Reprinted
March 3, 2020

ENGROSSED
HOUSE BILL No. 1004

DIGEST OF HB 1004 (Updated March 2, 2020 4:48 pm - DI 104)

Citations Affected: IC 12-7; IC 12-15; IC 16-18; IC 16-51; IC 25-1; IC 25-22.5; IC 27-1; IC 27-2; noncode.

Synopsis: Health matters. Requires a provider to include the service facility location in order to obtain Medicaid reimbursement from the office of the secretary of family and social services or the managed care organization. Requires health care providers to include the address of the service facility location on submitted reimbursement forms. Requires certain health care providers to provide a good faith estimate to individuals of the price for nonemergency health care services to be provided to the individual by the health care provider and sets forth

(Continued next page)

Effective: July 1, 2020.

Smaltz, Barrett, Lehman, Carbaugh
(SENATE SPONSORS — CHARBONNEAU, BASSLER, BREAUX, RANDOLPH LONNIE M)

January 6, 2020, read first time and referred to Committee on Insurance.
January 23, 2020, amended, reported — Do Pass.
January 27, 2020, read second time, ordered engrossed.
January 28, 2020, engrossed. Read third time, passed. Yeas 99, nays 0.

SENATE ACTION

February 5, 2020, read first time and referred to Committee on Health and Provider Services.
February 27, 2020, amended, reported favorably — Do Pass.
March 2, 2020, read second time, amended, ordered engrossed.

requirements. Provides that an out of network practitioner who provides health care services to a covered individual in an in network facility may not charge more for the health care services provided to a covered individual than allowed according to the rate or amount of compensation established by the covered individual's network plan unless: (1) at least five days before the health care services are scheduled to be provided, the covered individual is provided a statement that: (A) informs the covered individual that the facility or practitioner intends to charge more than allowed under the network plan; and (B) sets forth an estimate of the charge; and (2) the covered individual signs the statement, signifying the covered individual's consent to the charge. Prohibits employment contracts between employers and practitioner employees to include non-compete agreements. Provides for information and notification that an employer must give to a physician who leaves the employment of the provider. Requires insurers and health maintenance organization to annually report specified claims data to the department of insurance and the general assembly.

Reprinted
March 3, 2020

Second Regular Session of the 121st General Assembly (2020)

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 2019 Regular Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1004

A BILL FOR AN ACT to amend the Indiana Code concerning health.

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

SECTION 1. IC 12-7-2-174.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 174.7. (a) "Service facility location", for purposes of IC 12-15-11, means the address where the services of a provider facility or practitioner were provided.**

(b) The term consists of exact address and place of service codes as required on CMS forms 1500 and 1450, including an office, on-campus location of a hospital, and off-campus location of a hospital.

SECTION 2. IC 12-15-11-5, AS AMENDED BY P.L.195-2018, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 5. (a) A provider who participates in the Medicaid program must comply with the enrollment requirements that are established under rules adopted under IC 4-22-2 by the secretary.

(b) A provider who participates in the Medicaid program may be required to ~~use the centralized credentials verification organization established in section 9 of this chapter.~~ **include the address of the**

service facility location in order to obtain Medicaid reimbursement for a claim for health care services from the office or a managed care organization.

(c) The office or a managed care organization is not required to accept a claim for health care services that does not contain the service facility location.

SECTION 3. IC 12-15-11-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 6. **(a)** After a provider signs a provider agreement under this chapter, the office may not exclude the provider from participating in the Medicaid program by entering into an exclusive contract with another provider or group of providers, except as provided under section 7 of this chapter.

(b) The office or a managed care organization contracting with the office may not prohibit a provider from participating in a network of another insurer, managed care organization, or health maintenance organization.

SECTION 4. IC 16-18-2-163.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 163.6. "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-1.**

SECTION 5. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 167.8. "Health maintenance organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.**

SECTION 6. IC 16-18-2-190.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.9. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.**

SECTION 7. IC 16-18-2-288, AS AMENDED BY P.L.96-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 288. (a) "Practitioner", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-5.

(b) "Practitioner", for purposes of IC 16-41-14, has the meaning set forth in IC 16-41-14-4.

(c) "Practitioner", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-3.

(d) "Practitioner", for purposes of IC 16-42-22 and IC 16-42-25, has the meaning set forth in IC 16-42-22-4.5.

(e) "Practitioner", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.

SECTION 8. IC 16-18-2-295.3 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 295.3. "Provider facility", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.**

SECTION 9. IC 16-18-2-327.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 327.7. "Service facility location", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

SECTION 10. IC 16-51 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

ARTICLE 51. HEALTH CARE REQUIREMENTS

Chapter 1. Health Care Provider Billing

Sec. 1. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 2. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 3. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(e).

Sec. 4. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 5. As used in this chapter, "provider facility" means any of the following:

(1) A hospital.

(2) A skilled nursing facility.

(3) An end stage renal disease provider.

(4) A home health agency.

(5) A hospice organization.

(6) An outpatient physical therapy, occupational therapy, or speech pathology service provider.

(7) A comprehensive outpatient rehabilitation facility.

(8) A community mental health center.

(9) A critical access hospital.

(10) A federally qualified health center.

(11) A histocompatibility laboratory.

(12) An Indian health service facility.

(13) An organ procurement organization.

(14) A religious nonmedical health care institution.

(15) A rural health clinic.

Sec. 6. As used in this chapter, "service facility location" means the address where the services of a provider facility or practitioner were provided. The term consists of exact address and place of service codes as required on CMS forms 1500 and 1450, including an office, on-campus location of a hospital, and off-campus location of a hospital.

