Reprinted
February 1, 2022

SENATE BILL No. 249

DIGEST OF SB 249 (Updated January 31, 2022 5:02 pm - DI 104)

Citations Affected: IC 25-1; IC 27-1; IC 27-2; IC 27-8; IC 27-13; noncode.

Synopsis: Health insurance transparency. Specifies that the compliance of a practitioner and a provider facility with federal law meets the good faith estimate requirements concerning health service costs. Allows the commissioner of the department of insurance to issue an order to discontinue a violation of a law (current law specifies orders or rules). Requires a domestic stock insurer to file specified information with the department of insurance. Prohibits a health plan from requiring a health care provider to submit a prior authorization request to a third party and requires the health plan to transmit the request to the third party through secure electronic transmission. Amends the deadline by which a health plan must respond to a nonurgent care prior authorization request. Requires a health plan to offer a health care provider that submitted a prior authorization and received an adverse determination the option to request a peer to peer

(Continued next page)

Effective: Upon passage; July 1, 2022.

Brown L, Charbonneau, Crider,
Becker, Melton, Randolph Lonnie M

January 10, 2022, read first time and referred to Committee on Health and Provider Services.
January 27, 2022, amended, reported favorably — Do Pass.
January 31, 2022, read second time, amended, ordered engrossed.

review by a clinical peer concerning the adverse determination. Requires a health plan to post notice of a technical issue with its claims submission system on the health plan's Internet web site. Requires a health plan to post on its Internet web site not later than February 1 of each year: (1) the 30 most frequently submitted CPT codes in the previous calendar year; and (2) the percentage of the 30 most frequently submitted CPT codes that were approved in the previous calendar year. Establishes an approval process for a health plan's proposed premium rate increase of 5% or greater as compared to the previous calendar year. Prohibits an insurer and a health maintenance organization from altering a CPT code for a claim unless the medical record of the claim has been reviewed by an employee who is a licensed physician. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule: (1) every two years; and (2) when three or more CPT code rates change in a 12 month period. Urges the study by an interim committee of prior authorization exemptions for certain health care providers.

Reprinted
February 1, 2022

Second Regular Session of the 122nd General Assembly (2022)

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 2021 Regular Session of the General Assembly.

SENATE BILL No. 249

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 25-1-9-23, AS AMENDED BY P.L.202-2021, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: 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, "emergency services" means services that are:

(1) furnished by a provider qualified to furnish emergency services; and

(2) needed to evaluate or stabilize an emergency medical condition.

(d) 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.

(e) 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.

(f) As used in this section, "out of network" means that the health care services provided by the practitioner to a covered individual are not subject to the covered individual's health carrier network plan.

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

(1) An individual who holds:

(A) an unlimited license, certificate, or registration;

(B) a limited or probationary license, certificate, or registration;

(C) a temporary license, certificate, registration, or permit;

(D) an intern permit; or

(E) a provisional license;

issued by the board (as defined in IC 25-0.5-11-1) regulating the profession in question.

(2) An entity that:

(A) is owned by, or employs; or

(B) performs billing for professional health care services rendered by;

an individual described in subdivision (1).

The term does not include a dentist licensed under IC 25-14, an optometrist licensed under IC 25-24, or a provider facility (as defined in IC 25-1-9.8-10).

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

~~(i) This subsection is effective beginning January 1, 2022. Except as provided in subsection (n), a practitioner shall comply with the requirements set forth in Section 2799B-6 of the Public Health Service Act, as added by Public Law 116-260.~~

~~(j)~~ **(i)** An out of network practitioner who provides health care services at an in network facility to a covered individual may not be reimbursed more for the health care services than allowed according to the rate or amount of compensation established by the covered individual's network plan unless all of the following conditions are met:

(1) At least five (5) business 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 that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of practitioner] is an out of network practitioner providing [type of care] with [name of in network facility], which is an in network provider facility within your health carrier's plan. [Name of practitioner] will not be allowed to bill you the difference between the price charged by the practitioner and the rate your health carrier will reimburse for the services during your care at [name of in network facility] 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 by the greater of:

(i) one hundred dollars ($100); or

(ii) five percent (5%);

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.

