anniversary of the date the item or service was provided, the substitute requires a third-party insurer instead to respond to such an inquiry within that same 60-day period provided the inquiry was submitted not later than that third anniversary.