HOUSE BILL No. 1385

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-1-2.3.

Synopsis: Payment for ambulance services. Requires a health plan operator to provide payment to a nonparticipating ambulance service provider for ambulance service provided to a covered individual: (1) at a rate not to exceed the rates set or approved, by contract or ordinance, by the county or municipality in which the ambulance service originated; or (2) if there are no rates set or approved by the county or municipality in which the ambulance service originated: (A) at the rate of 500% of the published rate for ambulance services established under the Medicare law for the same ambulance service provided in the same geographic area; or (B) according to the nonparticipating ambulance provider's billed charges; whichever is less. Provides that if a health plan makes payment to a nonparticipating ambulance service provider in compliance with these requirements: (1) the payment shall be considered payment in full, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the health plan requires the covered individual to pay; and (2) the nonparticipating ambulance service provider is prohibited from billing the covered individual for any additional amount. Provides that the copayment, coinsurance, deductible, and other cost sharing amounts that a covered individual is required to pay in connection with ambulance service provided by a nonparticipating ambulance service provider shall not exceed the copayment, coinsurance, deductible, and other cost sharing amounts that the covered individual would be required to pay if the ambulance service had been provided by a participating ambulance service provider. Requires a health plan operator that receives a clean claim from a nonparticipating ambulance service provider to remit payment to the nonparticipating ambulance service provider not more than 30 days after receiving the clean claim.

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Effective: July 1, 2024.

Barrett

January 11, 2024, read first time and referred to Committee on Insurance.

Digest Continued

Provides that if a claim received by a health plan operator for ambulance service provided by a nonparticipating ambulance service provider is not a clean claim, the health plan operator, not more than 30 days after receiving the claim, shall: (1) remit payment; or (2) send a written notice that: (A) acknowledges the date of receipt of the claim; and (B) either explains why the heath plan operator is declining to pay the claim or states that additional information is needed for a determination whether to pay the claim. Repeals the requirement that a health plan operator negotiate rates and terms with any ambulance service provider willing to become a participating provider and the requirement that the department of insurance, not later than May 1, 2024, submit a report concerning these negotiations.

Introduced

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

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

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

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

HOUSE BILL No. 1385

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 27-1-2.3-2.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 2.8. As used in this chapter, "clean claim" means a claim for payment for ambulance service:**

(1) that is submitted to a health plan by an ambulance service provider; and

(2) about which there is no defect, impropriety, or particular circumstance requiring special treatment that may prevent or delay payment.

SECTION 2. IC 27-1-2.3-8 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 8. (a) A health plan operator shall fairly negotiate rates and terms with any ambulance service provider willing to become a participating provider with respect to the health plan.~~

~~(b) In negotiations under subsection (a), a health plan must consider all of the following:~~

~~(1) The ambulance service provider's usual and customary rates.~~

~~(2) The ambulance service provider's resources, and whether the~~

ambulance service provider's staff is available twenty-four (24) hours per day every day.

(3) The average wages and fuel costs in the geographical area in which the ambulance service provider operates.

(4) The number of times in which individuals covered by the health plan have sought ambulance service from the ambulance service provider but the ambulance service provider's response was canceled or did not result in a transport.

(5) The local ordinances and state rules concerning staffing, response times, and equipment under which the ambulance service provider must operate.

(6) The types of requests for ambulance service for individuals covered by the health plan that the ambulance service provider generally receives, and the requesting party or agency by which those requests are generally made.

(7) The average reimbursement rate per level of service that the ambulance service provider generally receives as a nonparticipating provider.

(8) The specific:

(A) clinical and staff capabilities; and

(B) equipment resources;

that an ambulance service provider must have to adequately meet the needs of individuals covered by the health plan, such as for the transportation of covered individuals from one (1) hospital to another after traumatic injury.

(9) The average transport cost data reported to the office of the secretary of family and social services by governmental ambulance service providers located within the counties, and contiguous counties, that the nonparticipating ambulance service provider serves.

