
SENATE BILL No. 416

DIGEST OF INTRODUCED BILL

Citations Affected: IC 4-13-16.5-1; IC 16-21-2-17; IC 25-1-9-22; IC 27-4-1-4; IC 27-8-11; IC 27-13-36-5.5.

Synopsis: Balance billing. Specifies certain requirements for a health facility, health care provider, health insurer, and health maintenance organization with respect to notice concerning balance billing for nonemergency care. Makes conforming amendments.

Effective: July 1, 2011.

Simpson, Holdman

January 12, 2011, read first time and referred to Committee on Health and Provider Services.

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First Regular Session 117th General Assembly (2011)

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 2010 Regular Session of the General Assembly.

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SENATE BILL No. 416



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

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

1 SECTION 1. IC 4-13-16.5-1, AS AMENDED BY P.L.114-2010,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2011]: Sec. 1. (a) The definitions in this section apply
4 throughout this chapter.

5 (b) "Commission" refers to the governor's commission on minority
6 and women's business enterprises established under section 2 of this
7 chapter.

8 (c) "Commissioner" refers to the deputy commissioner for minority
9 and women's business enterprises of the department.

10 (d) "Contract" means any contract awarded by a state agency or, as
11 set forth in section 2(f)(11) of this chapter, awarded by a recipient of
12 state grant funds, for construction projects or the procurement of goods
13 or services, including professional services. For purposes of this
14 subsection, "goods or services" may not include the following when
15 determining the total value of contracts for state agencies:

- 16 (1) Utilities.
- 17 (2) Health care services (as defined in ~~IC 27-8-11-1(c)~~).



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

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- 1 (A) ownership of at least fifty-one percent (51%) of the
- 2 enterprise, including corporate stock of a corporation;
- 3 (B) control over the management and active in the day-to-day
- 4 operations of the business; and
- 5 (C) an interest in the capital, assets, and profits and losses of
- 6 the business proportionate to the percentage of ownership.
- 7 (j) "Minority group" means:
- 8 (1) Blacks;
- 9 (2) American Indians;
- 10 (3) Hispanics; and
- 11 (4) Asian Americans.
- 12 (k) "Separate body corporate and politic" refers to an entity
- 13 established by the general assembly as a body corporate and politic.
- 14 (l) "State agency" refers to any authority, board, branch,
- 15 commission, committee, department, division, or other instrumentality
- 16 of the executive, including the administrative, department of state
- 17 government.
- 18 SECTION 2. IC 16-21-2-17 IS ADDED TO THE INDIANA CODE
- 19 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
- 20 1, 2011]: **Sec. 17. (a) As used in this section, "facility" means an**
- 21 **entity that is licensed under this article.**
- 22 **(b) As used in this section, "facility based provider" means an**
- 23 **individual provider:**
- 24 **(1) to whom a facility has granted clinical privileges; and**
- 25 **(2) who renders health care services to patients who are**
- 26 **treated at the facility.**
- 27 **The term includes a group of individual providers.**
- 28 **(c) As used in this section, "nonparticipating provider" means**
- 29 **a provider or group of providers that is not part of a provider**
- 30 **network.**
- 31 **(d) As used in this section, "participating provider" means a**
- 32 **provider or group of providers that is part of a provider network.**
- 33 **(e) As used in this section, "provider network" means a group**
- 34 **of two (2) or more providers that is represented by a person for**
- 35 **purposes of negotiations with third parties.**
- 36 **(f) A facility shall implement written policies related to billing**
- 37 **patients for nonemergency health care services as follows:**
- 38 **(1) A policy for, before admission or when a patient is initially**
- 39 **treated at the facility, provision of a conspicuous written**
- 40 **disclosure that informs the patient:**
- 41 **(A) based on information received from the patient,**
- 42 **whether the facility is a participating provider at the time**

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the admission or treatment occurs; and

(B) that if:

(i) the facility is a participating provider; and

(ii) a nonparticipating provider renders a health care service to the patient at the facility;

the patient may be billed for any amount unpaid by the patient's health plan.