~~(k)~~ **(j)** If an out of network practitioner does not meet the requirements of subsection ~~(j),~~ **(i),** the out of network practitioner shall include on any bill remitted to a covered individual a written statement in conspicuous type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

~~(l)~~ **(k)** If a covered individual's network plan remits reimbursement to the covered individual for health care services subject to the reimbursement limitation of subsection ~~(j),~~ **(i),** the network plan shall provide with the reimbursement a written statement in conspicuous

type that states that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan and that is included in the reimbursement plus any required copayment, deductible, or coinsurance.

~~(m)~~ **(l)** 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 ~~(j)(1)(B)~~ **(i)(1)(B)** by the greater of:

(1) one hundred dollars ($100); or

(2) five percent (5%);

the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

~~(n)~~ **(m)** An in network practitioner is not required to provide a covered individual with the good faith estimate ~~required under subsection (i)~~ if the nonemergency health care service is scheduled to be performed by the practitioner within five (5) business days after the health care service is ordered.

~~(o)~~ **(n)** The department of insurance shall adopt emergency rules under IC 4-22-2-37.1 to specify the requirements of the notifications set forth in subsections ~~(k)~~ **(j)** and ~~(l).~~ **(k).**

(o) A practitioner may satisfy the requirements of this section by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.

SECTION 2. IC 25-1-9.8-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 20. A practitioner may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 3. IC 27-1-3-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 19. (a) Whenever the commissioner determines that any insurance company to which this article is applicable:

(1) is conducting its business contrary to law or in an unsafe or unauthorized manner;

(2) has had its capital or surplus fund impaired or reduced below the amount required by law; or

(3) has failed, neglected, or refused to observe and comply with any **law,** order, or rule of the department or commissioner;

then the commissioner may, by an order in writing addressed to the board of directors, board of trustees, attorney in fact, partners, or

owners of or in any such insurance company, to direct the discontinuance of any such illegal, unauthorized, or unsafe practice, the restoration of an impairment to the capital or the surplus fund, or the compliance with any such law, order, or rule of the department or commissioner. The order shall be mailed to the last known principal office of the insurance company by certified or registered mail or delivered to an officer of the company and shall be considered to be received by the insurance company three (3) days after mailing or on the date of delivery.

(b) If the insurance company fails, neglects, or refuses to comply with the terms of that order within thirty (30) days after its receipt by the insurance company, or within a shorter period set out in the order if the commissioner determines that an emergency exists, the commissioner may, in addition to any other remedy conferred upon the department or the commissioner by law, bring an action against any such insurance company, its officers, and agents to compel that compliance.

(c) The action shall be brought by the commissioner in the Marion County circuit court. The action shall be commenced and prosecuted in accordance with the Indiana Rules of Trial Procedure, and relief for noncompliance of the order includes any remedy appropriate under the facts, including injunction, preliminary injunction, and temporary restraining order. In that action, a change of venue from the judge, but no change of venue from the county, is permitted.

SECTION 4. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 6.2. (a) As used in this section, "domestic stock insurer" means a person that:**

(1) provides coverage under a health plan (as defined in IC 27-1-48-4);

(2) is organized under the insurance laws of this state; and

(3) is a publicly traded stock corporation.

(b) A domestic stock insurer shall file the following with the department:

(1) Not later than March 1 of each calendar year, the domestic stock insurer's annual financial statement from the previous calendar year.

(2) Not later than May 15 of each calendar year, the domestic stock insurer's first quarter financial statement from the current calendar year.

(3) Not later than August 15 of each calendar year, the domestic stock insurer's second quarter financial statement

from the current calendar year.

(4) Not later than November 15 of each calendar year, the domestic stock insurer's third quarter financial statement from the current calendar year.

(c) The department must post the information filed under subsection (b) on the department's Internet web site on a single and easily accessible web page not later than ten (10) business days after receiving the information.

SECTION 5. IC 27-1-37.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 1.5. As used in this chapter, "adverse determination" means a denial of a request for benefits on the grounds that the health service or item:**

(1) is not medically necessary, appropriate, effective, or efficient;

(2) is not being provided in or at an appropriate health care setting or level of care; or

(3) is experimental or investigational.

