HR 3659

To amend title XIX of the Social Security Act to clarify policy with respect to collecting reimbursement from third-party payers for medical assistance paid under the Medicaid program, and for other purposes.

Congress: 113 (2013–2015, Ended)
Chamber: House
Policy Area: Health
Introduced: Dec 5, 2013
Current Status: Referred to the Subcommittee on Health.
Latest Action: Referred to the Subcommittee on Health. (Dec 6, 2013)
Official Text: https://www.congress.gov/bill/113th-congress/house-bill/3659

Sponsor

Name: Rep. Burgess, Michael C. [R-TX-26]
Party: Republican • **State:** TX • **Chamber:** House

Cosponsors

No cosponsors are listed for this bill.

Committee Activity

Committee	Chamber	Activity	Date
Energy and Commerce Committee	House	Referred to	Dec 6, 2013

Subjects & Policy Tags

Policy Area:

Health

Related Bills

No related bills are listed.

Summary (as of Dec 5, 2013)

Amends title XIX (Medicaid) of the Social Security Act (SSA) to repeal the requirement that state plans for medical assistance pay for covered prenatal or preventive pediatric care services, or other covered services provided to an individual on whose behalf a state agency is enforcing child support, without regard to a third party's liability for payment for such services, and then seek reimbursement from the third party.

Requires a state plan to require any contract with a managed care entity to specify whether the state is: (1) delegating to the entity all or some of its right of recovery for payment of an item or service, and (2) transferring to the entity all or some of the assignment to the state of any right of an individual or other entity to payment from a health insurer for an item or service.

Requires any state that makes such a delegation or transfer to have in effect laws requiring such health insurers, as a condition of doing business, to: (1) provide the managed care entity certain information upon request; (2) accept the delegated right of recovery and the transferred assignment of rights; and (3) agree not to deny a claim submitted by a managed care entity, for which the state has delegated or transferred rights, in the same manner that the insurer may not deny a claim submitted by a state.

Requires the state plan of any state that contracts with a health insurer to require that any contract of the health insurer with a pharmacy benefit manager to manage benefits under the insurer's health plan shall require that the pharmacy benefit manager regularly report to the state any relevant data it obtains to assist the state in determining whether the insurer is legally responsible for paying a claim for a health care item or service available under the plan.

Requires such a contract also to require the insurer to cooperate with the state Medicaid plan for the proper coordination of benefits offered in order to effectuate the principle of the Medicaid program's being the payer of last resort.

Directs the Secretary of Health and Human Services (HHS) to develop and make available to the states a model uniform reporting field that states may use for reporting to the Secretary within CME Form 64 (or any successor form) information identifying third-party health insurers and other relevant information for ascertaining the legal responsibility of such third parties to pay for care and services under Medicaid.

Requires the Secretary to apply the federal medical assistance percentage (FMAP) for the state in determining the amount, if any, of any overpayment with respect to Medicaid services for newly eligible individuals.

Prescribes an administrative penalty for non-compliance with the additional Medicaid requirements imposed by this Act.

Actions Timeline

- **Dec 6, 2013:** Referred to the Subcommittee on Health.
- **Dec 5, 2013:** Introduced in House
- **Dec 5, 2013:** Referred to the House Committee on Energy and Commerce.