(2) The facility provides to a patient, upon request, a list containing the name and contact information for each facility based provider at the facility.

(3) If the facility operates an Internet web site that includes a list of providers that have been granted clinical privileges at the facility, the:

(A) posting on the Internet web site of a list that contains the name and contact information for each facility based provider; and

(B) quarterly updating on the Internet web site of any change to the list.

(g) A violation of this chapter by a facility is grounds for disciplinary action under this article.

SECTION 3. IC 25-1-9-22 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 22. (a) As used in this section, "balance bill" means a nonparticipating practitioner's charge to a patient of the difference between:

(1) the nonparticipating practitioner's fee for a health care service rendered to the patient; and

(2) the sum of:

(A) the payments made to the nonparticipating practitioner by the patient's health plan; plus

(B) the patient's cost sharing amounts;

for the health care service under the terms of the patient's health plan.

(b) As used in this section, "facility" means an entity that is licensed under IC 16-21.

(c) As used in this section, "facility based practitioner" means an individual practitioner:

(1) to whom a facility has granted clinical privileges; and

(2) who renders health care services to patients who are treated at the facility.

The term includes a group of individual practitioners.

(d) As used in this section, "participating practitioner" means

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1 a practitioner or group of practitioners that is part of a
 2 practitioner network.
 3 (e) As used in this section, "nonparticipating practitioner"
 4 means a practitioner or group of practitioners that is not part of a
 5 practitioner network.
 6 (f) As used in this section, "practitioner network" means a
 7 group of two (2) or more practitioners that is represented by a
 8 person for purposes of negotiations with third parties.
 9 (g) If a facility based practitioner who is a nonparticipating
 10 practitioner charges a patient a balance bill for nonemergency care
 11 rendered at the facility, the facility based practitioner shall send to
 12 the patient a billing statement that contains the following:
 13 (1) An itemized list, including dates, of the nonemergency care
 14 and supplies rendered.
 15 (2) A conspicuous, plain language explanation that:
 16 (A) the facility based practitioner is a nonparticipating
 17 practitioner; and
 18 (B) the health plan has paid a rate that is less than the
 19 facility based practitioner's billed amount.
 20 (3) A telephone number for the patient to call to discuss the
 21 statement, receive an explanation for questions about the
 22 statement, and discuss payment issues.
 23 (4) Notice that the patient may call the facility based
 24 practitioner to discuss alternative payment arrangements.
 25 (5) Notice that the patient may file a complaint under
 26 IC 25-1-7, including the mailing address and telephone
 27 number of the division of consumer protection of the office of
 28 the attorney general.
 29 (6) For balance bills totaling more than two hundred dollars
 30 (\$200), a statement in plain language that if the patient:
 31 (A) finalizes a payment plan agreement less than:
 32 (i) thirty (30) days after receiving the first balance bill
 33 statement that includes all health plan payments and
 34 reflects the final amount owed by the patient; or
 35 (ii) six (6) months after the receipt of health care
 36 services;
 37 whichever occurs first; and
 38 (B) substantially complies with the payment plan
 39 agreement;
 40 the facility based practitioner may not furnish adverse
 41 information to a consumer reporting agency regarding an
 42 amount owed by the patient for the receipt of health care

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services.
(h) For purposes of subsection (g)(6), a patient is considered substantially noncompliant with a payment plan agreement if the patient does not make payments in compliance with the agreement for at least forty-five (45) days.

(i) A violation of this section by a practitioner is grounds for disciplinary action under IC 25-1-7.