Sec. 7. (a) A provider facility or practitioner shall include the address of the service facility location in order to obtain reimbursement for a commercial claim for health care services from an insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services.

(b) An insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services is not required to accept a bill for health care services that does not contain the service facility location.

Sec. 8. A patient is not liable for any additional payment that is the result of a practitioner or provider facility filing an incorrect form or not including the correct service facility location as required under this chapter.

SECTION 11. IC 25-1-9-23 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 23. (a) This section does not apply to emergency services.**

(b) As used in this section, "covered individual" means an individual who is entitled to be provided health care services at a cost established according to a network plan.

(c) As used in this section, "in network practitioner" means a practitioner who is required under a network plan to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

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

(e) As used in this section, "practitioner" means the following:

(1) An individual licensed under IC 25 who provides professional health care services to individuals in a facility.

(2) An organization:

(A) that consists of practitioners described in subdivision

(1); and

(B) through which practitioners described in subdivision (1) provide health care services.

(3) An entity that:

(A) is not a facility; and

(B) employs practitioners described in subdivision (1) to provide health care services.

(f) An in network practitioner who provides health care services to a covered individual may not charge more for the health care services than allowed according to the rate or amount of compensation established by the individual's network plan.

(g) An out of network practitioner who provides health care services at an in network facility to a covered individual may charge more for the health care services than allowed according to the rate or amount of compensation established by the individual's network plan if all of the following conditions are met:

(1) At least five (5) days before the health care services are scheduled to be provided to the covered individual, the practitioner provides to the covered individual, on a form separate from any other form provided to the covered individual by the practitioner, a statement in conspicuous type at least as large as fourteen (14) point type that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of practitioner] intends to charge you more for [name or description of health care services] than allowed according to the rate or amount of compensation established by the network plan applying to your coverage. [Name of practitioner] is not entitled to charge this much for [name or description of health care services] unless you give your written consent to the charge.".

(B) Sets forth the practitioner's good faith estimate of the amount that the practitioner intends to charge for the health care services provided to the covered individual.

(C) Includes a notice reading substantially as follows concerning the good faith estimate set forth under clause (B): "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate of the amount we will charge. If our actual charge for [name or description of health care services] exceeds our estimate, we will explain to you why the charge exceeds the

estimate.".

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

(h) If the charge of a practitioner for health care services provided to a covered individual exceeds the estimate provided to the covered individual under subsection (g)(1)(B), the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

SECTION 12. IC 25-1-9.8 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 9.8. Practitioner Good Faith Estimates

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to be provided health care services according to a health carrier's network plan.

Sec. 1.5. As used in this chapter, "episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.

Sec. 2. As used in this chapter, "good faith estimate" means a reasonable estimate of the price a practitioner anticipates charging for an episode of care for nonemergency health care services that:

(1) is made by a practitioner under this chapter upon the request of:

(A) the individual for whom the nonemergency health care service has been ordered; or

(B) the provider facility in which the nonemergency health care service will be provided; and

(2) is not binding upon the practitioner.

Sec. 3. (a) As used in this chapter, "health carrier" means an entity:

(1) that is subject to IC 27 and the administrative rules adopted under IC 27; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term also includes the following:

(1) An insurer, as defined in IC 27-1-2-3(x), that issues a policy of accident and sickness insurance, as defined in IC 27-8-5-1(a).

(2) A health maintenance organization, as defined in IC 27-13-1-19.

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined by IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

Sec. 4. As used in this chapter, "in network", when used in reference to a practitioner, means that the health care services provided by the practitioner are subject to a health carrier's network plan.

Sec. 5. (a) As used in this chapter, "network" means a group of provider facilities and practitioners that:

(1) provide health care services to covered individuals; and

(2) have agreed to, or are otherwise subject to, maximum limits on the prices for the health care services to be provided to the covered individuals.

(b) The term includes the following:

(1) A network described in subsection (a) that is established pursuant to a contract between an insurer providing coverage under a group health policy and:

(A) individual provider facilities and practitioners;

(B) a preferred provider organization; or

(C) an entity that employs or represents providers, including:

(i) an independent practice association; and

(ii) a physician-hospital organization.

(2) A health maintenance organization, as defined in IC 27-13-1-19.

Sec. 6. As used in this chapter, "network plan" means a plan of a health carrier that:

(1) requires a covered person to receive; or

(2) creates incentives, including financial incentives, for a covered person to receive;

health care services from one (1) or more providers that are under contract with, managed by, or owned by the health carrier.

Sec. 7. As used in this chapter, "nonemergency health care service" means a discrete service or series of services ordered by

a practitioner for an episode of care for the:

(1) diagnosis;

(2) prevention;

(3) treatment;

(4) cure; or

(5) relief;

of a physical, mental, or behavioral health condition, illness, injury, or disease that is not provided on an emergency or urgent care basis.

Sec. 8. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 8.5. As used in this chapter, "price" means the negotiated rate between the:

(1) provider facility and practitioner; and

(2) covered individual's primary health carrier.

Sec. 9. As used in this chapter, "provider" means:

(1) a provider facility; or

(2) a practitioner.

Sec. 10. As used in this chapter, "provider facility"means any of the following:

(1) A hospital licensed under IC 16-21-2.

(2) An ambulatory outpatient surgery center licensed under IC 16-21-2.

(3) An abortion clinic licensed under IC 16-21-2.

(4) A birthing center licensed under IC 16-21-2.

(5) Except for an urgent care facility (as defined by IC 27-1-46-10.5), a facility that provides diagnostic services to the medical profession or the general public.