SECTION 6. IC 27-1-37.5-1.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 1.7. As used in this chapter, "clinical peer" means a practitioner or other health care provider who either:**

(1) holds a nonrestricted license in the health care profession under IC 25;

(2) has been granted reciprocity in the state, if reciprocity exists; or

(3) holds a license that is part of a compact in which the state has entered.

SECTION 7. IC 27-1-37.5-10, AS ADDED BY P.L.208-2018, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 10. (a) This section applies to a request for prior authorization delivered to a health plan after December 31, 2019.

(b) A health plan shall accept a request for prior authorization delivered to the health plan by a covered individual's health care provider through a secure electronic transmission. A health care provider shall submit a request for prior authorization through a secure electronic transmission. A health plan shall provide for:

(1) a secure electronic transmission; and

(2) acknowledgment of receipt, by use of a transaction number or another reference code;

of a request for prior authorization and any supporting information.

(c) Subsection (b) does not apply and a health plan that requires prior authorization shall accept a request for prior authorization that is not submitted through a secure electronic transmission if a covered individual's health care provider and the health plan have entered into an agreement under which the health plan agrees to process prior authorization requests that are not submitted through a secure electronic transmission because:

(1) secure electronic transmission of prior authorization requests would cause financial hardship for the health care provider;

(2) the area in which the health care provider is located lacks sufficient Internet access; or

(3) the health care provider has an insufficient number of covered individuals as patients or customers, as determined by the commissioner, to warrant the financial expense that compliance with subsection (b) would require.

(d) If a covered individual's health care provider is described in subsection (c), the health plan shall accept from the health care provider a request for prior authorization as follows:

(1) The prior authorization request must be made on the standardized prior authorization form established by the department under section 16 of this chapter.

(2) The health plan shall provide for secure electronic transmission and ~~acknowledgement~~ **acknowledgment** of receipt of the standardized prior authorization form and any supporting information for the prior authorization by use of a transaction number or another reference code.

(e) A health plan that utilizes a third party to review requests for prior authorization:

(1) may not require a covered individual's health care provider to submit a request for prior authorization to the third party; and

(2) must transmit a request for prior authorization provided by a covered individual's health care provider through secure electronic transmission to the third party.

SECTION 8. IC 27-1-37.5-11, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 11. (a) This section applies to a prior authorization request delivered to a health plan after December 31, 2019.

(b) A health plan shall respond to a request delivered under section 10 of this chapter as follows:

(1) If the request is delivered under section 10(b) of this chapter, the health plan shall immediately send to the requesting health

care provider an electronic receipt for the request.

(2) If the request is for an urgent care situation, the health plan shall respond with a prior authorization determination not more than seventy-two (72) hours after receiving the request.

(3) If the request is for a nonurgent care situation, the health plan shall respond with a prior authorization determination not more than ~~seven (7)~~ **five (5)** business days after receiving the request.

(c) If a request delivered under section 10 of this chapter is incomplete:

(1) the health plan shall respond within the period required by subsection (b) and indicate the specific additional information required to process the request;

(2) if the request was delivered under section 10(b) of this chapter, upon receiving the response under subdivision (1), the health care provider shall immediately send to the health plan an electronic receipt for the response made under subdivision (1); and

(3) if the request is for an urgent care situation, the health care provider shall respond to the request for additional information not more than seventy-two (72) hours after the health care provider receives the response under subdivision (1).

(d) If a request delivered under section 10 of this chapter is denied, the health plan shall respond within the period required by subsection (b) and indicate the specific reason for the denial **in clear and easy to understand language.**

SECTION 9. IC 27-1-37.5-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 17. (a) If a health plan makes an adverse determination on a prior authorization request by a covered individual's health care provider, the health plan must offer the covered individual's health care provider the option to request a peer to peer review by a clinical peer concerning the adverse determination.**

(b) A covered individual's health care provider may request a peer to peer review by a clinical peer either in writing or electronically.

(c) If a peer to peer review by a clinical peer is requested under this section, the health plan must:

(1) provide the peer to peer review by a clinical peer not later than seven (7) business days from the date of receipt by the health plan of the request by the covered individual's health care provider; and

(2) have the peer to peer review conducted between the clinical peer and the covered individual's health care provider.

SECTION 10. IC 27-1-45-7, AS AMENDED BY P.L.202-2021, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 7. (a) This section is effective beginning January 1, 2022.