(c) If negotiations between an ambulance service provider and a health plan operator under this section that occur after June 30, 2022, do not result in the ambulance service provider becoming a participating provider with respect to the health plan, each party shall provide to the department a written notice:

(1) reporting that negotiations between the ambulance service provider and the health plan operator did not result in the ambulance service provider becoming a participating provider with respect to the health plan; and

(2) stating the points on which agreement between the ambulance service provider and the health plan operator was necessary for the ambulance service provider to become a participating

~~provider with respect to the health plan:~~

~~(A) that were discussed in the negotiations between the ambulance service provider and the health plan operator; but~~

~~(B) on which the ambulance service provider and the health plan operator did not reach agreement.~~

SECTION 3. IC 27-1-2.3-8.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.1. (a) Except as provided in subsection (b), a health plan operator shall provide payment to a nonparticipating ambulance service provider for ambulance service provided to a covered individual at a rate not to exceed the rates set or approved, by contract or ordinance, by the county or municipality in which the ambulance service originated.**

(b) If there are no rates set or approved for ambulance service by contract or ordinance by the county or municipality in which the ambulance service originated, the health plan operator shall provide payment to the ambulance service provider:

(1) at the rate of five hundred percent (500%) of the current published rate for ambulance service as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.) for the same ambulance service provided in the same geographic area; or

(2) according to the nonparticipating ambulance provider's billed charges;

whichever is less.

SECTION 4. IC 27-1-2.3-8.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.2. (a) If a health plan makes payment to a nonparticipating ambulance service provider according to section 8.1(a) or 8.1(b) of this chapter for ambulance service provided to a covered individual:**

(1) the payment shall be considered payment in full for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the health plan requires the covered individual to pay; and

(2) the nonparticipating ambulance service provider is prohibited from billing the covered individual for any additional amount for the ambulance service provided.

(b) The copayment, coinsurance, deductible, and other cost sharing amounts that a health plan requires a covered individual to pay in connection with ambulance service provided to the

covered individual by a nonparticipating ambulance service provider shall not exceed the copayment, coinsurance, deductible, and other cost sharing amounts that the covered individual would be required to pay if the ambulance service had been provided to the covered individual by a participating ambulance service provider.

SECTION 5. IC 27-1-2.3-8.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.3. (a) A health plan operator that receives a clean claim for ambulance service provided to a covered individual by a nonparticipating ambulance service provider:**

(1) shall remit payment for the ambulance service directly to the nonparticipating ambulance service provider not more than thirty (30) days after receiving the clean claim; and

(2) shall not send payment to the covered individual.

(b) If a claim that a health plan operator receives for ambulance service provided to a covered individual by a nonparticipating ambulance service provider is not a clean claim, the health plan operator, not more than thirty (30) days after receiving the claim, shall:

(1) remit payment for the ambulance service directly to the nonparticipating ambulance service provider; or

(2) send to the nonparticipating ambulance service provider a written notice that:

(A) acknowledges the date of the receipt of the claim; and

(B) either:

(i) states that the heath plan operator is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(ii) states that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

SECTION 6. IC 27-1-2.3-9 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 9. (a) Not later than May 1, 2024, the department shall submit, in an electronic format under IC 5-14-6, to:~~

~~(1) the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4(14); and~~

~~(2) the legislative council;~~

~~a report summarizing the notices that the department has received from ambulance service providers and health plan operators under section~~

~~8(c) of this chapter.~~

~~(b) The report submitted under subsection (a) must:~~

~~(1) indicate the number of notices received by the department under section 8(c) of this chapter reporting that negotiations between an ambulance service provider and a health plan operator did not result in the ambulance service provider becoming a participating provider with respect to the health plan; and~~

~~(2) include:~~

~~(A) a summary of the points described in section 8(c)(2) of this chapter that were stated in reports provided by ambulance service providers under section 8(c) of this chapter; and~~

~~(B) a summary of the points described in section 8(c)(2) of this chapter that were stated in reports provided by health plan operators under section 8(c) of this chapter.~~

~~(c) This section expires January 1, 2025.~~