(6) A laboratory where clinical pathology tests are carried out on specimens to obtain information about the health of a patient.

(7) A facility where radiologic and electromagnetic images are made to obtain information about the health of a patient.

(8) An infusion center that administers intravenous medications.

Sec. 11. (a) This section does not apply to an individual who is a Medicaid recipient.

(b) An individual for whom a nonemergency health care service has been ordered may request from the practitioner who may provide the nonemergency health care service a good faith estimate of the total price the practitioner will charge for providing the

nonemergency health care service.

(c) A practitioner who receives a request from a patient under subsection (b) shall, not more than five (5) business days after receiving all the relevant information from the individual, provide to the individual a good faith estimate of the price that the practitioner will charge for providing the nonemergency health care service.

(d) A practitioner must ensure that a good faith estimate provided to an individual under this section is accompanied by a notice stating that:

(1) an estimate provided under this section is not binding on the practitioner;

(2) the price the practitioner charges the individual may vary from the estimate based on the individual's medical needs; and

(3) the estimate provided under this section is only valid for thirty (30) days.

(e) A practitioner may not charge an individual for information provided under this section.

Sec. 12. (a) If:

(1) the individual who requests a good faith estimate from a practitioner under this chapter is a covered individual with respect to a network plan; and

(2) the practitioner from which the individual requests the good faith estimate is in network with respect to the same network plan;

the good faith estimate that the practitioner provides to the individual under this chapter must be based on the negotiated price to which the practitioner has agreed as an in network provider.

(b) If the individual who requests a good faith estimate from a practitioner under this chapter:

(1) is not a covered individual with respect to any network plan; or

(2) is not a covered individual with respect to a network plan with respect to which the practitioner is in network;

the good faith estimate that the practitioner provides to the individual under this chapter must be based on the price that the practitioner charges for the nonemergency health care service in the absence of any network plan.

Sec. 13. A practitioner may provide a good faith estimate to an individual under this chapter:

(1) in a writing delivered to the individual;

(2) by electronic mail; or

(3) through a mobile application or other Internet web based method, if available;

according to the preference expressed by the individual.

Sec. 14. (a) A good faith estimate provided by a practitioner to an individual under this chapter must meet the following requirements:

(1) Provide a summary of the services and material items that the good faith estimate is based on.

(2) Include:

(A) the price that the provider facility in which the health care service will be performed will charge for:

(i) the use of the provider facility to care for the individual for the nonemergency health care service;

(ii) the services rendered by the staff of the provider facility in connection with the nonemergency health care service; and

(iii) medication, supplies, equipment, and material items to be provided to or used by the individual while the individual is present in the provider facility in connection with the nonemergency health care service;

(B) the price charged for the services of all practitioners, support staff, and other persons who provide professional health services:

(i) who may provide services to or for the individual during the individual's presence in the provider facility for the nonemergency health care service; and

(ii) for whose services the individual will be charged separately from the charge of the provider facility;

for imaging, laboratory services, diagnostic services, therapy, observation services, and other services expected to be provided to the individual for the episode of care.

(3) Include a total figure that is a sum of the estimated prices referred to in subdivisions (1) and (2).

(b) Subsection (a) does not prohibit a practitioner from providing to an individual a good faith estimate that indicates how much of the total figure stated under subsection (a)(2) will be the individual's out-of-pocket expense after the health carrier's payment of charges.

(c) A health carrier and a provider facility must provide a practitioner with the information needed by the practitioner to comply with the requirements under this chapter not more than

two (2) business days after receiving the request.

(d) A practitioner is not subject to the penalties under section 19 of this chapter if:

(1) a health carrier or provider facility fails to provide the practitioner with the information as required under subsection (c);

(2) the practitioner provides the individual with a good faith estimate based on any information that the practitioner has; and

(3) the practitioner provides the individual with an updated good faith estimate after the health carrier or provider facility has provided the information required under subsection (c).

Sec. 15. If:

(1) a practitioner is expected to provide a nonemergency health care service to an individual in a provider facility; and

(2) the provider facility receives a request from an individual for a good faith estimate under IC 27-1-46;

the practitioner, upon request from the provider facility, shall provide to the provider facility a good faith estimate of the practitioner's price for providing the nonemergency health care service to enable the provider facility to comply with IC 27-1-46-11.

Sec. 16. (a) A practitioner that has ordered the individual for a nonemergency health care service shall provide to the individual an electronic or paper copy of a written notice that states the following, or words to the same effect: "A patient may at any time ask a health care provider for an estimate of the price the health care providers and health facility will charge for providing a nonemergency medical service. The law requires that the estimate be provided within 5 business days.".

(b) The Indiana professional licensing agency may adopt rules under IC 4-22-2 to establish requirements for practitioners to provide additional charging information under this section.

Sec. 17. If:

(1) a practitioner receives a request for a good faith estimate under this chapter; and

(2) the patient is eligible for Medicare coverage;

the practitioner shall provide a good faith estimate to the patient within five (5) business days based on available Medicare rates.

Sec. 18. (a) As used in this section, "waiting room" means a space in a building used by a practitioner in which people check in or register to:

(1) be seen by practitioners; or

(2) meet with members of the staff of a practitioner's office.

(b) A practitioner shall ensure that each waiting room of the practitioner's office includes at least one (1) printed notice that:

(1) is designed, lettered, and positioned within the waiting room so as to be conspicuous to and readable by any individual with normal vision who visits the waiting room; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in this practitioner office. The law requires that an estimate be provided within 5 business days.".

