Reprinted
February 24, 2017

HOUSE BILL No. 1273

DIGEST OF HB 1273 (Updated February 23, 2017 10:35 am - DI 97)

Citations Affected: IC 4-13; IC 5-10; IC 16-18; IC 16-21; IC 25-1; IC 27-1; IC 27-8.

Synopsis: Out of network health care services. Specifies patient, state and local government employee health plan, and accident and sickness insurer liability for payment for out of network health care services provided: (1) in an emergency; and (2) when non-emergent and the health care services are arranged by, provided in, or referred by an in network provider. Requires the commissioner of insurance to approve and post on the department of insurance Internet web site: (1) at least one independent data base to be used in establishing payments to out of network providers; and (2) a list of mediators to be used in certain out of network payment disputes between providers and the third party payers. Requires certain notices by the third party payers and out of network providers. Makes conforming amendments.

Effective: July 1, 2017.

Baird, Heaton, Harris, Schaibley

January 10, 2017, read first time and referred to Committee on Insurance.
February 20, 2017, amended, reported — Do Pass.
February 23, 2017, read second time, amended, ordered engrossed.

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February 24, 2017

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. 1273

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

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

1 SECTION 1. IC 4-13-16.5-1, AS AMENDED BY P.L.114-2010,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2017]: Sec. 1. (a) The definitions in this section apply
4 throughout this chapter.
5 (b) "Commission" refers to the governor's commission on minority
6 and women's business enterprises established under section 2 of this
7 chapter.
8 (c) "Commissioner" refers to the deputy commissioner for minority
9 and women's business enterprises of the department.
10 (d) "Contract" means any contract awarded by a state agency or, as
11 set forth in section 2(f)(11) of this chapter, awarded by a recipient of
12 state grant funds, for construction projects or the procurement of goods
13 or services, including professional services. For purposes of this
14 subsection, "goods or services" may not include the following when
15 determining the total value of contracts for state agencies:
16 (1) Utilities.
17 (2) Health care services (as defined in ~~IC 27-8-11-1(c)).~~

1 **IC 27-8-11-1).**
2 (3) Rent paid for real property or payments constituting the price
3 of an interest in real property as a result of a real estate
4 transaction.
5 (e) "Contractor" means a person or entity that:
6 (1) contracts with a state agency; or
7 (2) as set forth in section 2(f)(11) of this chapter:
8 (A) is a recipient of state grant funds; and
9 (B) enters into a contract:
10 (i) with a person or entity other than a state agency; and
11 (ii) that is paid for in whole or in part with the state grant
12 funds.
13 (f) "Department" refers to the Indiana department of administration
14 established by IC 4-13-1-2.
15 (g) "Minority business enterprise" or "minority business" means an
16 individual, partnership, corporation, limited liability company, or joint
17 venture of any kind that is owned and controlled by one (1) or more
18 persons who are:
19 (1) United States citizens; and
20 (2) members of a minority group or a qualified minority nonprofit
21 corporation.
22 (h) "Qualified minority or women's nonprofit corporation" means a
23 corporation that:
24 (1) is exempt from federal income taxation under Section
25 501(c)(3) of the Internal Revenue Code;
26 (2) is headquartered in Indiana;
27 (3) has been in continuous existence for at least five (5) years;
28 (4) has a board of directors that has been in compliance with all
29 other requirements of this chapter for at least five (5) years;
30 (5) is chartered for the benefit of the minority community or
31 women; and
32 (6) provides a service that will not impede competition among
33 minority business enterprises or women's business enterprises at
34 the time a nonprofit applies for certification as a minority
35 business enterprise or a women's business enterprise.
36 (i) "Owned and controlled" means:
37 (1) if the business is a qualified minority nonprofit corporation, a
38 majority of the board of directors are minority;
39 (2) if the business is a qualified women's nonprofit corporation,
40 a majority of the members of the board of directors are women; or
41 (3) if the business is a business other than a qualified minority or
42 women's nonprofit corporation, having:

1 (A) ownership of at least fifty-one percent (51%) of the
2 enterprise, including corporate stock of a corporation;
3 (B) control over the management and active in the day-to-day
4 operations of the business; and
5 (C) an interest in the capital, assets, and profits and losses of
6 the business proportionate to the percentage of ownership.
7 (j) "Minority group" means:
8 (1) Blacks;
9 (2) American Indians;
10 (3) Hispanics; and
11 (4) Asian Americans.
12 (k) "Separate body corporate and politic" refers to an entity
13 established by the general assembly as a body corporate and politic.
14 (l) "State agency" refers to any authority, board, branch,
15 commission, committee, department, division, or other instrumentality
16 of the executive, including the administrative, department of state
17 government.
18 SECTION 2. IC 5-10-8.2 IS ADDED TO THE INDIANA CODE
19 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
20 JULY 1, 2017]:
21 **Chapter 8.2. Government Employee Health Plans; Out of**
22 **Network Health Care Services**
23 **Sec. 1. As used in this chapter, "administrator" means the**
24 **following:**
25 **(1) For purposes of a state employee health plan:**
26 **(A) the state personnel department; or**
27 **(B) an entity with which the state contracts to administer**
28 **the health coverage.**
29 **(2) For purposes of a local unit health plan:**
30 **(A) the executive (as defined in IC 36-1-2-5) of the local**
31 **unit; or**
32 **(B) an entity with which the local unit contracts to**
33 **administer the health coverage.**
34 **Sec. 2. As used in this chapter, "covered individual" means an**
35 **individual who is entitled to coverage under a government**
36 **employee health plan.**
37 **Sec. 3. As used in this chapter, "emergency" has the meaning set**
38 **forth in IC 27-8-11-1.**
39 **Sec. 4. As used in this chapter, "government employee health**
40 **plan" means the following:**
41 **(1) A state employee health plan.**
42 **(2) A local unit health plan.**

