Reprinted
February 1, 2024

HOUSE BILL No. 1200

DIGEST OF HB 1200 (Updated January 31, 2024 11:47 am - DI 141)

Citations Affected: IC 5-10.

Synopsis: State employee health plan 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) the lesser of the amount of compensation established by the network plan or 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 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

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Effective: July 1, 2024.

McGuire, Carbaugh, Lehman, Schaibley

January 9, 2024, read first time and referred to Committee on Insurance.
January 25, 2024, amended, reported — Do Pass.
January 31, 2024, read second time, amended, ordered engrossed.

the terms of the state employee health plan. 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 "TB" or "JG" modifier that the medical facility would include in the billing if the medical facility were billing the Medicare program for the drugs.

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Second Regular Session of the 123rd General Assembly (2024)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2023 Regular Session of the General Assembly.

HOUSE BILL No. 1200

A BILL FOR AN ACT to amend the Indiana Code concerning state and local administration.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8-6.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 6.9. (a) This section applies after June 30, 2025.**

(b) As used in this section, "cost sharing" means one (1) or more of the following paid by or on behalf of a covered individual for medical facility services:

(1) Coinsurance.

(2) A copayment.

(3) A deductible.

(4) Any other payment of part of the cost of covered medical facility services that is made by the covered individual or by another individual on behalf of the covered individual.

(c) As used in this section, "covered individual" means an individual who is:

(1) entitled to coverage by a self-insurance program established under section 7(b) of this chapter for the cost of medical facility services provided to the individual; or

(2) entitled to be provided medical facility services through a prepaid health care delivery plan entered into under section 7(c) of this chapter.

(d) As used in this section, "in network provider" means a medical facility that is required under a network plan to provide health care services to certain covered individuals at not more than a preestablished rate or amount of compensation.

(e) As used in this section, "medical facility" means an institution in which health care services are provided to individuals. The term:

(1) includes:

(A) hospitals and other licensed ambulatory surgical centers; and

(B) ambulatory outpatient surgical centers; but

(2) does not include:

(A) a private mental health institution licensed under IC 12-25;

(B) a Medicare certified, freestanding rehabilitation hospital;

(C) a federal Centers for Medicare and Medicaid Services (CMS) certified critical access hospital; or

(D) a federal Centers for Medicare and Medicaid Services (CMS) certified rural emergency hospital.

(f) As used in this section, "medical facility service" means any of the following:

(1) An inpatient service provided by a medical facility.

(2) An outpatient service provided by a medical facility.

(3) Medical supplies provided to a covered individual in connection with:

(A) an inpatient service; or

(B) an outpatient service;

that is provided by a medical facility.

(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.

The term does not include any service for which a claim is submitted using a HIPAA X12 837P electronic claims transaction for professional services or its successor transaction, a CMS-1500 form or its successor form, or a HCFA-1500 form or its successor form.

(g) As used in this section, "Medicare program" means the program established and operated under 42 U.S.C. 1395 et seq.

(h) As used in this section, "network plan" means a plan under which providers are required by contract to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

(i) As used in this section, "out of network provider" means a medical facility that is not an in network provider.

(j) As used in this section, "payment" means the total compensation for a medical facility service provided to a covered individual that is paid:

(1) partly by a state employee health plan; and

(2) partly through cost sharing paid by or on behalf of the covered individual.

(k) As used in this section, "state employee health plan" means:

(1) a self-insurance program established under section 7(b) of this chapter; or

(2) a contract with a prepaid health care delivery plan entered into under section 7(c) of this chapter.

(l) The payment for a medical facility service provided to a covered individual may not exceed the following:

(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.

(2) For a medical facility service provided by an out of network provider, one hundred eighty-five percent (185%) of the amount paid by the Medicare program:

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

(B) for a medical facility service of a similar type.

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.

(m) A provider that receives payment for a medical facility service in accordance with subsection (l)(1) or (l)(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 (l)(1) or (l)(2), other than cost sharing amounts authorized by the terms of the state employee health plan.

(n) 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 (l)(1) and (l)(2). The payment methods used by a third party administrator may include:

(1) value based payments;

(2) capitation payments; and

(3) bundled payments.

(o) For purposes of subsection (l)(1)(B)(ii) and (l)(2)(B), a determination of:

(1) the state personnel department;

(2) a state employee health plan; or

(3) a firm providing administrative services to a state employee health plan under section 7(b) of this chapter;

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 upon the medical facility that provided the medical facility service, the covered individual to whom the medical facility service was provided, and the state employee health plan that provides coverage to the covered individual.

(p) This subsection applies if:

(1) a medical facility provides drugs to a covered individual;

(2) the medical facility bills a state employee health plan for the cost of the drugs; and

(3) the medical facility, based on the particular type of drugs provided to the covered individual, would include a "TB" modifier or "JG" modifier in the billing if the medical facility were billing the Medicare program for the drugs instead of billing the state employee health plan.

A medical facility described in subdivisions (1) through (3), in billing the state employee health plan, shall include in the billing the same "TB" modifier or "JG" modifier that the medical facility

would include in the billing if the medical facility were billing the Medicare program for the drugs.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1200, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

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.

The term does not include any service for which a claim is submitted using a HIPAA X12 837P electronic claims transaction for professional services or its successor transaction, a CMS-1500 form or its successor form, or a HCFA-1500 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)**".

and when so amended that said bill do pass.

(Reference is to HB 1200 as introduced.)

CARBAUGH

Committee Vote: yeas 9, nays 4.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1200 be amended to read as follows:

Page 1, line 3, after "(a)" insert "**This section applies after June 30, 2025.**

(b)".

Page 1, line 12, delete "(b)" and insert "**(c)**".

Page 2, line 3, delete "(c)" and insert "**(d)**".

Page 2, line 7, delete "(d)" and insert "**(e)**".

Page 2, line 16, delete "or".

Page 2, line 18, delete "hospital." and insert "**hospital;**".

Page 2, between lines 18 and 19, begin a new line double block indented and insert:

"**(C) a federal Centers for Medicare and Medicaid Services (CMS) certified critical access hospital; or**

(D) a federal Centers for Medicare and Medicaid Services (CMS) certified rural emergency hospital.".

Page 2, line 19, delete "(e)" and insert "**(f)**".

Page 2, line 38, delete "(f)" and insert "**(g)**".

Page 2, line 40, delete "(g)" and insert "**(h)**".

Page 3, line 2, delete "(h)" and insert "**(i)**".

Page 3, line 4, delete "(i)" and insert "**(j)**".

Page 3, line 10, delete "(j)" and insert "**(k)**".

Page 3, line 15, delete "(k)" and insert "**(l)**".

Page 3, line 38, delete "(l)" and insert "**(m)**".

Page 3, line 39, delete "(k)(1) or (k)(2)" and insert "**(l)(1) or (l)(2)**".

Page 4, line 1, delete "(k)(1)" and insert "**(l)(1)**".

Page 4, line 2, delete "(k)(2)," and insert "**(l)(2),**".

Page 4, line 4, delete "(m)" and insert "**(n)**".

Page 4, line 8, delete "(k)(1) and (k)(2)." and insert "**(l)(1) and (l)(2).**".

Page 4, line 13, delete "(n)" and insert "**(o)**".

Page 4, line 13, delete "(k)(1)(B)(ii) and (k)(2)(B)," and insert "**(l)(1)(B)(ii) and (l)(2)(B),**".

Page 4, line 26, delete "(o)" and insert "**(p)**".

(Reference is to HB 1200 as printed January 25, 2024.)

MCGUIRE