



Reprinted
January 29, 2008

HOUSE BILL No. 1055

DIGEST OF HB 1055 (Updated January 28, 2008 4:26 pm - DI 77)

Citations Affected: IC 27-8; IC 27-13.

Synopsis: Assignment of benefits. Specifies requirements concerning health benefit payments under an assignment of benefits.

Effective: July 1, 2008.

Brown C

January 8, 2008, read first time and referred to Committee on Public Health.
January 24, 2008, amended, reported — Do Pass.
January 28, 2008, read second time, amended, ordered engrossed.

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HB 1055—LS 6129/DI 97+



Second Regular Session 115th General Assembly (2008)

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 2007 Regular Session of the General Assembly.

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HOUSE BILL No. 1055

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 27-8-5.9 IS ADDED TO THE INDIANA CODE
2 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2008]:

4 **Chapter 5.9. Assignment of Benefits**

5 **Sec. 1. As used in this chapter, "assignment of benefits" means**
6 **a written instrument that:**

- 7 (1) **is executed by a covered individual or the authorized**
8 **representative of a covered individual; and**
9 (2) **assigns to a treating provider the covered individual's**
10 **right to receive reimbursement for health care services**
11 **provided to the covered individual.**

12 **Sec. 2. As used in this chapter, "covered individual" means an**
13 **individual entitled to benefits under a policy.**

14 **Sec. 3. As used in this chapter, "insurer" includes the following:**

- 15 (1) **An insurer that issues a policy.**
16 (2) **An administrator licensed under IC 27-1-25 that pays or**
17 **administers claims for benefits under a policy.**



1 **Sec. 4. (a) As used in this chapter, "policy" means a plan**
2 **through which coverage is provided for health care services**
3 **through insurance, prepayment, reimbursement, or otherwise. The**
4 **term includes the following:**

5 **(1) An employee welfare benefit plan (as defined in 29 U.S.C.**
6 **1002 et seq.).**

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

9 **(b) The term does not include the following:**

10 **(1) Accident-only, credit, Medicare supplement, long term**
11 **care, or disability income insurance.**

12 **(2) Coverage issued as a supplement to liability insurance.**

13 **(3) Worker's compensation or similar insurance.**

14 **(4) Automobile medical payment insurance.**

15 **(5) A specified disease policy issued as an individual policy.**

16 **(6) A short term insurance plan that:**

17 **(A) may not be renewed; and**

18 **(B) has a duration of not more than six (6) months.**

19 **(7) A policy that provides a stipulated daily, weekly, or**
20 **monthly payment to an insured during hospital confinement,**
21 **without regard to the actual expense of the confinement.**

22 **(8) An individual contract (as defined in IC 27-13-1-21) or a**
23 **group contract (as defined in IC 27-13-1-16).**

24 **Sec. 5. (a) Except as provided in subsection (b), if:**

25 **(1) a policy provides coverage for a health care service;**

26 **(2) the health care service is provided by a provider that has**
27 **not entered into an agreement with the insurer under**
28 **IC 27-8-11-3; and**

29 **(3) the provider described in subdivision (2):**

30 **(A) has an assignment of benefits from a covered**
31 **individual to whom the health care service is provided; and**

32 **(B) provides written or electronic notification to the**
33 **insurer that the provider:**

34 **(i) has provided the health care service to the covered**
35 **individual; and**

36 **(ii) has the assignment of benefits;**

37 **the insurer shall make a benefit payment directly to the provider**
38 **for the health care service and send written notice of the payment**
39 **to the covered individual or the authorized representative of the**
40 **covered individual.**

41 **(b) An insurer is not required to make a benefit payment**
42 **directly to a provider described in subsection (a)(2) if the provider**

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1 has been charged with or convicted of fraud.

2 (c) This section does not require:

3 (1) coverage for benefits not covered under the terms of the
4 policy; or

5 (2) payment to a provider that is not eligible for a benefit
6 payment under the terms of the policy.

7 Sec. 6. An insurer that does not comply with this chapter shall
8 pay seven percent (7%) interest, compounded daily, accruing from
9 the day after the benefit payment was due, on all amounts that are
10 unpaid thirty (30) days after the insurer receives all documentation
11 reasonably necessary to determine claim payment.

12 Sec. 7. If:

13 (1) a provider has an assignment of benefits from a covered
14 individual;

15 (2) the provider gives notice of the assignment of benefits
16 under section 5 of this chapter to the insurer required to
17 provide benefits to the covered individual under a policy;

18 (3) the provider provides health care services to the covered
19 individual;

20 (4) the insurer makes a benefit payment for the health care
21 services referred to in subdivision (3) not directly to the
22 provider but directly to the covered individual or the
23 authorized representative of the covered individual; and

24 (5) the provider notifies the insurer that the provider has not
25 received the benefit payment to which the provider was
26 entitled for the health care services referred to in subdivision
27 (3);

28 the insurer, not more than thirty (30) days after receiving notice
29 from the provider under subdivision (5) of the misdirected benefit
30 payment, shall make the benefit payment directly to the provider.