1 **Sec. 5. As used in this chapter, "health care services" has the**
2 **meaning set forth in IC 27-8-11-1.**
3 **Sec. 6. As used in this chapter, "independent data base" means**
4 **a data base that is approved by the commissioner under**
5 **IC 27-1-3-34.**
6 **Sec. 7. As used in this chapter, "in network" refers to a provider**
7 **that has entered into an agreement to be part of a network that**
8 **applies to coverage under a covered individual's government**
9 **employee health plan.**
10 **Sec. 8. As used in this chapter, "local unit health plan" means**
11 **a self-insurance program established or maintained under**
12 **IC 5-10-8-2.2(d)(2) or IC 5-10-8-2.6(b)(2) to provide group health**
13 **coverage.**
14 **Sec. 9. As used in this chapter, "network" means a group of two**
15 **(2) or more providers that, individually or through a third party**
16 **representative, have entered into an agreement to provide health**
17 **care services to a covered individual.**
18 **Sec. 10. As used in this chapter, "out of network" refers to a**
19 **provider that has not entered into an agreement to be part of a**
20 **network that applies to coverage under a covered individual's**
21 **government employee health plan.**
22 **Sec. 11. As used in this chapter, "provider" has the meaning set**
23 **forth in IC 27-8-11-1.**
24 **Sec. 12. As used in this chapter, "state employee health plan"**
25 **means a self-insurance program established or maintained under**
26 **IC 5-10-8-7(b) to provide group health coverage.**
27 **Sec. 13. (a) This section applies to a government employee**
28 **health plan:**
29 **(1) that is established, amended, or renewed after June 30,**
30 **2017; and**
31 **(2) to which a network applies.**
32 **(b) As used in this section, "care obtained in an emergency"**
33 **means, with respect to a covered individual, covered health care**
34 **services that are:**
35 **(1) rendered by a provider within the scope of the provider's**
36 **license and as otherwise authorized under law; and**
37 **(2) needed to evaluate or stabilize an individual in an**
38 **emergency.**
39 **(c) As used in this section, "stabilize" means to render medical**
40 **treatment to an individual in an emergency as may be necessary to**
41 **assure, within reasonable medical probability, that material**
42 **deterioration of the individual's condition is not likely to result**

1 **from or during any of the following:**
2 **(1) The discharge of the individual from an emergency**
3 **department or other care setting where emergency health**
4 **care services are rendered to the individual.**
5 **(2) The transfer of the individual:**
6 **(A) from an emergency department or other care setting**
7 **where emergency health care services are rendered to the**
8 **individual; and**
9 **(B) to another health care facility.**
10 **(3) The transfer of the individual:**
11 **(A) from a hospital emergency department or other**
12 **hospital care setting where emergency health care services**
13 **are rendered to the individual; and**
14 **(B) to the hospital's inpatient setting.**
15 **(d) As described in subsection (e), a government employee**
16 **health plan shall cover and reimburse expenses for care obtained**
17 **in an emergency by a covered individual without:**
18 **(1) prior authorization; or**
19 **(2) regard to whether the provider who rendered the health**
20 **care services to the covered individual in an emergency is in**
21 **network or out of network;**
22 **in a situation where a prudent lay person could reasonably believe**
23 **that the covered individual's condition required immediate medical**
24 **attention. The emergency care obtained by a covered individual**
25 **under this section includes care for the alleviation of severe pain,**
26 **which is a symptom of an emergency.**
27 **(e) A government employee health plan shall cover and**
28 **reimburse expenses for emergency health care services at a rate**
29 **equal to the lesser of the following:**
30 **(1) In accordance with an independent data base, the usual,**
31 **customary, and reasonable charge in the government**
32 **employee health plan's service area for health care services**
33 **rendered during the emergency.**
34 **(2) An amount agreed to between the administrator and the**
35 **out of network provider.**
36 **A provider that renders emergency health care services to a**
37 **covered individual under this section may not charge the covered**
38 **individual except for an applicable copayment, coinsurance, or**
39 **deductible. Care and treatment rendered to a covered individual**
40 **once the covered individual is stabilized is not care obtained in an**
41 **emergency.**
42 **Sec. 14. (a) This section applies to a government employee**

