HOUSE BILL No. 1486

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8-19; IC 12-15-5-13.5; IC 16-18-2; IC 16-21; IC 25-1-9; IC 27-1-3-33; IC 27-8-5-32; IC 27-13-9-6.

Synopsis: Health insurance coverage and cost information. Requires health care providers and health plans to provide to covered individuals and patients certain information concerning the cost of health care services. Requires health care providers to publish a payment policy for medically necessary health care services not covered by a third party payment source. Requires the department of insurance to establish, post, and maintain on the department's Internet web site a standardized prior authorization form for notice or authorization for health care services. Requires a state employee health plan, an accident and sickness insurer, and a health maintenance organization to: (1) use only the standardized prior authorization form; (2) allow electronic submission of the form and supporting information; and (3) respond verbally and electronically within 48 hours. Prohibits Medicaid, including risk based managed care organizations, from requiring prior authorization for certain drug testing of recipients enrolled in a drug treatment program. Urges the legislative council to assign issues related to health care prior authorization to an appropriate interim study committee for study and a report during the 2017 interim of the general assembly.

Effective: July 1, 2017.

Schaibley

January 18, 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. 1486

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 5-10-8-19 IS ADDED TO THE INDIANA CODE
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 2017]: **Sec. 19. (a) As used in this section, "covered individual"**
4 **means an individual who is entitled to coverage under a state**
5 **employee plan.**
6 **(b) As used in this section, "state employee plan" means one (1)**
7 **of the following:**
8 **(1) A self-insurance program established under section 7(b) of**
9 **this chapter to provide group health coverage.**
10 **(2) A contract with a prepaid health care delivery plan that is**
11 **entered into or renewed under section 7(c) of this chapter.**
12 **The term includes a person that pays or administers claims on**
13 **behalf of a state employee plan described in subdivision (1) or (2).**
14 **(c) Upon a covered individual's request to a state employee plan**
15 **for information concerning the out-of-pocket cost the covered**
16 **individual will incur for a prescribed, nonemergency health care**
17 **service, the following apply:**

1 **(1) The state employee plan may refer the covered individual**
2 **to an information resource, such as an Internet web site or an**
3 **application program, that provides a good faith estimate of**
4 **the out-of-pocket cost.**
5 **(2) If the state employee plan does not make a referral under**
6 **subdivision (1), a good faith estimate of the out-of-pocket cost**
7 **is not available under subdivision (1), or the covered**
8 **individual notifies the state employee plan that the covered**
9 **individual does not have access to the information resource,**
10 **the state employee plan shall, not more than three (3) business**
11 **days after receiving the request or notice, provide in verbal,**
12 **electronic, or, upon request, written form:**
13 **(A) a good faith estimate of the out-of-pocket cost the**
14 **covered individual will incur; and**
15 **(B) notice that:**
16 **(i) an estimate provided under this section is not binding**
17 **on the health care provider; and**
18 **(ii) the actual out-of-pocket cost may vary based on the**
19 **covered individual's medical needs.**
20 **A state employee plan may not charge a covered individual for**
21 **information provided under this subsection.**
22 **(d) A state employee plan shall:**
23 **(1) use only the standardized prior authorization form**
24 **established by the department of insurance under**
25 **IC 27-1-3-33(b) for purposes of any notice or authorization**
26 **required by the state employee plan with respect to payment**
27 **for health care services rendered to a covered individual;**
28 **(2) provide for electronic transmission and receipt of the**
29 **standardized prior authorization form and any supporting**
30 **information for all prior authorizations; and**
31 **(3) not more than forty-eight (48) hours after receiving the**
32 **standardized prior authorization form from a health care**
33 **provider, verbally and electronically communicate to the**
34 **covered individual and the health care provider the state**
35 **employee plan's determination concerning the requested prior**
36 **authorization.**
37 SECTION 2. IC 12-15-5-13.5 IS ADDED TO THE INDIANA
38 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
39 [EFFECTIVE JULY 1, 2017]: **Sec. 13.5. (a) The office (for purposes**
40 **of Medicaid fee for service), a managed care organization (for**
41 **purposes of the risk based managed care program), and the**
42 **healthy Indiana plan under IC 12-15-44.5:**