~~(b) Except as provided in subsection (c), A:~~

~~(1) facility; and~~

~~(2) practitioner;~~

~~shall comply with the requirements of Section 2799B-6 of the Public Health Service Act, as added by Public Law 116-260.~~

~~(c)~~ **(b)** A facility or a practitioner is not required to provide the good faith estimate ~~required in subsection (b)~~ if the health care service to be provided to the covered individual is scheduled to be performed within five (5) business days after the health care service is ordered.

SECTION 11. IC 27-1-45-8, AS AMENDED BY P.L.202-2021, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 8. (a) An out of network practitioner who provides health care services at an in network facility to a covered individual may not be reimbursed more for the health care services than allowed according to the rate or amount of compensation established by the covered individual's network plan as described in subsection (b) unless all of the following conditions are met:

(1) At least five (5) business days before the health care service is 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 that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of facility or practitioner] is an out of network practitioner providing [type of care], with [name of in network facility], which is an in network provider facility within your health carrier's plan. [Name of facility or practitioner] will not be allowed to bill you the difference between the price charged for the services and the rate your health carrier will reimburse for the services during your care at [name of in network facility] unless you give your written consent to the charge.".

(B) Sets forth the facility's or practitioner's good faith estimate of the established fee 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 the actual charge for [name or description of health care services] exceeds our estimate by the greater of:

(i) one hundred dollars ($100); or

(ii) five percent (5%);

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 an out of network practitioner does not meet the requirements of subsection (a), the out of network practitioner shall include on any bill remitted to a covered individual a written statement in conspicuous type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

(c) If a covered individual's network plan remits reimbursement to the covered individual for health care services that did not meet the requirements of subsection (a), the network plan shall provide with the reimbursement a written statement in conspicuous type that states that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan and that is included in the reimbursement plus any required copayment, deductible, or coinsurance.

(d) 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 (a)(1)(B) by an amount greater than:

(1) one hundred dollars ($100); or

(2) five percent (5%);

the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

(e) The department shall adopt emergency rules under IC 4-22-2-37.1 to specify the requirements of the notifications set forth in:

(1) subsections (b) and (c); and

(2) **IC 25-1-9-23(j) and** IC 25-1-9-23(k). ~~and IC 25-1-9-23(l).~~

SECTION 12. IC 27-1-45-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 10. A facility or a practitioner may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 13. IC 27-1-46-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 18. A provider facility may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 14. IC 27-1-48 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]:

Chapter 48. Health Plan Transparency

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 2. As used in this chapter, "CPT code" refers to the medical billing code that applies to a specific health care service, as published in the Current Procedural Terminology code set maintained by the American Medical Association.

Sec. 3. (a) As used in this chapter, "health care service" means a health care related service or product rendered or sold by a health care provider within the scope of the health care provider's license or legal authorization, including hospital, medical, surgical, mental health, and substance abuse services or products.

(b) The term does not include the following:

(1) Dental services.

(2) Vision services.

(3) Long term rehabilitation treatment.

(4) Pharmaceutical services or products.

Sec. 4. (a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(3) The Medicaid risk based managed care program under

IC 12-15.

(b) The term includes a person that administers any of the following:

(1) A policy described in subsection (a)(1).

(2) A contract described in subsection (a)(2).

(3) Medicaid risk based managed care.

Sec. 5. As used in this chapter, "participating provider" refers to the following:

(1) A health care provider that has entered into an agreement with an insurer under IC 27-8-11-3.

(2) A participating provider (as defined in IC 27-13-1-24).

Sec. 6. As used in this chapter, "prior authorization" means a practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.

Sec. 7. (a) Within twenty-four (24) hours of the identification of a technical issue with a health plan's claims submission system that would require a participating provider to submit a second claim for the same health care service, the health plan must post notice of the technical issue on the health plan's Internet web site.

(b) When a technical issue that was posted under subsection (a) is resolved, the health plan must post an update on the resolution of the technical issue on the health plan's Internet web site for not less than seventy-two (72) hours.

Sec. 8. (a) Not later than February 1 of each calendar year, a health plan must post on the health plan's Internet web site:

(1) the thirty (30) most frequently submitted CPT codes that were submitted by participating providers for prior authorization during the previous calendar year; and

(2) the percentage of the thirty (30) most frequently submitted CPT codes that were approved in the previous calendar year, disaggregated by CPT code.