1 **health plan:**
2 **(1) that is established, amended, or renewed after June 30,**
3 **2017; and**
4 **(2) to which a network applies.**
5 **(b) A government employee health plan:**
6 **(1) must provide for direct payment to an out of network**
7 **provider described in IC 16-21-2.5-5(2)(B) or**
8 **IC 25-1-9.1-6(2)(B) an amount equal to or less than the**
9 **payments to providers:**
10 **(A) of the same specialty; and**
11 **(B) for the same health care services;**
12 **at the sixtieth percentile in the same geographic area**
13 **according to an independent data base that is available for the**
14 **geographic area in which the health care services described in**
15 **IC 16-21-2.5-5(2) or IC 25-1-9.1-6(2) are provided; and**
16 **(2) may not require a covered individual to pay to an out of**
17 **network provider described in IC 16-21-2.5-5(2)(B) or**
18 **IC 25-1-9.1-6(2)(B) an amount that exceeds the coinsurance,**
19 **deductible, copayment, or other out of pocket part:**
20 **(A) of the amount payable on a claim under subdivision**
21 **(1); and**
22 **(B) that is the covered individual's responsibility under the**
23 **government employee health plan.**
24 **(c) An administrator shall provide for mediation of a dispute**
25 **between the administrator and an out of network provider as**
26 **follows:**
27 **(1) The amount in controversy on a disputed claim must be at**
28 **least five hundred dollars ($500) per billing code net of:**
29 **(A) the government employee health plan's out of network**
30 **payment amount; and**
31 **(B) the covered individual's out of pocket amount;**
32 **under the government employee health plan.**
33 **(2) The out of network provider alleges that the amount**
34 **payable under subsection (b) does not properly recognize:**
35 **(A) the out of network provider's training, qualifications,**
36 **and length of time in practice;**
37 **(B) the nature of the health care services;**
38 **(C) usual and customary charges for providers practicing**
39 **in the same geographic area; and**
40 **(D) other aspects of the out of network provider's practice**
41 **that are relevant to the value of the health care services.**
42 **(3) The out of network provider may initiate mediation by**

providing written notice of the dispute to the administrator.
(4) A single mediation may consider more than one (1) dispute between the out of network provider and the administrator if the claims are similar or involve common questions of fact or law.
(5) Upon receipt of a notice under subdivision (3), the administrator shall:
(A) select a different mediator for each mediation initiated under this section from the list of mediators approved by the commissioner under IC 27-1-3-34; and
(B) rotate the choice of a mediator among all approved mediators before repeating a selection.
(6) Mediation resolution must occur less than thirty (30) days after the date the notice described in subdivision (3) is received by the administrator.
(7) The mediator must accept either the out of network provider's or the administrator's reimbursement proposal.
(8) The physician fee schedule that applies to Medicare (42 U.S.C. 1395 et seq.) may not be used as a reference for the mediation process.
(d) Subsection (c) does not waive any rights of a covered individual or out of network provider to file a civil action or an administrative complaint:
(1) for alleged regulatory noncompliance of an administrator; or
(2) if the amount in controversy is less than the amount described in subsection (c)(1).

SECTION 3. IC 16-18-2-295, AS AMENDED BY P.L.161-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 295. (a) "Provider" **means the following:**
(1) For purposes of IC 16-21-2.5, a person licensed as described in IC 16-21-2-2.
(2) For purposes of IC 16-21-8, ~~has~~ the meaning set forth in IC 16-21-8-0.2.

(b) "Provider", for purposes of IC 16-38-5, IC 16-39 (except for IC 16-39-7), and IC 16-41-1 through IC 16-41-9, means any of the following:
(1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:
(A) A physician.

1 (B) A psychotherapist.
2 (C) A dentist.
3 (D) A registered nurse.
4 (E) A licensed practical nurse.
5 (F) An optometrist.
6 (G) A podiatrist.
7 (H) A chiropractor.
8 (I) A physical therapist.
9 (J) A psychologist.
10 (K) An audiologist.
11 (L) A speech-language pathologist.
12 (M) A dietitian.
13 (N) An occupational therapist.
14 (O) A respiratory therapist.
15 (P) A pharmacist.
16 (Q) A sexual assault nurse examiner.
17 (2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or
18 described in IC 12-24-1 or IC 12-29.
19 (3) A health facility licensed under IC 16-28-2.
20 (4) A home health agency licensed under IC 16-27-1.
21 (5) An employer of a certified emergency medical technician, a
22 certified advanced emergency medical technician, or a licensed
23 paramedic.
24 (6) The state department or a local health department or an
25 employee, agent, designee, or contractor of the state department
26 or local health department.
27 (c) "Provider", for purposes of IC 16-39-7-1, has the meaning set
28 forth in IC 16-39-7-1(a).
29 (d) "Provider", for purposes of IC 16-48-1, has the meaning set forth
30 in IC 16-48-1-3.
31 SECTION 4. IC 16-21-2.5 IS ADDED TO THE INDIANA CODE
32 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
33 JULY 1, 2017]:
34 **Chapter 2.5. Out of Network Providers**
35 **Sec. 1. (a) This chapter applies to a health care service rendered**
36 **after June 30, 2018.**
37 **(b) This chapter does not apply to the following:**
38 **(1) A patient who is a Medicaid recipient.**
39 **(2) Health care services rendered in an emergency (as defined**
40 **in IC 27-8-11-1).**
41 **Sec. 2. As used in this chapter, "in network" has the meaning set**
42 **forth in IC 27-8-11-1.**

Sec. 3. As used in this chapter, "out of network" has the meaning set forth in IC 27-8-11-1.

Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. However, the term does not include the coverages described in IC 27-8-5-2.5(a).

Sec. 5. A patient who:

(1) is covered under a policy of accident and sickness insurance; and

(2) receives health care services:

(A) in or as the result of a referral from an in network provider:

(i) for a particular clinical condition; and

(ii) as part of a single series of health care services rendered for the particular clinical condition; and

(B) rendered by an out of network provider:

(i) without the patient's knowledge that the out of network provider was an out of network provider; or

(ii) because an in network provider was not available to render the health care services without unreasonable travel or delay;

is liable to the out of network provider only for the coinsurance, deductible, copayment, or other out of pocket part of the amount payable on a claim under the patient's government employee health plan under IC 5-10-8.2-14 or policy under IC 27-8-11-13.

Sec. 6. An out of network provider described in section 5 of this chapter shall not collect from a patient described in section 5 of this chapter any amount that exceeds the amount for which the patient is liable under section 5 of this chapter unless the patient elects to pay the balance of the bill as described in the notice required by section 8 of this chapter.

Sec. 7. An in network provider that makes arrangements for or refers a patient to an out of network provider for a health care service must do the following:

(1) At the time the in network provider schedules or seeks prior authorization for the health care service, provide to the patient a written disclosure that states all of the following:

(A) That certain out of network providers may be called upon to render health care services to the patient during the course of treatment.

(B) That the out of network providers described in clause (A) are not bound by the in network provider payment amounts.

(C) A description of the range of charges for the out of network health care services for which the patient may be responsible.

(D) Notice that the patient may:

(i) agree to accept and pay the out of network charges;

(ii) contact the patient's insurer for additional assistance; or

(iii) rely on any other rights and remedies that may be available under state or federal law.

(E) A statement that the patient may obtain a list of in network providers from the patient's insurer and request that the in network providers render the health care service.

(2) At the time of admission to an in network provider in which the health care service will be performed, the in network provider shall provide to the patient the written disclosure described in subdivision (1) and obtain the patient's signature on the document acknowledging that the patient received the document before admission.

Sec. 8. If an out of network provider directly bills a patient for a health care service rendered as described in this section, the out of network provider shall include with the bill the following notice:

"PAYMENT RESPONSIBILITY NOTICE: The health care services outlined below were rendered by an out of network provider with your health care plan. At this time, you are responsible for paying your applicable cost sharing obligation - copayment, coinsurance, or deductible amount - just as you would be if the provider is within your health care plan's network. With regard to the remaining balance, you have three choices: (1) you may choose to pay the balance of the bill; OR (2) if the difference in the billed charge and your health care plan's allowable amount is more than $500.00, you may send the bill to your health care plan for processing pursuant to the health care plan's out of network provider billing process or the provider mediation process required by IC 5-10-8.2-14 or IC 27-8-11-13; OR (3) you may rely on other rights and remedies available in your state.".

SECTION 5. IC 16-21-3-2, AS AMENDED BY P.L.197-2011, SECTION 61, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 2. The state health commissioner may take action under section 1 of this chapter on any of the following grounds:

(1) Violation of any of the provisions of this chapter or of the

1 rules adopted under this chapter.
2 (2) Permitting, aiding, or abetting the commission of any illegal
3 act in an institution.
4 (3) Knowingly collecting or attempting to collect from a
5 subscriber (as defined in IC 27-13-1-32) or an enrollee (as defined
6 in IC 27-13-1-12) of a health maintenance organization (as
7 defined in IC 27-13-1-19) any amounts that are owed by the
8 health maintenance organization.
9 (4) Conduct or practice found by the state department to be
10 detrimental to the welfare of the patients of an institution.
11 **(5) A violation of IC 16-21-2.5.**
12 SECTION 6. IC 25-1-9.1 IS ADDED TO THE INDIANA CODE
13 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
14 JULY 1, 2017]:
15 **Chapter 9.1. Out of Network Providers**
16 **Sec. 1. (a) This chapter applies to a health care service rendered**
17 **after June 30, 2018.**
18 **(b) This chapter does not apply to the following:**
19 **(1) A patient who is a Medicaid recipient.**
20 **(2) Health care services rendered in an emergency (as defined**
21 **in IC 27-8-11-1).**
22 **Sec. 2. As used in this chapter, "in network" has the meaning set**
23 **forth in IC 27-8-11-1.**
24 **Sec. 3. As used in this chapter, "out of network" has the**
25 **meaning set forth in IC 27-8-11-1.**
26 **Sec. 4. As used in this chapter, "policy of accident and sickness**
27 **insurance" has the meaning set forth in IC 27-8-5-1. However, the**
28 **term does not include the coverages described in IC 27-8-5-2.5(a).**
29 **Sec. 5. As used in this chapter, "provider" refers to the**
30 **following:**
31 **(1) A person described in IC 16-18-2-295(a)(1).**
32 **(2) A practitioner (as defined in IC 25-1-9-2). However, the**
33 **term does not include an individual who holds a license,**
34 **certification, registration, or permit issued under the**
35 **following:**
36 **(A) IC 25-19.**
37 **(B) IC 25-38.1.**
38 **Sec. 6. A patient who:**
39 **(1) is covered under a policy of accident and sickness**
40 **insurance; and**
41 **(2) receives health care services:**
42 **(A) in or as the result of a referral from an in network**