(c) If a practitioner maintains an Internet web site, the practitioner shall ensure that the Internet web site includes at least one (1) printed notice that:

(1) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in our office. The law requires that an estimate be provided within 5 business days.".

Sec. 19. The appropriate board (as defined in IC 25-1-9-1) may take action against a practitioner:

(1) under IC 25-1-9-9(a)(3) or IC 25-1-9-9(a)(4) for an initial violation or isolated violations of this chapter; or

(2) under IC 25-1-9-9(a)(6) for repeated or persistent violations of this chapter;

concerning the providing of a good faith estimate to an individual for whom a nonemergency health care service has been ordered or the providing of notice in the practitioner's waiting room or on the practitioner's Internet web site that a patient may at any time ask for an estimate of the price that the patient will be charged for a medical service.

SECTION 13. IC 25-1-9.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 9.9. Practitioner Employment Contracts And Non-Compete Agreements

Sec. 1. This chapter applies to an employment contract entered

into, modified, renewed, or extended after June 30, 2020.

Sec. 2. As used in this chapter, "employee" means a practitioner (as defined in IC 25-1-9-2) employed by an employer for wages or salary. The term includes an individual who has received an offer of employment from a prospective employer.

Sec. 3. As used in this chapter, "employer" means an individual, corporation, partnership, limited liability company, or any other legal entity that has at least one (1) employee and is legally doing business in Indiana.

Sec. 4. As used in this chapter, "non-compete agreement" means a contractual provision by which an employer attempts to limit an employee's ability to seek future employment or engage in future business activity after the employment relationship has terminated.

Sec. 5. An employment contract entered into by an employer and employee may not contain a non-compete agreement.

Sec. 6. A non-compete agreement in an employment contract in violation of this chapter is unenforceable and void.

SECTION 14. IC 25-22.5-17 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 17. Physician's Patient Information

Sec. 1. If a physician licensed under this article leaves the employment of an employer, the following apply:

(1) The employer of the physician must provide the physician with a copy of any notice that:

(A) concerns the physician's departure from the employer; and

(B) was sent to any patient seen or treated by the physician during the two (2) year period preceding the termination of the physician's employment or the expiration of the physician's contract. However, the patient names and contact information must be redacted from the copy of the notice provided from the employer of the physician to the physician.

(2) The physician's employer must, in good faith, provide the physician's last known or current contact and location information to a patient who:

(A) requests updated contact and location information for the physician; and

(B) was seen or treated by the physician during the two (2) year period preceding the termination of the physician's employment or the expiration of the physician's contract.

(3) The physician's employer must provide the physician with:

(A) access to; or

(B) copies of;

any medical record associated with a patient described in subdivision (1) or (2) upon receipt of the patient's consent.

(4) The physician's employer may not provide patient medical records to a requesting physician in a format that materially differs from the format used to create or store the medical record during the routine or ordinary course of business, unless a different format is mutually agreed upon by the parties. Paper or portable document format copies of the medical records satisfy the formatting provisions of this chapter.

Sec. 2. A person or entity required to create, copy, or transfer a patient medical record for a reason specified in this chapter may charge a reasonable fee for the service as permitted under applicable state or federal law.

SECTION 15. IC 27-1-45 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 45. Health Facility Compensation

Sec. 0.5. This chapter does not apply to emergency services.

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to be provided health care services at a cost established according to a network plan.

Sec. 2. As used in this chapter, "facility" means an institution in which health care services are provided to individuals. The term includes:

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

(2) ambulatory outpatient surgical centers.

Sec. 3. As used in this chapter, "in network provider" means a provider that is required under a network plan to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

Sec. 4. As used in this chapter, "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.

Sec. 5. As used in this chapter, "practitioner" means the following:

(1) An individual licensed under IC 25 who provides

professional health care services to individuals in a facility.

(2) An organization:

(A) that consists of practitioners described in subdivision (1); and

(B) through which practitioners described in subdivision (1) provide health care services.

(3) An entity that:

(A) is not a facility; and

(B) employs practitioners described in subdivision (1) to provide health care services.

Sec. 6. As used in this chapter, "provider" means:

(1) a facility; or

(2) a practitioner.

Sec. 7. (a) An out of network practitioner who provides health care services at an in network facility to a covered individual may charge more for the health care services than allowed according to the rate or amount of compensation established by the individual's network plan if all of the following conditions are met:

(1) At least five (5) days before the health care services are scheduled to be provided to the covered individual, the facility or practitioner provides to the covered individual, on a form separate from any other form provided to the covered individual by the facility or practitioner, a statement in conspicuous type at least as large as fourteen (14) point type that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of facility or practitioner] intends to charge you more for [name or description of health care services] than allowed according to the rate or amount of compensation established by the network plan applying to your coverage. [Name of facility or practitioner] is not entitled to charge this much for [name or description of health care services] unless you give your written consent to the charge.".

(B) Sets forth the facility's or practitioner's good faith estimate of the amount that the facility or practitioner intends to charge for the health care services provided to the covered individual.

(C) Includes a notice reading substantially as follows concerning the good faith estimate set forth under clause (B): "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate

of the amount we will charge. If our actual charge for [name or description of health care services] exceeds our estimate, we will explain to you why the charge exceeds the estimate.".

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

(b) If the charge of a facility or practitioner for health care services provided to a covered individual exceeds the estimate provided to the covered individual under subsection (b)(1)(B), the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

Sec. 8. (a) The insurance commissioner may, after notice and hearing under IC 4-21.5, impose on the provider facility a civil penalty of not more than one thousand dollars ($1,000) for each violation of this chapter.