31 Sec. 8. If:

32 (1) a provider has an assignment of benefits from a covered
33 individual;

34 (2) the provider gives notice of the assignment of benefits
35 under section 5 of this chapter to the insurer required to
36 provide benefits to the covered individual under a policy;

37 (3) the provider provides health care services to the covered
38 individual; and

39 (4) there is a good faith dispute regarding:

40 (A) the legitimacy of the claim relating to the health care
41 services provided;

42 (B) the appropriate amount of reimbursement for the

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claim; or
(C) the authorization for the assignment of benefits;
the insurer, not more than fourteen (14) business days after the insurer receives the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the provider or the provider's authorized representative.

Sec. 9. A provider, by accepting an assignment of benefits under this chapter, does not agree to accept an insurer's fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 10. A provision that:
(1) is contained in an agreement between an insurer and a provider under this chapter; and
(2) violates this chapter;
is void.

Sec. 11. Except in a situation in which a patient is unconscious, incoherent, or incompetent, in which an emergency exists, or in which a provider does not know or could not reasonably know that the patient is a covered individual with which the provider has not entered into an agreement for the delivery of health care services, a provider or the provider's agent shall disclose to a covered individual the following applicable information:

- (1) The provider has not entered into an agreement with the insurer to provide health care services to the covered individual.
- (2) The covered individual may be billed for health care services not paid by the insurer.

SECTION 2. IC 27-13-36.3 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]:

Chapter 36.3. Payment to Nonparticipating Providers

Sec. 1. As used in this chapter, "health maintenance organization" includes the following:

- (1) A limited service health maintenance organization.
- (2) A person that pays or administers claims on behalf of a health maintenance organization or limited service health maintenance organization.

Sec. 2. (a) Except as provided in subsection (b), if:

- (1) an individual contract or group contract provides coverage for a health care service;
- (2) the health care service is provided by a nonparticipating provider; and

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1 (3) the nonparticipating provider provides written or
2 electronic notification to the health maintenance organization
3 that the nonparticipating provider has provided the health
4 care service to an enrollee who is covered under the individual
5 contract or group contract;

6 the health maintenance organization shall make a benefit payment
7 directly to the nonparticipating provider for the health care service
8 and send written notice of the payment to the enrollee or the
9 authorized representative of the enrollee.

10 (b) A health maintenance organization is not required to make
11 a benefit payment directly to a nonparticipating provider if the
12 nonparticipating provider has been charged with or convicted of
13 fraud.

14 (c) This section does not require:

15 (1) coverage for benefits not covered under the terms of the
16 individual contract or group contract; or

17 (2) payment to a nonparticipating provider that is not eligible
18 for a benefit payment under the terms of the individual
19 contract or group contract.

20 Sec. 3. A health maintenance organization that does not make
21 benefit payments as required under section 2 of this chapter shall
22 pay seven percent (7%) interest, compounded daily, accruing from
23 the day after the benefit payment was due, on all amounts that are
24 unpaid thirty (30) days after the health maintenance organization
25 receives all documentation reasonably necessary to determine
26 claim payment.

27 Sec. 4. If:

28 (1) a nonparticipating provider provides health care services
29 described in section 2 of this chapter;

30 (2) the health maintenance organization makes a benefit
31 payment for the health care services referred to in subdivision

32 (1) not directly to the nonparticipating provider but directly
33 to the enrollee or the authorized representative of the
34 enrollee; and

35 (3) the nonparticipating provider notifies the health
36 maintenance organization that the nonparticipating provider
37 has not received the benefit payment to which the
38 nonparticipating provider was entitled for the health care
39 services referred to in subdivision (1);

40 the health maintenance organization, not more than thirty (30)
41 days after receiving notice from the nonparticipating provider
42 under subdivision (3) of the misdirected benefit payment, shall

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1 make the benefit payment directly to the nonparticipating
2 provider.

3 Sec. 5. If:
4 (1) a nonparticipating provider provides health care services
5 described in section 2 of this chapter; and
6 (2) there is a good faith dispute regarding:
7 (A) the legitimacy of the claim relating to the services
8 provided;
9 (B) the appropriate amount of reimbursement for the
10 claim; or
11 (C) the payment of the claim under the terms of the
12 individual contract or group contract;

13 the health maintenance organization, not more than fourteen (14)
14 business days after the health maintenance organization receives
15 the claim and all documentation reasonably necessary to determine
16 claim payment, shall provide notice of the dispute to the
17 nonparticipating provider or the nonparticipating provider's
18 authorized representative.