provider:
(i) for a particular clinical condition; and
(ii) as part of a single series of health care services rendered for the particular clinical condition; and
(B) rendered by an out of network provider:
(i) without the patient's knowledge that the out of network provider was an out of network provider; or
(ii) because an in network provider was not available to render the health care services without unreasonable travel or delay;

is liable to the out of network provider only for the coinsurance, deductible, copayment, or other out of pocket part of the amount payable on a claim that is the patient's responsibility under the patient's government employee health plan under IC 5-10-8.2-14 or policy under IC 27-8-11-13.

Sec. 7. An out of network provider described in section 6 of this chapter shall not collect from a patient described in section 6 of this chapter any amount that exceeds the amount for which the patient is liable under section 6 of this chapter unless the patient elects to pay the balance of the bill as described in the notice required by section 9 of this chapter.

Sec. 8. An in network provider that makes arrangements for or refers a patient to an out of network provider for a health care service must do the following:

(1) At the time the in network provider schedules or seeks prior authorization for the health care service, provide to the patient a written disclosure that states all of the following:
(A) That certain out of network providers may be called upon to render health care services to the patient during the course of treatment.
(B) That the out of network providers described in clause (A) are not bound by the in network provider payment amounts.
(C) A description of the range of charges for the out of network health care services for which the patient may be responsible.
(D) Notice that the patient may:
(i) agree to accept and pay the out of network charges;
(ii) contact the patient's insurer for additional assistance; or
(iii) rely on any other rights and remedies that may be available under state or federal law.

1 **(E) A statement that the patient may obtain a list of in network providers from the patient's insurer and request that the in network providers render the health care service.**
5 **(2) Obtain the patient's signature on the written disclosure document described in subdivision (1) acknowledging that the patient received the document before receiving the health care service.**
9 **Sec. 9. If an out of network provider directly bills a patient for a health care service rendered as described in this section, the out of network provider shall include with the bill the following notice:**
12 **"PAYMENT RESPONSIBILITY NOTICE: The health care services outlined below were rendered by an out of network provider with your health care plan. At this time, you are responsible for paying your applicable cost sharing obligation - copayment, coinsurance, or deductible amount - just as you would be if the provider is within your health care plan's network. With regard to the remaining balance, you have three choices: (1) you may choose to pay the balance of the bill; OR (2) if the difference in the billed charge and your health care plan's allowable amount is more than $500.00, you may send the bill to your health care plan for processing pursuant to the health care plan's out of network provider billing process or the provider mediation process required by IC 5-10-8.2-14 or IC 27-8-11-13; OR (3) you may rely on other rights and remedies available in your state.".**
27 SECTION 7. IC 27-1-3-34 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 34. (a) As used in this section, "independent data base" means a data base that:**
31 **(1) is maintained by an independent, nonprofit entity that is not:**
33 **(A) affiliated with; or**
34 **(B) financially or otherwise supported by;**
35 **the insurance or health care industry; and**
36 **(2) contains information:**
37 **(A) concerning charges and reimbursements that are made for health care services rendered by providers; and**
39 **(B) that may be sorted by geographic areas in which the health care services are rendered.**
41 **(b) The commissioner shall, not later than January 1, 2018:**
42 **(1) approve, for use by administrators under IC 5-10-8.2-14**

1 **and insurers under IC 27-8-11-13 in making claim payments**
2 **to out of network providers, at least one (1) independent data**
3 **base; and**
4 **(2) publish any approved independent data base on the**
5 **department's Internet web site.**
6 **(c) The commissioner shall, not later than January 1, 2018:**
7 **(1) approve, for use by:**
8 **(A) administrators and out of network providers under**
9 **IC 5-10-8.2-14; and**
10 **(B) insurers and out of network providers under**
11 **IC 27-8-11-3;**
12 **in mediating disputes, at least one (1) mediator that meets**
13 **criteria (including an appropriate mediation process)**
14 **determined by the commissioner; and**
15 **(2) publish a list of contact information for each mediator**
16 **approved under subdivision (1) on the department's Internet**
17 **web site.**
18 SECTION 8. IC 27-8-11-1, AS AMENDED BY P.L.26-2005,
19 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
20 JULY 1, 2017]: Sec. 1. (a) The definitions in this section apply
21 throughout this chapter.
22 (b) "Credentialing" means a process through which an insurer
23 makes a determination:
24 (1) based on criteria established by the insurer; and
25 (2) concerning whether a provider is eligible to:
26 (A) provide health care services to an insured; and
27 (B) receive reimbursement for the health care services;
28 under an agreement entered into between the provider and the
29 insurer under section 3 of this chapter.
30 **(c) "Emergency" means a medical condition that arises**
31 **suddenly and unexpectedly and manifests itself by acute symptoms**
32 **of such severity, including severe pain, that the absence of**
33 **immediate medical attention could reasonably be expected by a**
34 **prudent lay person who possesses an average knowledge of health**
35 **and medicine to:**
36 **(1) place an individual's health in serious jeopardy;**
37 **(2) result in serious impairment to the individual's bodily**
38 **functions; or**
39 **(3) result in serious dysfunction of a bodily organ or part of**
40 **the individual.**
41 ~~(c)~~ **(d)** "Health care services":
42 (1) means health care related services or products rendered or

