FTC, state scrutiny of noncompetes shifts labor market

Physician groups keep getting snapped up: 10 major deals to know

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SB 276

This bill introduces new regulations for hospitals' billing practices and financial disclosures to patients in Indiana. It prohibits the garnishment of a consumer's unpaid earnings in satisfaction of any amount of healthcare debt. It also bars healthcare providers from sharing information related to healthcare debt to consumer reporting agencies, and requires them to include a provision in their contracts to prevent third-party furnishers from reporting or sharing such information. If healthcare debt information is reported or shared against these prohibitions, the consumer is relieved from any liability to pay the amount of debt reported, while the healthcare provider and third-party furnisher are not allowed to collect the amount reported. The bill also mandates consumer reporting agencies to delete any record of healthcare debt from a consumer's file upon the consumer's request. It further restricts a healthcare provider from charging excessive interest rates on the unpaid balances of healthcare debt and from initiating any delinquent account action while an appeal for insurance coverage is pending. It also outlines various policies and prohibitions on health care debt and credit.

States push to rein in hospital prices amid site-neutral debate

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Where do noncompetes target physicians?

HB 1359

Provides that if a party to a health provider contract intends to terminate the contractual relationship with another party to the health provider contract as of January 1 of the following calendar year, the terminating party must provide written notice to the other party before September 1. Provides that if a party intending to terminate a health provider contract fails to provide the required written notice before September 1 of a particular calendar year, the health provider contract remains in effect and is binding upon the parties in the following calendar year. Allows a party to terminate a health provider contract after September 1 under certain circumstances. Provides that the law governing the amendment of a health provider contract does not apply to the termination of a health provider contract under the bill.

HB 1414

Requires the budget committee to review certain contracts with managed care organizations for the Medicaid program. Allows a managed care organization and a Medicaid provider to enter into a value based health care reimbursement agreement in writing providing for a reimbursement rate that is different than an established reimbursement rate for that service. Defines “value based health care reimbursement agreement”. Prohibits a managed care organization from imposing a different rate or payment methodology through a notice of contract change to a provider. Requires a managed care organization to notify the office of the

secretary of family and social services if the managed care organization and a provider enter into a value based health care reimbursement agreement. Provides that a managed care organization may not deny any provider willing and qualified to meet the terms and conditions of an agreement to provide services under the risk based managed care program for Medicaid recipients who are eligible to participate in the Medicare program and receive nursing facility services or home and community based services the right to enter into an agreement.

SB 3

Provides that a utilization review entity may only impose prior authorization requirements on less than 1% of any given specialty or health care service and 1% of health care providers overall in a calendar year. Prohibits a utilization review entity from requiring prior authorization for: (1) a health care service that is part of the usual and customary standard of care; (2) a prescription drug that is approved by the federal Food and Drug Administration; (3) medication for opioid use disorder; (4) pre-hospital transportation; or (5) the provision of an emergency health care service. Sets forth requirements for a utilization review entity that requires prior authorization of a health care service. Provides that all adverse determinations and appeals must be reviewed by a physician who meets certain conditions. Requires a utilization review entity to provide an exemption from prior authorization requirements if in the most recent 12 month period the utilization review entity has approved or would have approved at least 80% of the prior authorization requests submitted by the health care provider for a particular health care service. Repeals superseded provisions regarding prior authorization. Makes corresponding changes.

States Target Health Insurers' 'Prior Authorization' Red Tape

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HB 1091

Requires, on or after January 1, 2026, health plans (plan) to allow health professionals who have at least an 85% approval rate of prior authorization requests through a plan to receive a one year exemption from the plan’s prior authorization requirements. Provides that health professionals have a right to an appeal of a prior authorization denial or rescission. Provides that the appeal is to be conducted by a health professional of the same or similar specialty as the health professional who has or is being considered for an exemption.