(b) A health plan must maintain the information required under subsection (a) on the health plan's Internet web site, organized by year and on a single and easily accessible web page.

SECTION 15. IC 27-2-28 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]:

Chapter 28. Premium Rate Increases

Sec. 1. As used in this chapter, "health insurance policy" includes the following:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(2) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

Sec. 2. If the premium rate for a health insurance policy will increase five percent (5%) or more as compared to the previous calendar year:

(1) the insurer must submit:

(A) the planned premium rate increase; and

(B) written justification for the planned premium rate increase;

to the commissioner or the commissioner's designee for review and approval prior to the planned premium rate increase going into effect. The department must post the written justification for the planned premium rate increase on the department's Internet web site not later than ten (10) calendar days after receiving the written justification for the planned premium rate increase;

(2) after reviewing the insurer's written justification for the planned premium rate increase, the commissioner or the commissioner's designee must approve or deny the insurer's planned premium rate increase in writing within twenty (20) calendar days;

(3) if the insurer's planned premium rate increase is denied by the commissioner or the commissioner's designee under subdivision (2), the insurer may submit:

(A) a lower planned premium rate increase; and

(B) written justification for the lower planned premium rate increase;

to the commissioner or the commissioner's designee for review and approval prior to the lower planned premium rate increase going into effect. The department must post the written justification for the lower planned premium rate increase on the department's Internet web site not later than ten (10) calendar days after receiving the written justification for the planned premium rate increase;

(4) after reviewing the insurer's written justification for the lower planned premium rate increase, the commissioner or the commissioner's designee must approve or deny the insurer's lower planned premium rate increase in writing

within twenty (20) calendar days; and

(5) if the commissioner or the commissioner's designee denies an insurer's lower planned premium rate increase submitted under subdivision (3), the insurer may not increase the premium rate five percent (5%) or more for that calendar year.

Sec. 3. If an insurer's planned premium rate increase of five percent (5%) or more is approved under section 2 of this chapter, the insurer must provide written justification of the premium rate increase to an individual or entity covered by the health insurance policy not less than thirty (30) days prior to the premium rate increase going into effect.

SECTION 16. IC 27-8-5.7-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 2.5. As used in this chapter, "CPT code" refers to the medical billing code that applies to a specific health care service, as published in the Current Procedural Terminology code set maintained by the American Medical Association.**

SECTION 17. IC 27-8-5.7-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 5. (a) An insurer shall pay or deny each clean claim in accordance with ~~section~~ **sections** 6 **and 6.5** of this chapter.

(b) An insurer shall notify a provider of any deficiencies in a submitted claim not more than:

(1) thirty (30) days for a claim that is filed electronically; or

(2) forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a clean claim.

(c) Failure of an insurer to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

SECTION 18. IC 27-8-5.7-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 6.5. (a) An insurer may not:**

(1) alter the CPT code submitted for a clean claim; and

(2) pay for a CPT code of lesser monetary value;

unless the medical record of the clean claim has been reviewed by an employee of the insurer who is licensed under IC 25-22.5.

(b) An insurer may not alter a clean claim to only pay for the CPT codes necessary for an individual's final diagnosis, if the CPT codes billed were deemed medically necessary to reach the final diagnosis.

SECTION 19. IC 27-8-11-3 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 3. (a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with an insurer under subsection (a)(1), the insurer shall make available to the provider a written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(c) No hospital, physician, pharmacist, or other provider designated in IC 27-8-6-1 willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the terms and conditions established by the insurer for providers entering into agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer's denial; and

(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

(d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not

referred to the provider by a person acting on behalf of or under an agreement with the insurer.

(e) No cause of action shall arise against any person or insurer for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.

Nor shall such a cause of action arise against any person or provider for furnishing personal or privileged information to an insurer. However, this subsection provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person, provider, or insurer.

(f) Nothing in this chapter abrogates the privileges and immunities established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).

(g) An insurer that enters into an agreement with a provider under subsection (a)(1) must provide the provider a current reimbursement rate schedule:

(1) every two (2) years; and

(2) when three (3) or more CPT code (as defined in IC 27-1-37.5-3) rates under the agreement are changed in a twelve (12) month period.