1 sold by a provider within the scope of the provider's license or
2 legal authorization; and
3 (2) includes hospital, medical, surgical, dental, vision, and
4 pharmaceutical services or products.
5 **(e) "Independent data base" means a data base that is approved**
6 **by the commissioner under IC 27-1-3-34.**
7 **(f) "In network" refers to a provider that has entered into an**
8 **agreement to be part of a network that applies to coverage under**
9 **an insured's policy.**
10 ~~(d)~~ **(g)** "Insured" means an individual entitled to reimbursement for
11 expenses of health care services under a policy issued or administered
12 by an insurer.
13 ~~(e)~~ **(h)** "Insurer" means an insurance company authorized in this
14 state to issue policies that provide reimbursement for expenses of
15 health care services.
16 **(i) "Network" means a group of two (2) or more providers that,**
17 **individually or through a third party representative, have entered**
18 **into an agreement with an insurer under section 3(a) of this**
19 **chapter.**
20 **(j) "Out of network" refers to a provider that has not entered**
21 **into an agreement to be part of a network that applies to coverage**
22 **under an insured's policy.**
23 ~~(f)~~ **(k)** "Person" means an individual, an agency, a political
24 subdivision, a partnership, a corporation, an association, or any other
25 entity.
26 ~~(g)~~ **(l)** "Preferred provider plan" means an undertaking to enter into
27 agreements with providers relating to terms and conditions of
28 reimbursements for the health care services of insureds, members, or
29 enrollees relating to the amounts to be charged to insureds, members,
30 or enrollees for health care services.
31 ~~(h)~~ **(m)** "Provider" means an individual or entity duly licensed or
32 legally authorized to provide health care services.
33 SECTION 9. IC 27-8-11-12 IS ADDED TO THE INDIANA CODE
34 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
35 1, 2017]: **Sec. 12. (a) This section applies to policy that is issued,**
36 **delivered, amended, or renewed after June 30, 2017.**
37 **(b) As used in this section, "care obtained in an emergency"**
38 **means, with respect to an insured, covered health care services that**
39 **are:**
40 **(1) rendered by a provider within the scope of the provider's**
41 **license and as otherwise authorized under law; and**
42 **(2) needed to evaluate or stabilize an individual in an**

emergency.

(c) As used in this section, "stabilize" means to render medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(1) The discharge of the individual from an emergency department or other care setting where emergency health care services are rendered to the individual.

(2) The transfer of the individual:

(A) from an emergency department or other care setting where emergency health care services are rendered to the individual; and

(B) to another health care facility.

(3) The transfer of the individual:

(A) from a hospital emergency department or other hospital care setting where emergency health care services are rendered to the individual; and

(B) to the hospital's inpatient setting.

(d) As described in subsection (e), an insurer shall cover and reimburse expenses for care obtained in an emergency by an insured without:

(1) prior authorization; or

(2) regard to whether provider who rendered the health care services to the insured in an emergency is in network or out of network;

in a situation where a prudent lay person could reasonably believe that the insured's condition required immediate medical attention. The emergency care obtained by an insured under this section includes care for the alleviation of severe pain, which is a symptom of an emergency.

(e) An insurer shall cover and reimburse expenses for emergency health care services at a rate equal to the lesser of the following:

(1) In accordance with an independent data base, the usual, customary, and reasonable charge in the insurer's service area for health care services rendered during the emergency.

(2) An amount agreed to between the insurer and the out of network provider.

A provider that renders emergency health care services to an insured under this section may not charge the insured except for an applicable copayment, coinsurance, or deductible. Care and