(b) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

SECTION 16. IC 27-1-46 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 46. Provider Facility Good Faith Estimates

Sec. 0.5. Nothing in this chapter prohibits:

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); or

(2) a self-insurance program established to provide group health coverage as described in IC 5-10-8-7(b), or a contract for health services as described in IC 5-10-8-7(c);

from providing information requested by a practitioner or provider facility under this chapter.

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to be provided health care services according to a health carrier's network plan.

Sec. 1.5. As used in this chapter, "episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.

Sec. 2. As used in this chapter, "good faith estimate" means a reasonable estimate of the price a provider anticipates charging for an episode of care for nonemergency health care services that:

(1) is made by a provider under this chapter upon the request of the individual for whom the nonemergency health care service has been ordered; and

(2) is not binding upon the provider.

Sec. 3. (a) As used in this chapter, "health carrier" means an entity:

(1) that is subject to IC 27 and the administrative rules adopted under IC 27; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term also includes the following:

(1) An insurer, as defined in IC 27-1-2-3(x), that issues a policy of accident and sickness insurance, as defined in IC 27-8-5-1(a).

(2) A health maintenance organization, as defined in IC 27-13-1-19.

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined by IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

Sec. 4. As used in this chapter, "in network", when used in reference to a provider, means that the health care services provided by the provider are subject to a health carrier's network plan.

Sec. 5. (a) As used in this chapter, "network" means a group of provider facilities and practitioners that:

(1) provide health care services to covered individuals; and

(2) have agreed to, or are otherwise subject to, maximum limits on the prices for the health care services to be provided to the covered individuals.

(b) The term includes the following:

(1) A network described in subsection (a) that is established pursuant to a contract between an insurer providing coverage under a group health policy and:

(A) individual provider facilities and practitioners;

(B) a preferred provider organization; or

(C) an entity that employs or represents providers, including:

(i) an independent practice association; and

(ii) a physician-hospital organization.

(2) A health maintenance organization, as defined in IC 27-13-1-19.

Sec. 6. As used in this chapter, "network plan" means a plan of a health carrier that:

(1) requires a covered person to receive; or

(2) creates incentives, including financial incentives, for a covered person to receive;

health care services from one (1) or more providers that are under contract with, managed by, or owned by the health carrier.

Sec. 7. As used in this chapter, "nonemergency health care service" means a discrete service or series of services ordered by a practitioner for an episode of care for the purpose of:

(1) diagnosis;

(2) prevention;

(3) treatment;

(4) cure; or

(5) relief;

of a physical, mental, or behavioral health condition, illness, injury, or disease that is not provided on an emergency or urgent care basis.

Sec. 8. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 8.5. As used in this chapter, "price" means the negotiated rate between the:

(1) provider facility and practitioner; and

(2) covered individual's primary health carrier.

Sec. 9. As used in this chapter, "provider" means:

(1) a provider facility; or

(2) a practitioner.

Sec. 10. As used in this chapter, "provider facility"means any of the following:

(1) A hospital licensed under IC 16-21-2.

(2) An ambulatory outpatient surgery center licensed under IC 16-21-2.

(3) An abortion clinic licensed under IC 16-21-2.

(4) A birthing center licensed under IC 16-21-2.

(5) Except for an urgent care facility, a facility that provides

diagnostic services to the medical profession or the general public, including outpatient facilities.

(6) A laboratory where clinical pathology tests are carried out on specimens to obtain information about the health of a patient.

(7) A facility where radiologic and electromagnetic images are made to obtain information about the health of a patient.

(8) An infusion center that administers intravenous medications.

Sec. 10.5. (a) As used in this chapter, "urgent care facility" means a freestanding health care facility that offers episodic, walk-in care for the treatment of acute, but not life threatening, health conditions.

(b) The term does not include an emergency department of a hospital or a nonprofit or government operated health clinic.

Sec. 11. (a) This section does not:

(1) apply to a individual who is a Medicaid recipient; or

(2) limit the authority of a legal representative of the patient.

(b) An individual for whom a nonemergency health care service has been ordered may request from the provider facility in which the health care service will be provided a good faith estimate of the price that will be charged as a result of the nonemergency health care service.

(c) A provider facility that receives a request from an individual under subsection (b) shall, not more than five (5) business days after receiving all the relevant information from the individual, provide to the individual a good faith estimate of:

(1) the price that the provider facility in which the health care service will be performed will charge for:

(A) the use of the provider facility to care for the individual for the nonemergency health care service;

(B) the services rendered by the staff of the provider facility in connection with the nonemergency health care service; and

(C) medication, supplies, equipment, and material items to be provided to or used by the individual while the individual is present in the provider facility in connection with the nonemergency health care service; and

(2) the price charged for the services of all practitioners, support staff, and other persons who provide professional health services:

(A) who may provide services to or for the individual

during the individual's presence in the provider facility for the nonemergency health care service; and

(B) for whose services the individual will be charged separately from the charge of the provider facility.

(d) The price that must be included in a good faith estimate under this section includes all services under subsection (c)(1) or (c)(2) for imaging, laboratory services, diagnostic services, therapy, observation services, and other services expected to be provided to the individual for the episode of care.

(e) A provider facility shall ensure that a good faith estimate states that:

(1) an estimate provided under this section is not binding on the provider facility;

(2) the price the provider facility charges the individual may vary from the estimate based on the individual's medical needs; and

(3) the estimate provided under this section is only valid for thirty (30) days.

(f) A provider facility may not charge a patient for information provided under this section.