SECTION 20. IC 27-13-15-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 1. (a) A contract between a health maintenance organization and a participating provider of health care services:

(1) must be in writing;

(2) may not prohibit the participating provider from disclosing:

(A) the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider; or

(B) all treatment options available to an insured, including those not covered by the insured's policy;

(3) may not provide for a financial or other penalty to a provider for making a disclosure permitted under subdivision (2); and

(4) must provide that in the event the health maintenance organization fails to pay for health care services as specified by the contract, the subscriber or enrollee is not liable to the participating provider for any sums owed by the health maintenance organization.

(b) An enrollee is not entitled to coverage of a health care service under a group or an individual contract unless that health care service is included in the enrollee's contract.

(c) A provider is not entitled to payment under a contract for health

care services provided to an enrollee unless the provider has a contract or an agreement with the carrier.

(d) A health maintenance organization that enters into a contract with a participating provider must provide the participating provider with a current reimbursement rate schedule:

(1) every two (2) years; and

(2) when three (3) or more CPT code (as defined in IC 27-1-37.5-3) rates under the contract change in a twelve (12) month period.

~~(d) This section applies to a contract entered, renewed, or modified after June 30, 1996.~~

SECTION 21. IC 27-13-36.2-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 4.5. (a) A health maintenance organization may not:**

(1) alter the CPT code submitted for a clean claim; and

(2) pay for a CPT code of lesser monetary value;

unless the medical record of the clean claim has been reviewed by an employee of the health maintenance organization who is licensed under IC 25-22.5.

(b) A health maintenance organization may not alter a clean claim to only pay for the CPT codes necessary for an individual's final diagnosis, if the CPT codes billed were deemed medically necessary to reach the final diagnosis.

SECTION 22. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to the appropriate interim study committee the task of studying the issue of whether a health insurer or a health maintenance organization should be required to exempt a participating health care provider from needing to receive prior authorization on a particular health care service if the participating health care provider has continuously received approval for the health care service for a determined number of months.**

(b) This SECTION expires January 1, 2023.

SECTION 23. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 249, 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:

Page 2, line 2, reset in roman "may,".
Page 2, line 2, delete "shall,".
Page 4, delete lines 25 through 42.
Page 5, delete lines 1 through 27.
Page 7, delete lines 18 through 22.
Page 7, line 23, delete "(2)" and insert "**(1)**".
Page 7, line 26, delete "(3)" and insert "**(2)**".
Page 7, line 29, delete "(4)" and insert "**(3)**".
Page 7, line 32, delete "(5)" and insert "**(4)**".
Page 9, line 37, delete "An".
Page 9, delete lines 38 through 42.
Page 10, delete lines 1 through 2.
Page 10, line 3, delete "(c)" and insert "**(b)**".
Page 11, delete lines 28 through 42.
Delete page 12.
Page 13, delete lines 1 through 33.
Page 14, delete lines 26 through 42.
Delete pages 15 and 16.
Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 249 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 10, Nays 1.

SENATE MOTION

Madam President: I move that Senate Bill 249 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 25-1-9-23, AS AMENDED BY P.L.202-2021,

SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: 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, "emergency services" means services that are:

(1) furnished by a provider qualified to furnish emergency services; and

(2) needed to evaluate or stabilize an emergency medical condition.

(d) 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.

(e) 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.

(f) As used in this section, "out of network" means that the health care services provided by the practitioner to a covered individual are not subject to the covered individual's health carrier network plan.

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

(1) An individual who holds:

(A) an unlimited license, certificate, or registration;

(B) a limited or probationary license, certificate, or registration;

(C) a temporary license, certificate, registration, or permit;

(D) an intern permit; or

(E) a provisional license;

issued by the board (as defined in IC 25-0.5-11-1) regulating the profession in question.

(2) An entity that:

(A) is owned by, or employs; or

(B) performs billing for professional health care services rendered by;

an individual described in subdivision (1).

The term does not include a dentist licensed under IC 25-14, an optometrist licensed under IC 25-24, or a provider facility (as defined in IC 25-1-9.8-10).

(h) An in network practitioner who provides covered health care

services to a covered individual may not charge more for the covered health care services than allowed according to the rate or amount of compensation established by the individual's network plan.

