PROPOSED AMENDMENT
HB 1200 # 5

DIGEST

State employee health plan payment limits. Amends the definition of "medical facility service" to include any service for which a claim is submitted using a HIPAA X12 837I, CMS-1450, or UB-04 form or a successor form. Provides that the payment for a medical facility service provided by an in network provider to an individual covered by a state employee health plan may not exceed the lesser of: (1) the amount of compensation established by the network plan for in network providers; or (2) 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. Provides that the payment limits based on the amount that the Medicare program pays for a medical facility service apply to a medical facility service provided to an individual covered by a state employee health plan as of the date of the service and the date of adjudication, and that the limit applying to a service provided is not subject to an increase based on any adjustment that the federal Centers for Medicare and Medicaid Services (CMS) may later make in the amount paid by the Medicare program for the service. Provides that a provider, after receiving payment from a state employee health plan for a medical facility service provided to a covered individual, is prohibited from charging the covered individual an additional amount, other than cost sharing amounts authorized by the terms of the state employee health plan. Provides that if a third party administrator making payments for medical facility services for a state employee health plan does not provide payment on a fee-for-service basis, the payment method that the third party administrator uses must take into account the payment limits that are based on the amount that the Medicare program pays for the type of medical facility service provided.

Page 2, between lines 27 and 28, begin a new line block indented and insert:

"**(4) Any service for which a claim is submitted using a:**

(A) HIPAA X12 837I institutional form or its successor form;

(B) CMS-1450 form or its successor form; or

(C) UB-04 form or its successor form.".

Page 3, delete lines 7 through 11, begin a new line block indented and insert:

"**(1) For a medical facility service provided by an in network provider, the lesser of:**

(A) the rate or amount of compensation established by the network plan for in network providers; or

(B) two hundred percent (200%) of the amount paid by the Medicare program:

(i) for that type of medical facility service; or

(ii) for a medical facility service of a similar type.".

Page 3, between lines 16 and 17, begin a new line blocked left and insert:

"**The limit on the amount of payment for a medical facility service shall be determined under subdivision (1) or (2) based on the date of service and date of adjudication of the service. The limit applying to the amount of payment for a medical facility service is not subject to an increase after the date of adjudication based on any adjustment that the federal Centers for Medicare and Medicaid Services (CMS) may make in the amount paid by the Medicare program for a type of medical facility service.**

(l) A provider that receives payment for a medical facility service in accordance with subsection (k)(1) or (k)(2) may not charge to or collect from:

(1) the covered individual; or

(2) a person financially responsible for the covered individual; an amount in addition to the amount paid under subsection (k)(1) or (k)(2), other than cost sharing amounts authorized by the terms of the state employee health plan.

(m) If a third party administrator making payments for medical facility services for a state employee health plan does not provide payment on a fee-for-service basis, the payment method that the third party administrator uses must take into account the limits specified in subsection (k)(1) and (k)(2). The payment methods used by a third party administrator may include:

(1) value based payments;

(2) capitation payments; and

(3) bundled payments.".

Page 3, line 17, delete "(l)" and insert "**(n)**".

Page 3, line 17, delete "(k)(1)(B)" and insert "**(k)(1)(B)(ii)**".

Page 3, line 30, delete "(m)" and insert "**(o)**".

(Reference is to HB 1200 as introduced.)