REPORT OF THE GENERAL GOVERNMENT SUBCOMMITTEE

(Cobb-Hunter, Hayes, Herbkersman, Gagnon, & Moss – Staff Contact: Ryan Tooley)

HOUSE BILL 5235

H. 5230 -- Reps. Bannister and Herbkersman: TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY AMENDING SECTION 43-7-465, RELATING TO INSURERS PROVIDING COVERAGE TO PERSONS RECEIVING MEDICAID, SO AS TO COMPORT WITH THE FEDERAL CONSOLIDATED APPROPRIATIONS ACT OF 2022.

Received by Ways and Means: ***3/7/2024***

Summary of Bill: The General Government subcommittee reported favorably. This bill would amend current S.C. law to conform with the Federal Medicaid guidelines. Specifically, it would require the acceptance of authorization by the State that an healthcare item or service is covered under the state plan for such individuals as if such authorization were the prior authorization. Additionally, claims submitted by the State cannot be denied solely on the basis of the following certain conditions: date of submission of the claim, type or format of the claim form, a failure to present proper documentation at the point-of-sale that is the basis of the claim, or in the case of a responsible third party, failure to obtain prior authorization.

Estimated Revenue Impact: This bill could increase the recovery of state funds from responsible third-party payers, creating an undetermined increase in Other Funds revenue beginning in FY24-25.

Other Notes/Comments: N/A

This fiscal impact statement is produced in compliance with the South Carolina Code of Laws and House and Senate rules. The focus of the analysis is on governmental expenditure and revenue impacts and may not provide a comprehensive summary of the legislation.

Bill Number:	H. 5235 Introduced on March 6, 2024
Author:	Bannister
Subject:	Medicaid
Requestor:	House Ways and Means
RFA Analyst(s):	Boggs and Vesely
Impact Date:	March 25, 2024

Fiscal Impact Summary

This bill amends law related to health insurers that provide coverage to people receiving Medicaid to conform with Federal requirements for Medicaid.

This bill will have no expenditure impact for the Public Employee Benefit Authority (PEBA), the Department of Insurance (DOI), and the Department of Health and Human Services (DHHS). Each of these agencies anticipate that this bill does not fiscally or operationally impact them.

Under this bill, third-party payers would no longer be able to refuse payment for an item or service rendered to a Medicaid beneficiary on the basis that the item or service did not receive prior authorization from the third-party payer. According to DHHS, this bill could increase the recovery of state funds from responsible third-party payers, creating an undetermined increase in Other Funds revenue beginning in FY 2024-25.

Explanation of Fiscal Impact

Introduced on March 6, 2024
State Expenditure
This bill amends law related to health insurers that provide coverage to people receiving Medicaid to conform with Federal requirements for Medicaid. PEBA, DOI, and DHHS anticipate that this bill will have no fiscal impact on the agency.

State Revenue
Under this bill, third-party payers would no longer be able to refuse payment for an item or service rendered to a Medicaid beneficiary on the basis that the item or service did not receive prior authorization from the third-party payer. According to DHHS, this bill could increase the recovery of state funds from responsible third-party payers, creating an undetermined increase in Other Funds revenue beginning in FY 2024-25.

Local Expenditure and Revenue
N/A

Frank A. Rainwater, Executive Director

South Carolina General Assembly
125th Session, 2023-2024

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~~Indicates Matter Stricken~~
Indicates New Matter

H. 5235

STATUS INFORMATION

General Bill
Sponsors: Reps. Bannister and Herbkersman
Document Path: LC-0418VR24.docx

Introduced in the House on March 6, 2024
Ways and Means

Summary: Medicaid

HISTORY OF LEGISLATIVE ACTIONS

Date	Body	Action Description with journal page number
3/6/2024	House	Introduced and read first time (House Journal-page 45)
3/6/2024	House	Referred to Committee on **Ways and Means** (House Journal-page 45)

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VERSIONS OF THIS BILL

03/06/2024

A BILL

TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY AMENDING SECTION 43-7-465, RELATING TO INSURERS PROVIDING COVERAGE TO PERSONS RECEIVING

MEDICAID, SO AS TO COMPORT WITH THE FEDERAL CONSOLIDATED APPROPRIATIONS ACT OF 2022.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 43-7-465 of the S.C. Code is amended to read:

Section 43-7-465. A health insurer, including a self-insured plan, group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service-benefit plan, managed-care organization, pharmacy benefit manager, or another party that is legally responsible by statute, contract, or agreement for payment of a claim for a health care item or service, as a condition of doing business in this State, shall:

(1) provide, with respect to an individual eligible for or receiving medical assistance under the state plan, on request of the single state agency, information to determine during what period the individual or his spouse or dependent may be, or may have been, covered by a health insurer and the nature of coverage provided or that may have been provided by the insurer in a manner prescribed by the secretary of the United States Department of Health and Human Services or by the single state agency. This information must include the insured's name, address, and the plan's identifying number;

(2) accept the state's right of recovery and the assignment to the State of an individual or another entity's right to payment for a health care item or service for which payment was made under the state plan (or under a waiver of such plan);

~~(3) respond to an inquiry by the State regarding a claim for payment for a health care item or service submitted within three years of the date the item or service was provided;~~

~~(4) agree not to deny a claim submitted by the State solely on the basis of the date the claim was submitted, the type or format of claim form, or a failure to present proper documentation at the point of sale that provides 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 item or service was furnished; and~~

~~(b) an action by the State to enforce its right with respect to the claim is commenced within six years of the state's submission of the claim.~~

(3) in the case of a responsible third party (other than the original Medicare fee-for-service program under parts A and B of subchapter XVIII of the Social Security Act, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of subchapter XVIII of the Social Security Act, a reasonable cost reimbursement plan under Section 1395mm of Title XVIII of the Social Security Act, a health care prepayment plan under Section 1395I of Title XVIII of the Social Security Act, or a prescription drug plan offered by a PDP sponsor under part D of subchapter XVIII of the Social Security Act) that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under this subchapter, accept authorization provided by the State that the item or service is covered under

the state plan (or waiver of such plan) for such individual, as if such authorization were the prior authorization made by the third party for such item or service;

(4) not later than sixty days after receiving 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 such health care item or service, respond to such inquiry; 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, a failure to present proper documentation at the point-of-sale that is the basis of the claim, or in the case of a responsible third party (other than the original Medicare fee-for-service program under parts A and B of subchapter XVIII of the Social Security Act, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of subchapter XVIII of the Social Security Act, a reasonable cost reimbursement plan under Section 1395mm of Title XVIII of the Social Security Act, a health care prepayment plan under Section 1395I of Title XVIII of the Social Security Act, or a prescription drug plan offered by a PDP sponsor under part D of such title) a failure to obtain prior authorization for the item or service for which the claim is being submitted, if:

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

(b) any action by the State to enforce its rights with respect to such claim is commenced within six years of the State submission of such claim.

SECTION 2. This act takes effect upon approval by the Governor.

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