1 **(1) shall not require prior authorization; and**
2 **(2) shall cover and pay;**
3 **a claim for a definitive drug test that uses drug identification**
4 **methods to identify individual drugs and distinguish between**
5 **structural isomers for a recipient who is receiving substance abuse**
6 **treatment provided by an addiction services Medicaid provider.**
7 **(b) Subsection (a) does not apply to a claim submitted by a**
8 **person that is under investigation under IC 4-6-10 for fraud or**
9 **abuse.**
10 SECTION 3. IC 16-18-2-41.2 IS ADDED TO THE INDIANA
11 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
12 [EFFECTIVE JULY 1, 2017]: **Sec. 41.2. "Bundled service**
13 **information" means information related to the combination of two**
14 **(2) or more health care service components for purposes of health**
15 **care service claim billing or payment.**
16 SECTION 4. IC 16-18-2-129.6 IS ADDED TO THE INDIANA
17 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
18 [EFFECTIVE JULY 1, 2017]: **Sec. 129.6. "Financial assistance**
19 **policy" has the meaning set forth in in 26 CFR 1.501(r)-1, as in**
20 **effect January 1, 2017.**
21 SECTION 5. IC 16-18-2-295.5 IS ADDED TO THE INDIANA
22 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
23 [EFFECTIVE JULY 1, 2017]: **Sec. 295.5. "Provider facility" refers**
24 **to a hospital, an ambulatory outpatient surgery center, an abortion**
25 **clinic, or a birthing center that is licensed under IC 16-21-2.**
26 SECTION 6. IC 16-21-2-17 IS ADDED TO THE INDIANA CODE
27 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
28 1, 2017]: **Sec. 17. (a) This section does not apply to a patient who is**
29 **a Medicaid recipient.**
30 **(b) Upon receiving an order for a prescribed, nonemergency**
31 **health care service, a provider facility shall do the following**
32 **concerning the out-of-pocket cost the patient will incur:**
33 **(1) If the patient does not have coverage by a third party**
34 **payment source and requests the information from the**
35 **provider facility, the provider facility shall, not more than**
36 **seventy-two (72) hours after receiving the request, provide to**
37 **the patient a good faith estimate of the out-of-pocket cost for**
38 **all professional and technical health care services provided in**
39 **connection with the prescribed, nonemergency health care**
40 **service:**
41 **(A) through an Internet web site or an application**
42 **program through which the patient has access to the**

1 **patient's personal health care information; or**
2 **(B) in verbal or written form, as specified by the patient.**
3 **(2) If the patient has coverage by a third party payment**
4 **source, the provider facility shall, not more than seventy-two**
5 **(72) hours after receiving the order, provide to the patient all**
6 **billing information related to the prescribed, nonemergency**
7 **health care service, including all applicable procedure names,**
8 **billing codes, and bundled service information:**
9 **(A) through an Internet web page or application program**
10 **through which the patient has access to the patient's**
11 **personal health care information; or**
12 **(B) in verbal or written form, as specified by the patient.**
13 **(c) The billing information described in subsection (b)(2) must**
14 **be in a form that enables the third party payment source to**
15 **provide, upon request of the patient and based on the billing**
16 **information, a good faith estimate of the out-of-pocket cost for the**
17 **prescribed, nonemergency health care service.**
18 **(d) A good faith estimate provided under this section must be**
19 **accompanied by a notice that:**
20 **(1) the estimate is not binding on the provider facility; and**
21 **(2) the actual out-of-pocket cost may vary based on the**
22 **patient's medical needs.**
23 **A provider facility may not charge a patient for information**
24 **provided under this subsection.**
25 **(e) A provider facility shall:**
26 **(1) if the provider has an Internet web site, publish on the**
27 **provider facility's Internet web site; or**
28 **(2) if the provider does not have an Internet web site, post in**
29 **a visible location in the provider facility;**
30 **the provider facility's policy concerning payment for medically**
31 **necessary health care services for which a patient does not have**
32 **coverage by a third party payment source. A provider facility that**
33 **meets the requirements of 26 U.S.C. 501(r) and 26 CFR 1.501(r),**
34 **as in effect on January 1, 2017, is considered to meet the**
35 **requirements of this subsection with respect to health care services**
36 **determined to be medically necessary under the provider facility's**
37 **financial assistance policy.**
38 SECTION 7. IC 16-21-3-2, AS AMENDED BY P.L.197-2011,
39 SECTION 61, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
40 JULY 1, 2017]: Sec. 2. The state health commissioner may take action
41 under section 1 of this chapter on any of the following grounds:
42 (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 16-21-2-17.**
12 SECTION 8. IC 25-1-9-1.2 IS ADDED TO THE INDIANA CODE
13 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
14 1, 2017]: **Sec. 1.2. "Bundled service information" means**
15 **information related to the combination of two (2) or more health**
16 **care service components for purposes of health care service claim**
17 **billing or payment.**
18 SECTION 9. IC 25-1-9-2 IS AMENDED TO READ AS FOLLOWS
19 [EFFECTIVE JULY 1, 2017]: Sec. 2. **(a) Except as provided in**
20 **subsection (b),** as used in this chapter, "practitioner" means an
21 individual who holds:
22 (1) an unlimited license, certificate, or registration;
23 (2) a limited or probationary license, certificate, or registration;
24 (3) a temporary license, certificate, registration, or permit;
25 (4) an intern permit; or
26 (5) a provisional license;
27 issued by the board regulating the profession in question, including a
28 certificate of registration issued under IC 25-20.
29 **(b) As used in section 4.5 of this chapter, the term does not**
30 **include an individual who holds a license, certification,**
31 **registration, or permit issued under the following:**
32 **(1) IC 25-19.**
33 **(2) IC 25-38.1.**
34 SECTION 10. IC 25-1-9-4.5 IS ADDED TO THE INDIANA CODE
35 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
36 1, 2017]: **Sec. 4.5. (a) This section does not apply to a patient who**
37 **is a Medicaid recipient.**
38 **(b) Upon ordering a prescribed, nonemergency health care**
39 **service, a practitioner shall do the following concerning the**
40 **out-of-pocket cost the patient will incur:**
41 **(1) If the patient does not have coverage by a third party**
42 **payment source and requests the information from the**