19 Sec. 6. A nonparticipating provider, by providing health care
20 services described in section 2 of this chapter, does not agree to
21 accept the health maintenance organization's fee schedule or
22 specific payment rate as payment in full, partial payment, or
23 appropriate payment.

24 Sec. 7. A contract provision that violates this chapter is void.

25 Sec. 8. Except in a situation in which a patient is unconscious,
26 incoherent, or incompetent, in which an emergency exists, or in
27 which a provider does not know or could not reasonably know that
28 the patient is an enrollee with which the provider has not entered
29 into an agreement for the delivery of health care services, a
30 provider or the provider's agent shall disclose to an enrollee the
31 following applicable information:

- 32 (1) The provider is a nonparticipating provider.
33 (2) The enrollee may, subject to IC 27-13-36-5 and
34 IC 27-13-36-9, be billed for health care services not paid by
35 the health maintenance organization.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1055, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 2, line 1, after "4." insert "(a)".

Page 2, between lines 2 and 3, begin a new paragraph and insert:

"(b) The term does not include the following:

- (1) Accident only, credit, vision, Medicare supplement, long term care, or disability income insurance.**
- (2) Coverage issued as a supplement to liability insurance.**
- (3) Automobile medical payment insurance.**
- (4) A specified disease policy.**
- (5) A short term insurance plan that:**
 - (A) may not be renewed; and**
 - (B) has a duration of not more than six (6) months.**
- (6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**
 - (A) hospital confinement, critical illness, or intensive care;**
 - or**
 - (B) gaps for deductibles or copayments.**
- (7) Worker's compensation or similar insurance.**
- (8) A student health plan.**
- (9) A supplemental plan that always pays in addition to other coverage.**
- (10) An employer sponsored health benefit plan that is:**
 - (A) provided to individuals who are eligible for Medicare; and**
 - (B) not marketed as, or held out to be, a Medicare supplement policy."**

Page 2, delete lines 23 through 24, begin a new paragraph and insert:

"(c) This section does not require:

- (1) coverage for benefits not covered under the terms of the policy; or**
- (2) payment to a provider that is not eligible for a benefit payment under the terms of the policy."**

Page 4, delete lines 20 through 22, begin a new paragraph and insert:

"(c) This section does not require:

- (1) coverage for benefits not covered under the terms of the**

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**individual contract or group contract; or
(2) payment to a nonparticipating provider that is not eligible
for a benefit payment under the terms of the individual
contract or group contract."**

and when so amended that said bill do pass.

(Reference is to HB 1055 as introduced.)

BROWN C, Chair

Committee Vote: yeas 8, nays 1.

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1055 be amended to read as follows:

Page 4, between lines 18 and 19, begin a new paragraph and insert:

"Sec. 11. Except in a situation in which a patient is unconscious, incoherent, or incompetent, in which an emergency exists, or in which a provider does not know or could not reasonably know that the patient is a covered individual with which the provider has not entered into an agreement for the delivery of health care services, a provider or the provider's agent shall disclose to a covered individual the following applicable information:

- (1) The provider has not entered into an agreement with the insurer to provide health care services to the covered individual.**
- (2) The covered individual may be billed for health care services not paid by the insurer."**

Page 6, after line 15, begin a new paragraph and insert:

"Sec. 8. Except in a situation in which a patient is unconscious, incoherent, or incompetent, in which an emergency exists, or in which a provider does not know or could not reasonably know that the patient is an enrollee with which the provider has not entered into an agreement for the delivery of health care services, a provider or the provider's agent shall disclose to an enrollee the following applicable information:

- (1) The provider is a nonparticipating provider.**
- (2) The enrollee may, subject to IC 27-13-36-5 and IC 27-13-36-9, be billed for health care services not paid by**



the health maintenance organization."

(Reference is to HB 1055 as printed January 25, 2008.)

WELCH

HOUSE MOTION

Mr. Speaker: I move that House Bill 1055 be amended to read as follows:

Page 2, line 1, delete "refers to a policy of" and insert "**means a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes the following:**

- (1) **An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).**
- (2) **A policy of accident and sickness insurance (as defined in IC 27-8-5-1).**

(b) The term does not include the following:

- (1) **Accident-only, credit, Medicare supplement, long term care, or disability income insurance.**
- (2) **Coverage issued as a supplement to liability insurance.**
- (3) **Worker's compensation or similar insurance.**
- (4) **Automobile medical payment insurance.**
- (5) **A specified disease policy issued as an individual policy.**
- (6) **A short term insurance plan that:**
 - (A) **may not be renewed; and**
 - (B) **has a duration of not more than six (6) months.**
- (7) **A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.**
- (8) **An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16)."**

Page 2, delete lines 2 through 26.

(Reference is to HB 1055 as printed January 25, 2008.)

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