~~(i) This subsection is effective beginning January 1, 2022. Except as provided in subsection (n), a practitioner shall comply with the requirements set forth in Section 2799B-6 of the Public Health Service Act, as added by Public Law 116-260.~~

~~(j)~~ **(i)** An out of network practitioner who provides health care services at an in network facility to a covered individual may not be reimbursed more for the health care services than allowed according to the rate or amount of compensation established by the covered individual's network plan unless all of the following conditions are met:

(1) At least five (5) business 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 that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of practitioner] is an out of network practitioner providing [type of care] with [name of in network facility], which is an in network provider facility within your health carrier's plan. [Name of practitioner] will not be allowed to bill you the difference between the price charged by the practitioner and the rate your health carrier will reimburse for the services during your care at [name of in network facility] 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 by the greater of:

(i) one hundred dollars ($100); or

(ii) five percent (5%);

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.

~~(k)~~ **(j)** If an out of network practitioner does not meet the requirements of subsection ~~(j),~~ **(i),** the out of network practitioner shall include on any bill remitted to a covered individual a written statement in conspicuous type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

~~(l)~~ **(k)** If a covered individual's network plan remits reimbursement to the covered individual for health care services subject to the reimbursement limitation of subsection ~~(j),~~ **(i),** the network plan shall provide with the reimbursement a written statement in conspicuous type that states that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan and that is included in the reimbursement plus any required copayment, deductible, or coinsurance.

~~(m)~~ **(l)** 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 ~~(j)(1)(B)~~ **(i)(1)(B)** by the greater of:

(1) one hundred dollars ($100); or

(2) five percent (5%);

the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

~~(n)~~ **(m)** An in network practitioner is not required to provide a covered individual with the good faith estimate ~~required under subsection (i)~~ if the nonemergency health care service is scheduled to be performed by the practitioner within five (5) business days after the health care service is ordered.

~~(o)~~ **(n)** The department of insurance shall adopt emergency rules under IC 4-22-2-37.1 to specify the requirements of the notifications set forth in subsections ~~(k)~~ **(j)** and ~~(l).~~ **(k).**

(o) A practitioner may satisfy the requirements of this section by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.".

Page 2, between lines 26 and 27, begin a new paragraph and insert:

"SECTION 4. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 6.2. (a) As used in this section,**

"domestic stock insurer" means a person that:

(1) provides coverage under a health plan (as defined in IC 27-1-48-4);

(2) is organized under the insurance laws of this state; and

(3) is a publicly traded stock corporation.

(b) A domestic stock insurer shall file the following with the department:

(1) Not later than March 1 of each calendar year, the domestic stock insurer's annual financial statement from the previous calendar year.

(2) Not later than May 15 of each calendar year, the domestic stock insurer's first quarter financial statement from the current calendar year.

(3) Not later than August 15 of each calendar year, the domestic stock insurer's second quarter financial statement from the current calendar year.

(4) Not later than November 15 of each calendar year, the domestic stock insurer's third quarter financial statement from the current calendar year.

(c) The department must post the information filed under subsection (b) on the department's Internet web site on a single and easily accessible web page not later than ten (10) business days after receiving the information.

SECTION 5. IC 27-1-37.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 1.5. As used in this chapter, "adverse determination" means a denial of a request for benefits on the grounds that the health service or item:**

(1) is not medically necessary, appropriate, effective, or efficient;

(2) is not being provided in or at an appropriate health care setting or level of care; or

(3) is experimental or investigational.

SECTION 6. IC 27-1-37.5-1.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 1.7. As used in this chapter, "clinical peer" means a practitioner or other health care provider who either:**

(1) holds a nonrestricted license in the health care profession under IC 25;

(2) has been granted reciprocity in the state, if reciprocity exists; or

(3) holds a license that is part of a compact in which the state has entered.".

Page 4, line 1, reset in roman "seventy-two (72)".

Page 4, line 1, delete "twenty-four (24)".

Page 4, line 5, delete "two (2)" and insert "**five (5)**".

Page 4, line 18, reset in roman "seventy-two (72)".

Page 4, line 18, delete "twenty-four (24)".