Sec. 12. (a) If:

(1) the individual who requests a good faith estimate from a provider facility under this chapter and has been verified as a covered individual with respect to a network plan; and

(2) the provider facility from which the individual requests the good faith estimate is in network with respect to the same network plan;

the good faith estimate that the provider facility provides to the individual under this chapter must be based on the price to which the provider facility and any practitioners referred to in section 11(c)(2) of this chapter have agreed as in network providers.

(b) If the individual who requests a good faith estimate from a provider facility under this chapter:

(1) is not a covered individual with respect to any network plan; or

(2) is not a covered individual with respect to a network plan with respect to which the provider facility is in network;

the good faith estimate that the provider facility provides to the individual under this chapter must be based on the price that the provider facility and any practitioners referred to in section 11(c)(2) of this chapter charge for the nonemergency health care services in the absence of any network plan.

Sec. 13. A provider facility may provide a good faith estimate to an individual under this chapter:

(1) in a writing delivered to the individual;

(2) by electronic mail; or

(3) through a mobile application or other Internet web based method, if available;

according to the preference expressed by the individual.

Sec. 14. (a) A good faith estimate provided by a provider facility to an individual under this chapter must:

(1) provide a summary of the services and material items that the good faith estimate is based on; and

(2) include a total figure that is a sum of the estimated prices referred to in subdivision (1).

(b) Subsection (a) does not prohibit a provider facility from providing to an individual a good faith estimate that indicates how much of the total figure stated under subsection (a)(2) will be the individual's out-of-pocket expense after the health carrier's payment of charges.

(c) A health carrier or practitioner must provide a provider facility with the information needed by the provider facility to comply with the requirements under this chapter not more than two (2) business days after receiving the request.

(d) A provider facility is not subject to the penalties under section 17 of this chapter if:

(1) a health carrier or practitioner fails to provide the provider facility with the information as required under subsection (c);

(2) the provider facility provides the individual with a good faith estimate based on any information that the provider facility has; and

(3) the provider facility provides the individual with an updated good faith estimate after the health carrier or practitioner has provided the information required under subsection (c).

Sec. 15. (a) As used in this section, "waiting room" means a space in a building used by a provider facility in which people check in or register to:

(1) be seen by practitioners; or

(2) meet with members of the staff of the provider facility.

(b) A provider facility shall ensure that each waiting room of the provider facility includes at least one (1) printed notice that:

(1) is designed, lettered, and positioned within the waiting

room so as to be conspicuous to and readable by any individual with normal vision who visits the waiting room; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in this facility. The law requires that an estimate be provided within 5 business days.".

(c) If a provider facility maintains an Internet web site, the provider facility shall ensure that the Internet web site includes at least one (1) printed notice that:

(1) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in our facility. The law requires that an estimate be provided within 5 business days.".

Sec. 16. If:

(1) a provider facility receives a request for a good faith estimate under this chapter; and

(2) the patient is eligible for Medicare coverage;

the provider facility shall provide a good faith estimate to the patient within five (5) business days based on available Medicare rates.

Sec. 17. (a) If a provider facility fails or refuses:

(1) to provide a good faith estimate as required by this chapter; or

(2) to provide notice on the provider facility's Internet web site as required under this chapter;

the insurance commissioner may, after notice and hearing under IC 4-21.5, impose on the provider facility a civil penalty of not more than one thousand dollars ($1,000) for each violation.

(b) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

SECTION 17. IC 27-2-25 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 25. Health Carrier Good Faith Estimates

Sec. 1. As used in this chapter, "coverage" means the right of an individual to receive:

(1) health care services; or

(2) payment or reimbursement for health care services;

from a health carrier.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage from a health carrier.

Sec. 2.5. As used in this chapter, "episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.

Sec. 3. As used in this chapter, "good faith estimate" means a health carrier's reasonable estimate of:

(1) the amount of the cost of a nonemergency health care service that the health carrier will:

(A) pay for; or

(B) reimburse to;

a covered individual; or

(2) the applicable benefit limitations of the nonemergency health care service a covered individual is entitled to receive;

that a health carrier provides upon request to a covered individual for whom a nonemergency health care service has been ordered.

Sec. 4. (a) As used in this chapter, "health carrier" means an entity:

(1) that is subject to this title and the administrative rules adopted under this title; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term also includes the following:

(1) An insurer, as defined in IC 27-1-2-3(x), that issues a policy of accident and sickness insurance, as defined in IC 27-8-5-1(a).

(2) A health maintenance organization, as defined in IC 27-13-1-19.

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined by IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

Sec. 5. As used in this chapter, "in network", when used in

reference to a practitioner, means that the health care services provided by the practitioner are subject to a health carrier's network plan.

Sec. 6. (a) As used in this chapter, "network" means a group of provider facilities and practitioners that:

(1) provide health care services to covered individuals; and

(2) have agreed to, or are otherwise subject to, maximum limits on the prices for the health care services to be provided to the covered individuals.

(b) The term includes the following:

(1) A network described in subsection (a) that is established pursuant to a contract between an insurer providing coverage under a group health policy and:

(A) individual provider facilities and practitioners;

(B) a preferred provider organization; or

(C) an entity that employs or represents providers, including:

(i) an independent practice association; and

(ii) a physician-hospital organization.

(2) A health maintenance organization, as defined in IC 27-13-1-19.

Sec. 7. As used in this chapter, "network plan" means a plan of a health carrier that:

(1) requires a covered person to receive; or

(2) creates incentives, including financial incentives, for a covered person to receive;

health care services from one (1) or more providers that are under contract with, managed by, or owned by the health carrier.