1 **practitioner, the practitioner shall, not more than seventy-two**
2 **(72) hours after receiving the request, provide to the patient**
3 **a good faith estimate of the out-of-pocket cost for all**
4 **professional and technical health care services provided in**
5 **connection with the prescribed, nonemergency health care**
6 **service:**
7 **(A) through an Internet web site or an application**
8 **program through which the patient has access to the**
9 **patient's personal health care information; or**
10 **(B) in verbal or written form, as specified by the patient.**
11 **(2) If the patient has coverage by a third party payment**
12 **source, the practitioner shall, not more than seventy-two (72)**
13 **hours after ordering the health care service, provide to the**
14 **patient all billing information related to the prescribed,**
15 **nonemergency health care service, including all applicable**
16 **procedure names, billing codes, and bundled service**
17 **information:**
18 **(A) through an Internet web page or application program**
19 **through which the patient has access to the patient's**
20 **personal health care information; or**
21 **(B) in verbal or written form, as specified by the patient.**
22 **(c) The billing information described in subsection (b)(2) must**
23 **be in a form that enables the third party payment source to**
24 **provide, upon request of the patient and based on the billing**
25 **information, a good faith estimate of the out-of-pocket cost for the**
26 **prescribed, nonemergency health care service.**
27 **(d) A good faith estimate provided under this section must be**
28 **accompanied by a notice that:**
29 **(1) the estimate is not binding on the practitioner; and**
30 **(2) the actual out-of-pocket cost may vary based on the**
31 **patient's medical needs.**
32 **A practitioner may not charge a patient for information provided**
33 **under this subsection.**
34 **(e) A practitioner shall:**
35 **(1) if the practitioner has an Internet web site, publish on the**
36 **practitioner's Internet web site; or**
37 **(2) if the practitioner does not have an Internet web site, post**
38 **in a visible location in the practitioner's office;**
39 **the practitioner's policy concerning payment for medically**
40 **necessary health care services for which a patient does not have**
41 **coverage by a third party payment source.**
42 SECTION 11. IC 27-1-3-33, AS ADDED BY P.L.18-2016,

1 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
2 JULY 1, 2017]: Sec. 33. **(a)** The department shall develop, post, and
3 maintain on the department's Internet web site information concerning
4 the internal and external grievance procedures for accident and
5 sickness insurance policies and health maintenance organization
6 contracts. The department shall include on the web site:
7 (1) information concerning the process that a consumer should
8 follow in filing an internal grievance or an external grievance; and
9 (2) a telephone number for the department where consumers may
10 call to obtain additional information.
11 **(b) The department shall establish, post, and maintain on the**
12 **department's Internet web site a standardized prior authorization**
13 **form for use by health care providers, accident and sickness**
14 **insurers, health maintenance organizations, and third party**
15 **administrators for purposes of any notice or authorization**
16 **required by an accident and sickness insurer or a health**
17 **maintenance organization with respect to payment for health care**
18 **services rendered to an individual entitled to coverage under a**
19 **policy of accident and sickness insurance or a health maintenance**
20 **organization contract.**
21 SECTION 12. IC 27-8-5-32 IS ADDED TO THE INDIANA CODE
22 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
23 1, 2017]: **Sec. 32. (a) Upon an insured's request to an insurer that**
24 **issues a policy of accident and sickness insurance for information**
25 **concerning the out-of-pocket cost the insured will incur for a**
26 **prescribed, nonemergency health care service, the following apply:**
27 **(1) The insurer may refer the insured to an information**
28 **resource, such as an Internet web site or an application**
29 **program, that provides a good faith estimate of the**
30 **out-of-pocket cost.**
31 **(2) If the insurer does not make a referral under subdivision**
32 **(1), a good faith estimate of the out-of-pocket cost is not**
33 **available under subdivision (1), or the insured notifies the**
34 **insurer that the insured does not have access to the**
35 **information resource, the insurer shall, not more than three**
36 **(3) business days after receiving the request or notice, provide**
37 **in verbal, electronic, or, upon request, written form:**
38 **(A) a good faith estimate of the out-of-pocket cost the**
39 **insured will incur; and**
40 **(B) a notice that:**
41 **(i) an estimate provided under this section is not binding**
42 **on the insurer; and**