Page 4, between lines 23 and 24, begin a new paragraph and insert:

"SECTION 9. IC 27-1-37.5-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 17. (a) If a health plan makes an adverse determination on a prior authorization request by a covered individual's health care provider, the health plan must offer the covered individual's health care provider the option to request a peer to peer review by a clinical peer concerning the adverse determination.**

(b) A covered individual's health care provider may request a peer to peer review by a clinical peer either in writing or electronically.

(c) If a peer to peer review by a clinical peer is requested under this section, the health plan must:

(1) provide the peer to peer review by a clinical peer not later than seven (7) business days from the date of receipt by the health plan of the request by the covered individual's health care provider; and

(2) have the peer to peer review conducted between the clinical peer and the covered individual's health care provider.

SECTION 10. IC 27-1-45-7, AS AMENDED BY P.L.202-2021, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 7. (a) This section is effective beginning January 1, 2022.

~~(b) Except as provided in subsection (c), A:~~

~~(1) facility; and~~

~~(2) practitioner;~~

~~shall comply with the requirements of Section 2799B-6 of the Public Health Service Act, as added by Public Law 116-260.~~

~~(c)~~ **(b)** A facility or a practitioner is not required to provide the good faith estimate ~~required in subsection (b)~~ if the health care service to be provided to the covered individual is scheduled to be performed within five (5) business days after the health care service is ordered.

SECTION 11. IC 27-1-45-8, AS AMENDED BY P.L.202-2021,

SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 8. (a) An out of network practitioner who provides health care services at an in network facility to a covered individual may not be reimbursed more for the health care services than allowed according to the rate or amount of compensation established by the covered individual's network plan as described in subsection (b) unless all of the following conditions are met:

(1) At least five (5) business days before the health care service is 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 that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of facility or practitioner] is an out of network practitioner providing [type of care], with [name of in network facility], which is an in network provider facility within your health carrier's plan. [Name of facility or practitioner] will not be allowed to bill you the difference between the price charged for the services and the rate your health carrier will reimburse for the services during your care at [name of in network facility] unless you give your written consent to the charge.".

(B) Sets forth the facility's or practitioner's good faith estimate of the established fee 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 the actual charge for [name or description of health care services] exceeds our estimate by the greater of:

(i) one hundred dollars ($100); or

(ii) five percent (5%);

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 an out of network practitioner does not meet the requirements of subsection (a), the out of network practitioner shall include on any

bill remitted to a covered individual a written statement in conspicuous type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

(c) If a covered individual's network plan remits reimbursement to the covered individual for health care services that did not meet the requirements of subsection (a), the network plan shall provide with the reimbursement a written statement in conspicuous type that states that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan and that is included in the reimbursement plus any required copayment, deductible, or coinsurance.

(d) 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 (a)(1)(B) by an amount greater than:

(1) one hundred dollars ($100); or

(2) five percent (5%);

the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

(e) The department shall adopt emergency rules under IC 4-22-2-37.1 to specify the requirements of the notifications set forth in:

(1) subsections (b) and (c); and

(2) **IC 25-1-9-23(j) and** IC 25-1-9-23(k). ~~and IC 25-1-9-23(l).~~

SECTION 12. IC 27-1-45-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 10. A facility or a practitioner may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**".

Page 6, delete lines 13 through 29.

Page 6, line 41, delete "greater" and insert "**more**".

Page 11, after line 3, begin a new paragraph and insert:

"SECTION 16. IC 27-13-36.2-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 4.5. (a) A health maintenance organization may not:**

(1) alter the CPT code submitted for a clean claim; and

(2) pay for a CPT code of lesser monetary value;

unless the medical record of the clean claim has been reviewed by

an employee of the health maintenance organization who is licensed under IC 25-22.5.

(b) A health maintenance organization may not alter a clean claim to only pay for the CPT codes necessary for an individual's final diagnosis, if the CPT codes billed were deemed medically necessary to reach the final diagnosis.

SECTION 17. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to the appropriate interim study committee the task of studying the issue of whether a health insurer or a health maintenance organization should be required to exempt a participating health care provider from needing to receive prior authorization on a particular health care service if the participating health care provider has continuously received approval for the health care service for a determined number of months.**

(b) This SECTION expires January 1, 2023.

SECTION 18. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to SB 249 as printed January 28, 2022.)

BROWN L