Sec. 8. As used in this chapter, "nonemergency health care service" means a discrete service or series of services ordered by a practitioner for an episode of care for the:

(1) diagnosis;

(2) prevention;

(3) treatment;

(4) cure; or

(5) relief;

of a physical, mental, or behavioral health condition, illness, injury, or disease that is not provided on an emergency or urgent care basis.

Sec. 9. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 9.5. As used in this chapter, "price" means the negotiated rate between the:

(1) provider facility and practitioner; and

(2) covered individual's primary health carrier;

minus the amount that the health carrier will pay.

Sec. 10. As used in this chapter, "provider" means:

(1) a provider facility; or

(2) a practitioner.

Sec. 11. As used in this chapter, "provider facility"means any of the following:

(1) A hospital licensed under IC 16-21-2.

(2) An ambulatory outpatient surgery center licensed under IC 16-21-2.

(3) An abortion clinic licensed under IC 16-21-2.

(4) A birthing center licensed under IC 16-21-2.

(5) Except for an urgent care facility (as defined by IC 27-1-46-10.5), a facility that provides diagnostic services to the medical profession or the general public.

(6) A laboratory where clinical pathology tests are carried out on specimens to obtain information about the health of a patient.

(7) A facility where radiologic and electromagnetic images are made to obtain information about the health of a patient.

(8) An infusion center that administers intravenous medications.

Sec. 12. (a) A covered individual for whom a nonemergency health care service has been ordered may request from the health carrier a good faith estimate of:

(1) the amount of the cost of the nonemergency health care service that the health carrier will:

(A) pay for; or

(B) reimburse to;

the covered individual; or

(2) the applicable benefit limitations of the ordered nonemergency health care service a covered individual is entitled to receive from the health carrier.

(b) If:

(1) a health carrier provides coverage to a covered individual through a network plan; and

(2) the health carrier receives a request for a good faith estimate from a covered individual for whom a nonemergency health care service has been ordered;

the health carrier shall inform the covered individual whether the provider facility in which the nonemergency health care service will be provided is in network and whether each scheduled practitioner who may provide the nonemergency health care service is in network.

(c) A health carrier that receives a request from a covered individual patient under subsection (b) shall, not more than five (5) business days after receiving all the relevant information, provide to the individual a good faith estimate as described in section 14 of this chapter.

(d) A health carrier must ensure that a good faith estimate states that the estimate provided under this section is only valid for thirty (30) days and that:

(1) the amount that the health carrier will:

(A) pay; or

(B) reimburse;

for or to the covered individual for the nonemergency health care services the individual receives; and

(2) the applicable benefit limitations of the nonemergency health care services the individual will receive;

may vary from the health carrier's good faith estimate based on the individual's medical needs.

(e) A health carrier may not charge an individual for information provided under this section.

(f) A practitioner and provider facility shall provide a health carrier with the information needed by the health carrier to comply with the requirements under this chapter not more than two (2) business days after receiving the request.

Sec. 13. A health carrier may provide a good faith estimate to an individual under this chapter:

(1) in a writing delivered to the individual;

(2) by electronic mail; or

(3) through a mobile application or other Internet web based method, if available;

according to the preference expressed by the individual.

Sec. 14. (a) A good faith estimate provided by a health carrier to an individual under this chapter must:

(1) in the case of an insurer or another health carrier that pays or reimburses the cost of health care services:

(A) provide a summary of the services and material items that the good faith estimate is based on;

(B) include a total figure that is a sum of the amounts

referred to in clause (A); and

(C) state the out-of-pocket costs the covered individual will incur, if any, beyond the amount that the health carrier will pay or reimburse; and

(2) in the case of a health maintenance organization or another health carrier that provides health care services:

(A) provide a summary of the applicable benefit limitations of the health care services to which the covered individual is entitled; and

(B) state the out-of-pocket costs the covered individual will incur, if any, beyond being provided the health care services referred to in clause (A).

(b) A practitioner and provider facility shall provide a health carrier with the information needed by the health carrier to comply with the requirements under this chapter not more than two (2) business days after receiving the request.

(c) A health carrier is not subject to the penalties under section 16 of this chapter if:

(1) a provider facility or practitioner fails to provide the health carrier with the information as required under subsection (b);

(2) the health carrier provides the individual with a good faith estimate based on any information that the health carrier has; and

(3) the health carrier provides the individual with an updated good faith estimate after the provider facility or practitioner has provided the information required under subsection (b).

Sec. 15. A health carrier that provides an Internet web site for the use of its covered individuals shall ensure that the Internet web site includes a printed notice that:

(1) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site; and

(2) states the following, or words to the same effect: "A covered individual may at any time ask the health carrier for an estimate of the amount the health carrier will pay for or reimburse to a covered individual for nonemergency health care services that have been ordered for the covered individual or the applicable benefit limitations of the ordered nonemergency health care services a covered individual is entitled to receive from the health carrier. The law requires that an estimate be provided within 5 business days.".

Sec. 16. (a) If a health carrier fails or refuses:

(1) to provide a good faith estimate as required by this chapter; or

(2) to provide notice on the health carrier's Internet web site as required by section 15 of this chapter;

the insurance commissioner may, after notice and hearing under IC 4-21.5, impose on the health carrier a civil penalty of not more than one thousand dollars ($1,000) for each day of noncompliance.

(b) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

SECTION 18. [EFFECTIVE JULY 1, 2020] **(a) As used in this SECTION, "department" refers to the department of insurance.**

(b) The following shall submit, before September 1, 2021, and before September 1 of each year thereafter, a report described in this SECTION to the department and the general assembly in an electronic format under IC 5-14-6:

(1) An insurer (as defined in IC 27-1-2-3) that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(2) A health maintenance organization (as defined in IC 27-13-1-19).

