HOUSE BILL No. 1028

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-11-4.7; IC 27-13-34-15.2.

Synopsis: Dental and optometry service coverage. Prohibits dental and vision insurers and health maintenance organizations from requiring dentists and optometrists to accept certain payments unless the health care services are covered under the policy or contract. Prohibits dentists and optometrists from charging for noncovered health care services an amount that exceeds the usual and customary charges for the health care services.

Effective: July 1, 2017.

Bacon

January 4, 2017, read first time and referred to Committee on Insurance.

Introduced

First Regular Session of the 120th General Assembly (2017)

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 2016 Regular Session of the General Assembly.

HOUSE BILL No. 1028

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

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

SECTION 1. IC 27-8-11-4.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 4.7. (a) As used in this section, "covered services" means health care services for which reimbursement:**

(1) is available under an insured's policy; or

(2) would be available under an insured's policy if not eliminated by application of a contractual limitation, including a deductible, copayment, or coinsurance.

(b) As used in this section, "discount" means a percentage reduction from a provider's usual and customary charge for covered services that is required under an agreement under section 3 of this chapter.

(c) As used in this section, "provider" means only a dentist or an optometrist.

(d) An insurer shall not, under an agreement under section 3 of this chapter, require a provider to charge for health care services provided to an insured an amount that is limited or set by the

insurer unless the health care services are covered services.

(e) A provider shall not charge, for providing to an insured health care services that are not covered services, an amount that exceeds the provider's usual and customary charge for the health care services.

(f) A discount may not result in a charge that is less than the reimbursement that would be available under the insured's policy if the reimbursement were not eliminated by application of a contractual limitation, including a deductible, copayment, or coinsurance.

(g) Reimbursement paid for covered services under an insured's policy:

(1) must be reasonable; and

(2) may not be in an amount so small that the health care services cannot reasonably be considered to be covered under the policy.

(h) This section applies to an agreement under section 3 of this chapter that is entered into, renewed, or amended after June 30, 2017.

SECTION 2. IC 27-13-34-15.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 15.2. (a) As used in this section, "covered services" means limited health care services for which coverage:**

(1) is available under an enrollee's individual contract or group contract; or

(2) would be available under an enrollee's individual contract or group contract if not eliminated by application of a contractual limitation, including a deductible, copayment, or coinsurance.

(b) As used in this section, "discount" means a percentage reduction from a participating provider's usual and customary charge for covered services that is required under a contract described in section 15 of this chapter.

(c) As used in this section, "participating provider" means only a dentist or an optometrist.

(d) A limited service health maintenance organization shall not, under a contract described in section 15 of this chapter, require a participating provider to charge for limited health care services provided to an enrollee an amount that is limited or set by the limited service health maintenance organization unless the limited health care services are covered services.

(e) A participating provider shall not charge, for providing to an enrollee limited health care services that are not covered services, an amount that exceeds the participating provider's usual and customary charge for the limited health care services.

(f) A discount may not result in a charge that is less than the payment that would be available under the enrollee's individual contract or group contract if the payment were not eliminated by application of a contractual limitation, including a deductible, copayment, or coinsurance.

(g) Payment for covered services under an enrollee's individual contract or group contract:

(1) must be reasonable; and

(2) may not be in an amount so small that the limited health care services cannot reasonably be considered to be covered under the individual contract or group contract.

(h) This section applies to an individual contract or a group contract described in section 15 of this chapter that is entered into, renewed, or amended after June 30, 2017.