1 **treatment rendered to an insured once the insured is stabilized is**
2 **not care obtained in an emergency.**
3 SECTION 10. IC 27-8-11-13 IS ADDED TO THE INDIANA
4 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
5 [EFFECTIVE JULY 1, 2017]: **Sec. 13. (a) This section applies to a**
6 **policy that is issued, delivered, amended, or renewed after June 30,**
7 **2017.**
8 **(b) As used in this section, "insurer" includes the following:**
9 **(1) An administrator licensed under IC 27-1-25.**
10 **(2) A person that pays or administers claims on behalf of an**
11 **insurer.**
12 **(c) As used in this section, "policy" does not include the**
13 **coverages described in IC 27-8-5-2.5(a).**
14 **(d) A policy issued in accordance with section 3 of this chapter:**
15 **(1) must provide for direct payment to an out of network**
16 **provider described in IC 16-21-2.5-5(2)(B) or**
17 **IC 25-1-9.1-6(2)(B) an amount equal to or less than the**
18 **payments to providers:**
19 **(A) of the same specialty; and**
20 **(B) for the same health care services;**
21 **at the sixtieth percentile in the same geographic area**
22 **according to an independent data base that is available for the**
23 **geographic area in which the health care services described in**
24 **IC 16-21-2.5-5(2) or IC 25-1-9.1-6(2) are provided; and**
25 **(2) may not require an insured to pay to an out of network**
26 **provider described in IC 16-21-2.5-5(2)(B) or**
27 **IC 25-1-9.1-6(2)(B) an amount that exceeds the coinsurance,**
28 **deductible, copayment, or other out of pocket part:**
29 **(A) of the amount payable on a claim under subdivision**
30 **(1); and**
31 **(B) that is the insured's responsibility under the policy.**
32 **(e) An insurer shall provide for mediation of a dispute between**
33 **the insurer and an out of network provider as follows:**
34 **(1) The amount in controversy on a disputed claim must be at**
35 **least five hundred dollars ($500) per billing code net of:**
36 **(A) the insurer's out of network payment amount; and**
37 **(B) the insured's out of pocket amount;**
38 **under the policy.**
39 **(2) The out of network provider alleges that the amount**
40 **payable under subsection (d) does not properly recognize:**
41 **(A) the out of network provider's training, qualifications,**
42 **and length of time in practice;**

1 **(B) the nature of the health care services;**
2 **(C) usual and customary charges for providers practicing**
3 **in the same geographic area; and**
4 **(D) other aspects of the out of network provider's practice**
5 **that are relevant to the value of the health care services.**
6 **(3) The out of network provider may initiate mediation by**
7 **providing written notice of the dispute to the insurer.**
8 **(4) A single mediation may consider more than one (1) dispute**
9 **between the out of network provider and the insurer if the**
10 **claims are similar or involve common questions of fact or law.**
11 **(5) Upon receipt of a notice under subdivision (3), the insurer**
12 **shall:**
13 **(A) select a different mediator for each mediation initiated**
14 **under this section from the list of mediators approved by**
15 **the commissioner under IC 27-1-3-34; and**
16 **(B) rotate the choice of a mediator among all approved**
17 **mediators before repeating a selection.**
18 **(6) Mediation resolution must occur less than thirty (30) days**
19 **after the date the notice described in subdivision (3) is**
20 **received by the insurer.**
21 **(7) The mediator must accept either the out of network**
22 **provider's or the insurer's reimbursement proposal.**
23 **(8) The physician fee schedule that applies to Medicare (42**
24 **U.S.C. 1395 et seq.) may not be used as a reference for the**
25 **mediation process.**
26 **(f) Subsection (e) does not waive any rights of an insured or out**
27 **of network provider to file a civil action or an administrative**
28 **complaint:**
29 **(1) for alleged regulatory noncompliance of an insurer; or**
30 **(2) if the amount in controversy is less than the amount**
31 **described in subsection (e)(1).**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1273, 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 the title and insert the following:

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

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 1273 as introduced.)

CARBAUGH

Committee Vote: yeas 10, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1273 be amended to read as follows:

Page 3, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 2. IC 5-10-8.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]:

Chapter 8.2. Government Employee Health Plans; Out of Network Health Care Services

Sec. 1. As used in this chapter, "administrator" means the following:

(1) For purposes of a state employee health plan:

(A) the state personnel department; or

(B) an entity with which the state contracts to administer the health coverage.

(2) For purposes of a local unit health plan:

(A) the executive (as defined in IC 36-1-2-5) of the local unit; or

(B) an entity with which the local unit contracts to administer the health coverage.

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

employee health plan.

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

Sec. 4. As used in this chapter, "government employee health plan" means the following:

(1) A state employee health plan.

(2) A local unit health plan.

Sec. 5. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

Sec. 6. As used in this chapter, "independent data base" means a data base that is approved by the commissioner under IC 27-1-3-34.

Sec. 7. As used in this chapter, "in network" refers to a provider that has entered into an agreement to be part of a network that applies to coverage under a covered individual's government employee health plan.

Sec. 8. As used in this chapter, "local unit health plan" means a self-insurance program established or maintained under IC 5-10-8-2.2(d)(2) or IC 5-10-8-2.6(b)(2) to provide group health coverage.

Sec. 9. As used in this chapter, "network" means a group of two (2) or more providers that, individually or through a third party representative, have entered into an agreement to provide health care services to a covered individual.

Sec. 10. As used in this chapter, "out of network" refers to a provider that has not entered into an agreement to be part of a network that applies to coverage under a covered individual's government employee health plan.

Sec. 11. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 12. As used in this chapter, "state employee health plan" means a self-insurance program established or maintained under IC 5-10-8-7(b) to provide group health coverage.

Sec. 13. (a) This section applies to a government employee health plan:

(1) that is established, amended, or renewed after June 30, 2017; and

(2) to which a network applies.

(b) As used in this section, "care obtained in an emergency" means, with respect to a covered individual, covered health care services that are:

(1) rendered by a provider within the scope of the provider's

license and as otherwise authorized under law; and

(2) needed to evaluate or stabilize an individual in an emergency.

