HB 1597

State employee health plan hospital payment limits. Limits the amount that a state employee health plan may pay for a medical facility service provided to a covered individual to: (1) 200% of the amount paid by the Medicare program for that type of medical facility service or for a medical facility service of a similar type, if the medical facility service is provided by an in network provider; and (2) 185% of the amount paid by the Medicare program for that type of medical facility service or for a medical facility service of a similar type, if the medical facility service is provided by an out of network provider. Provides that a determination of the state personnel department, a state employee health plan, or a firm providing administrative services to a state employee health plan that a medical facility service provided to a covered individual is of a type similar to a particular type of medical facility service covered by the Medicare program is conclusive. Requires a medical facility that provides drugs to a covered individual, in billing a state employee health plan for the cost of the drugs, to include in the billing the same “JG” modifier that the medical facility would include in the billing if the medical facility were billing the Medicare program for the drugs.

HB 1291

Information about health care and health coverage. Amends the law requiring a hospital to file an annual report with the Indiana department of health: (1) to require that a hospital’s report also be filed with the all payer claims data base; and (2) to require a hospital to include in the report additional information concerning the hospital’s medical loss ratio, the total funding received by the hospital under the CARES Act, and other matters. Requires the insurance commissioner, when deciding whether to approve a premium rate increase or decrease for an accident and sickness insurance policy or an increase or decrease in the rates to be used by a health maintenance organization (HMO), to consider the median cost sharing for the affected insurance policy or HMO contract, the benefits provided under the policy or contract, the underlying costs of the health services covered by the policy or contract, and other matters.

HB 1472

Hospital and health care cost and quality controls. Provides for implementation of a health care improvement and cost control strategy in Indiana that requires equalization of hospital reimbursement rates for all payers by July 1, 2025, and a total cost of care model of health care improvement and cost control for all heath care providers by July 1, 2030. Conditions implementation of the strategy upon approval of the strategy by federal Medicare and Medicaid agencies. Proposes the hospital global budget and population-based model.

HB 1292

Physician noncompete agreements. Specifies that the reasonable price of a noncompete agreement buyout may not exceed $75,000 under the following circumstances: (1) the physician’s employer is a hospital system located in Allen County; (2) the physician has completed a minimum of eight years of employment with the hospital system; and (3) the physician practices primary care and specializes in family medicine.

States Step In as Telehealth and Clinic Patients Get Blindsided by Hospital Fees

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HB 1004

Establishes the health care cost oversight task force and sets forth duties of the task force. Provides a credit against state tax liability to certain physicians who have an ownership interest in a physician practice and meet other eligibility criteria. Allows a credit against the state tax liability of an employer with fewer than 50 employees if the employer has adopted a health reimbursement arrangement in lieu of a traditional employer provided health insurance

plan and if the employer's contribution toward the health reimbursement arrangement meets a certain standard. Requires the office of the secretary of family and social services to research and compile data concerning Medicaid reimbursement rates for Indiana and all other states and the national reimbursement rate average. Requires the submission of a report to the health care cost oversight task force and the general assembly. Establishes the payer affordability penalty fund. Specifies additional information that a hospital must report to the Indiana department of health in the hospital's annual report and establishes a fine for a hospital that fails to timely file the report. Provides that a bill for health care services provided by certain qualified providers in an office setting must be submitted on an individual provider form. Prohibits an insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services from accepting a bill that is submitted on an institutional provider form. Repeals language requiring a hospital to hold a public forum. Requires the department of insurance to contract with a third party to calculate an Indiana nonprofit hospital system's prices from certain health plans for specified calendar years. Before November 1, 2024, and before November 1 each subsequent year, requires the department's third party contractor to compare certain Indiana nonprofit hospital system facility pricing information with 285% of Medicare. Requires the calculations to be submitted as a report for review. Provides that a health care provider that enters into: (1) a value-based health care reimbursement agreement; and (2) an electronic medical records access agreement; with a health plan may qualify to participate in the health plan's program to reduce or eliminate prior authorization requirements. Requires a health plan that establishes a program to reduce or eliminate prior authorization requirements to provide certain information to health care providers concerning the program. Requires a third party administrator, insurer, or health maintenance organization that has contracted with a person to administer a self-funded insurance plan or a fully insured group plan to provide claims data to the person not later than 15 days from a request for the data. Specifies certain claims data to be provided and establishes a fine for a failure to timely provide the claims data. Requires the all payer claims data base advisory board to discuss specified issues concerning reimbursement rates. Allows for the provisional credentialing of physicians who establish or join an independent primary care practice.

SB 7

Physician noncompete agreements. Provides that beginning July 1, 2023, a physician and an employer may not enter into a noncompete agreement.

SB 6

Health care billing forms. Provides that a bill for health care services provided by a provider in an office setting must be submitted on an individual provider form. Prohibits an insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services from accepting a bill that is submitted on an institutional provider form. Requires the Indiana department of health to adopt rules for the enforcement of these provisions.

Hospital Price Caps Among State Ideas to Lower Health-Care Costs

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