(c) The report must include the following concerning claims from the preceding calendar year:

(1) The number of claims submitted to an insurer or health maintenance organization described in subsection (b) for each address for which a claim was submitted.

(2) For the claims described in subdivision (1), the number of claims that were submitted for reimbursement at an institutional provider rate or an office setting rate, and the type of rate the claim was reimbursed at by the insurer or health maintenance organization.

(d) The department may prescribe the manner in which the report is made.

(e) This SECTION expires December 31, 2026.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1004, 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:

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1004 as introduced.)

CARBAUGH

Committee Vote: yeas 12, nays 0.

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1004, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1004 as printed January 24, 2020.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 8, Nays 4.

SENATE MOTION

Madam President: I move that Engrossed House Bill 1004 be amended to read as follows:

Page 2, line 19, delete "(a)".

Page 2, delete lines 22 through 23.

Page 2, line 26, delete "(a)".

Page 2, delete lines 29 through 42.

Page 3, delete lines 1 through 3.

Page 3, line 7, delete "IC 16-51-1-6." and insert "**IC 16-51-1-3.**".

Page 3, delete lines 8 through 13.

Page 3, line 24, delete "IC 16-51-2," and insert "**IC 16-51-1,**".

Page 3, line 25, delete "IC 16-51-2-4." and insert "**IC 16-51-1-4.**".

Page 3, delete lines 26 through 42.

Page 4, delete lines 1 through 27.

Page 4, line 31, delete "IC 16-51-2," and insert "**IC 16-51-1,**".

Page 4, line 31, delete "IC 16-51-2-5." and insert "**IC 16-51-1-5.**".

Page 4, line 35, delete "IC 16-51-2," and insert "**IC 16-51-1,**".

Page 4, line 36, delete "IC 16-51-2-6." and insert "**IC 16-51-1-6.**".

Page 4, delete line 42.

Delete page 5.

Page 6, delete lines 1 through 18.

Page 16, delete lines 36 through 42.

Delete page 17.

Page 18, delete lines 1 through 3.

Page 32, line 4, after "2021," insert "**and before September 1 of each year thereafter,**".

Page 32, delete lines 11 through 16, begin a new paragraph and insert:

"**(c) The report must include the following concerning claims from the preceding calendar year:**

(1) The number of claims submitted to an insurer or health maintenance organization described in subsection (b) for each address for which a claim was submitted.

(2) For the claims described in subdivision (1), THE number of claims that were submitted for reimbursement at an institutional provider rate or an office setting rate, and the type of rate the claim was reimbursed at by the insurer or health maintenance organization.

(d) The department may prescribe the manner in which the report is made.

(e) This SECTION expires December 31, 2026.".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1004 as printed February 28, 2020.)

CHARBONNEAU

SENATE MOTION

Madam President: I move that Engrossed House Bill 1004 be amended to read as follows:

Page 7, line 30, after "(a)" insert "**This section does not apply to emergency services.**

(b)".

Page 7, line 33, delete "(b)" and insert "**(c)**".

Page 7, line 37, delete "(c)" and insert "**(d)**".

Page 7, line 41, delete "(d)" and insert "**(e)**".

Page 8, line 11, delete "(e)" and insert "**(f)**".

Page 8, line 15, delete "(f)" and insert "**(g)**".

Page 8, line 16, after "services" insert "**at an in network facility**".

Page 9, line 10, delete "(g)" and insert "**(h)**".

Page 9, line 12, delete "(f)(1)(B)," and insert "**(g)(1)(B),**".

Page 14, line 1, after "carrier" insert " **and a provider facility**".

Page 14, line 5, delete "18" and insert "**19**".

Page 14, line 34, delete "state department" and insert "**Indiana professional licensing agency**".

Page 15, line 1, after "18." insert "**(a) As used in this section, "waiting room" means a space in a building used by a practitioner in which people check in or register to:**

(1) be seen by practitioners; or

(2) meet with members of the staff of a practitioner's office.

(b) A practitioner shall ensure that each waiting room of the practitioner's office includes at least one (1) printed notice that:

(1) is designed, lettered, and positioned within the waiting room so as to be conspicuous to and readable by any individual with normal vision who visits the waiting room; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in this practitioner office. The law requires that an estimate be provided within 5 business days.".

(c) If a practitioner maintains an Internet web site, the practitioner shall ensure that the Internet web site includes at least one (1) printed notice that:

(1) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will

be charged for a nonemergency medical service provided in our office. The law requires that an estimate be provided within 5 business days.".

Sec. 19.".

Page 15, line 9, delete "office" and insert "**waiting room**".

Page 18, between lines 7 and 8, begin a new paragraph and insert:

"**Sec. 0.5. This chapter does not apply to emergency services.**".

Page 18, delete lines 41 through 42.

Page 19, delete lines 1 through 12, begin a new paragraph and insert:

"**Sec. 7. (a) An out of network practitioner who provides health care services at an in network facility to a covered individual may charge more for the health care services than allowed according to the rate or amount of compensation established by the individual's network plan if all of the following conditions are met:** ".

Page 19, line 37, delete "charge."." and insert "**charge. If our actual charge for [name or description of health care services] exceeds our estimate, we will explain to you why the charge exceeds the estimate.".**".

Page 20, line 1, delete "(c)" and insert "**(b)**".

(Reference is to EHB 1004 as printed February 28, 2020.)

CHARBONNEAU