(c) As used in this section, "stabilize" means to render medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(1) The discharge of the individual from an emergency department or other care setting where emergency health care services are rendered to the individual.

(2) The transfer of the individual:

(A) from an emergency department or other care setting where emergency health care services are rendered to the individual; and

(B) to another health care facility.

(3) The transfer of the individual:

(A) from a hospital emergency department or other hospital care setting where emergency health care services are rendered to the individual; and

(B) to the hospital's inpatient setting.

(d) As described in subsection (e), a government employee health plan shall cover and reimburse expenses for care obtained in an emergency by a covered individual without:

(1) prior authorization; or

(2) regard to whether the provider who rendered the health care services to the covered individual in an emergency is in network or out of network;

in a situation where a prudent lay person could reasonably believe that the covered individual's condition required immediate medical attention. The emergency care obtained by a covered individual under this section includes care for the alleviation of severe pain, which is a symptom of an emergency.

(e) A government employee health plan shall cover and reimburse expenses for emergency health care services at a rate equal to the lesser of the following:

(1) In accordance with an independent data base, the usual, customary, and reasonable charge in the government employee health plan's service area for health care services rendered during the emergency.

(2) An amount agreed to between the administrator and the out of network provider.

A provider that renders emergency health care services to a covered individual under this section may not charge the covered individual except for an applicable copayment, coinsurance, or deductible. Care and treatment rendered to a covered individual once the covered individual is stabilized is not care obtained in an emergency.

Sec. 14. (a) This section applies to a government employee health plan:

(1) that is established, amended, or renewed after June 30, 2017; and

(2) to which a network applies.

(b) A government employee health plan:

(1) must provide for direct payment to an out of network provider described in IC 16-21-2.5-5(2)(B) or IC 25-1-9.1-6(2)(B) an amount equal to or less than the payments to providers:

(A) of the same specialty; and

(B) for the same health care services;

at the sixtieth percentile in the same geographic area according to an independent data base that is available for the geographic area in which the health care services described in IC 16-21-2.5-5(2) or IC 25-1-9.1-6(2) are provided; and

(2) may not require a covered individual to pay to an out of network provider described in IC 16-21-2.5-5(2)(B) or IC 25-1-9.1-6(2)(B) an amount that exceeds the coinsurance, deductible, copayment, or other out of pocket part:

(A) of the amount payable on a claim under subdivision (1); and

(B) that is the covered individual's responsibility under the government employee health plan.

(c) An administrator shall provide for mediation of a dispute between the administrator and an out of network provider as follows:

(1) The amount in controversy on a disputed claim must be at least five hundred dollars ($500) per billing code net of:

(A) the government employee health plan's out of network payment amount; and

(B) the covered individual's out of pocket amount;

under the government employee health plan.

(2) The out of network provider alleges that the amount payable under subsection (b) does not properly recognize:

(A) the out of network provider's training, qualifications,

and length of time in practice;

(B) the nature of the health care services;

(C) usual and customary charges for providers practicing in the same geographic area; and

(D) other aspects of the out of network provider's practice that are relevant to the value of the health care services.

(3) The out of network provider may initiate mediation by providing written notice of the dispute to the administrator.

(4) A single mediation may consider more than one (1) dispute between the out of network provider and the administrator if the claims are similar or involve common questions of fact or law.

(5) Upon receipt of a notice under subdivision (3), the administrator shall:

(A) select a different mediator for each mediation initiated under this section from the list of mediators approved by the commissioner under IC 27-1-3-34; and

(B) rotate the choice of a mediator among all approved mediators before repeating a selection.

(6) Mediation resolution must occur less than thirty (30) days after the date the notice described in subdivision (3) is received by the administrator.

(7) The mediator must accept either the out of network provider's or the administrator's reimbursement proposal.

(8) The physician fee schedule that applies to Medicare (42 U.S.C. 1395 et seq.) may not be used as a reference for the mediation process.

(d) Subsection (c) does not waive any rights of a covered individual or out of network provider to file a civil action or an administrative complaint:

(1) for alleged regulatory noncompliance of an administrator; or

(2) if the amount in controversy is less than the amount described in subsection (c)(1).".

Page 5, line 13, after "patient's" insert "**government employee health plan under IC 5-10-8.2-14 or**".

Page 6, line 24, after "by" insert "**IC 5-10-8.2-14 or**".

Page 8, line 3, after "patient's" insert "**government employee health plan under IC 5-10-8.2-14 or**".

Page 9, line 12, after "by" insert "**IC 5-10-8.2-14 or**".

Page 9, line 30, after "by" insert "**administrators under IC 5-10-8.2-14 and**".

Page 9, delete lines 36 through 39, begin a new line block indented and insert:

"**(1) approve, for use by:**

(A) administrators and out of network providers under IC 5-10-8.2-14; and

(B) insurers and out of network providers under IC 27-8-11-3;

in mediating disputes, at least one (1) mediator that meets criteria (including an appropriate mediation process) determined by the commissioner; and".

Renumber all SECTIONS consecutively.

(Reference is to HB 1273 as printed February 20, 2017.)

CARBAUGH