1 **(ii) the actual out-of-pocket cost may vary based on the**
2 **insured's medical needs.**
3 **An insurer may not charge an insured for information provided**
4 **under this section.**
5 **(b) An insurer that issues a policy of accident and sickness**
6 **insurance (including a person that administers benefits under a**
7 **policy of accident and sickness insurance) shall:**
8 **(1) use only the standardized prior authorization form**
9 **established by the department of insurance under**
10 **IC 27-1-3-33(b) for purposes of any notice or authorization**
11 **required by the insurer with respect to payment for health**
12 **care services rendered to an insured;**
13 **(2) provide for electronic transmission and receipt of the**
14 **standardized prior authorization form and any supporting**
15 **information for all prior authorizations; and**
16 **(3) not more than forty-eight (48) hours after receiving the**
17 **standardized prior authorization form from a health care**
18 **provider, verbally and electronically communicate to the**
19 **insured and the health care provider the insurer's**
20 **determination concerning the requested prior authorization.**
21 SECTION 13. IC 27-13-9-6 IS ADDED TO THE INDIANA CODE
22 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
23 1, 2017]: **Sec. 6. (a) Upon an enrollee's request to a health**
24 **maintenance organization for information concerning the**
25 **out-of-pocket cost the enrollee will incur for a prescribed,**
26 **nonemergency health care service, the following apply:**
27 **(1) The health maintenance organization may refer the**
28 **enrollee to an information resource, such as an Internet web**
29 **site or an application program, that provides a good faith**
30 **estimate of the out-of-pocket cost.**
31 **(2) If the health maintenance organization does not make a**
32 **referral under subdivision (1), a good faith estimate of the**
33 **out-of-pocket cost is not available under subdivision (1), or**
34 **the enrollee notifies the health maintenance organization that**
35 **the enrollee does not have access to the information resource,**
36 **the health maintenance organization shall, not more than**
37 **three (3) business days after receiving the request or notice,**
38 **provide in verbal, electronic, or, upon request, written form:**
39 **(A) a good faith estimate of the out-of-pocket cost the**
40 **enrollee will incur; and**
41 **(B) notice that:**
42 **(i) an estimate provided under this section is not binding**

1 **on the health maintenance organization; and**
2 **(ii) the actual out-of-pocket cost may vary based on the**
3 **enrollee's medical needs.**
4 **A health maintenance organization may not charge an enrollee for**
5 **information provided under this section.**
6 **(b) A health maintenance organization, including a person that**
7 **administers benefits under an individual contract or a group**
8 **contract, shall:**
9 **(1) use only the standardized prior authorization form**
10 **established by the department of insurance under**
11 **IC 27-1-3-33(b) for purposes of any notice or authorization**
12 **required by the health maintenance organization with respect**
13 **to payment for health care services rendered to an enrollee;**
14 **(2) provide for electronic transmission and receipt of the**
15 **standardized prior authorization form and any supporting**
16 **information for all prior authorizations; and**
17 **(3) not more than forty-eight (48) hours after receiving the**
18 **standardized prior authorization form from a health care**
19 **provider, verbally and electronically communicate to the**
20 **enrollee and the health care provider the health maintenance**
21 **organization's determination concerning the requested prior**
22 **authorization.**
23 SECTION 14. [EFFECTIVE JULY 1, 2017] **(a) The legislative**
24 **council is urged to assign to an appropriate interim study**
25 **committee for study during the 2017 interim of the general**
26 **assembly the following:**
27 **(1) The effects of prior authorization requirements on**
28 **patients, health care providers, and health care delivery.**
29 **(2) The changes in prior authorization requirements of third**
30 **party payment sources from 2007 through 2017.**
31 **(b) If the legislative council assigns the topic specified in**
32 **subsection (a), the interim study committee shall report findings**
33 **and recommendations concerning the topic to the legislative**
34 **council in an electronic format under IC 5-14-6 not later than**
35 **November 1, 2017.**
36 **(c) Recommendations under subsection (b) must include**
37 **recommendations to facilitate a reduction in prior authorization**
38 **requirements.**
39 **(d) This SECTION expires December 31, 2017.**