SECTION 4. IC 27-4-1-4, AS AMENDED BY P.L.1-2009, SECTION 146, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making,

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- 1 publishing, disseminating, or circulating of any oral or written
 2 statement or any pamphlet, circular, article, or literature which is
 3 false, or maliciously critical of or derogatory to the financial
 4 condition of an insurer, and which is calculated to injure any
 5 person engaged in the business of insurance.
- 6 (4) Entering into any agreement to commit, or individually or by
 7 a concerted action committing any act of boycott, coercion, or
 8 intimidation resulting or tending to result in unreasonable
 9 restraint of, or a monopoly in, the business of insurance.
- 10 (5) Filing with any supervisory or other public official, or making,
 11 publishing, disseminating, circulating, or delivering to any person,
 12 or placing before the public, or causing directly or indirectly, to
 13 be made, published, disseminated, circulated, delivered to any
 14 person, or placed before the public, any false statement of
 15 financial condition of an insurer with intent to deceive. Making
 16 any false entry in any book, report, or statement of any insurer
 17 with intent to deceive any agent or examiner lawfully appointed
 18 to examine into its condition or into any of its affairs, or any
 19 public official to which such insurer is required by law to report,
 20 or which has authority by law to examine into its condition or into
 21 any of its affairs, or, with like intent, willfully omitting to make a
 22 true entry of any material fact pertaining to the business of such
 23 insurer in any book, report, or statement of such insurer.
- 24 (6) Issuing or delivering or permitting agents, officers, or
 25 employees to issue or deliver, agency company stock or other
 26 capital stock, or benefit certificates or shares in any common law
 27 corporation, or securities or any special or advisory board
 28 contracts or other contracts of any kind promising returns and
 29 profits as an inducement to insurance.
- 30 (7) Making or permitting any of the following:
- 31 (A) Unfair discrimination between individuals of the same
 32 class and equal expectation of life in the rates or assessments
 33 charged for any contract of life insurance or of life annuity or
 34 in the dividends or other benefits payable thereon, or in any
 35 other of the terms and conditions of such contract. However,
 36 in determining the class, consideration may be given to the
 37 nature of the risk, plan of insurance, the actual or expected
 38 expense of conducting the business, or any other relevant
 39 factor.
- 40 (B) Unfair discrimination between individuals of the same
 41 class involving essentially the same hazards in the amount of
 42 premium, policy fees, assessments, or rates charged or made

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for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

- (i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;
- (ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or
- (iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or

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1 purchase as inducement to such insurance or annuity or in
2 connection therewith, any stocks, bonds, or other securities of any
3 insurance company or other corporation, association, limited
4 liability company, or partnership, or any dividends, savings, or
5 profits accrued thereon, or anything of value whatsoever not
6 specified in the contract. Nothing in this subdivision and
7 subdivision (7) shall be construed as including within the
8 definition of discrimination or rebates any of the following
9 practices:

10 (A) Paying bonuses to policyholders or otherwise abating their
11 premiums in whole or in part out of surplus accumulated from
12 nonparticipating insurance, so long as any such bonuses or
13 abatement of premiums are fair and equitable to policyholders
14 and for the best interests of the company and its policyholders.

15 (B) In the case of life insurance policies issued on the
16 industrial debit plan, making allowance to policyholders who
17 have continuously for a specified period made premium
18 payments directly to an office of the insurer in an amount
19 which fairly represents the saving in collection expense.

20 (C) Readjustment of the rate of premium for a group insurance
21 policy based on the loss or expense experience thereunder, at
22 the end of the first year or of any subsequent year of insurance
23 thereunder, which may be made retroactive only for such
24 policy year.

25 (D) Paying by an insurer or insurance producer thereof duly
26 licensed as such under the laws of this state of money,
27 commission, or brokerage, or giving or allowing by an insurer
28 or such licensed insurance producer thereof anything of value,
29 for or on account of the solicitation or negotiation of policies
30 or other contracts of any kind or kinds, to a broker, an
31 insurance producer, or a solicitor duly licensed under the laws
32 of this state, but such broker, insurance producer, or solicitor
33 receiving such consideration shall not pay, give, or allow
34 credit for such consideration as received in whole or in part,
35 directly or indirectly, to the insured by way of rebate.

36 (9) Requiring, as a condition precedent to loaning money upon the
37 security of a mortgage upon real property, that the owner of the
38 property to whom the money is to be loaned negotiate any policy
39 of insurance covering such real property through a particular
40 insurance producer or broker or brokers. However, this
41 subdivision shall not prevent the exercise by any lender of the
42 lender's right to approve or disapprove of the insurance company

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selected by the borrower to underwrite the insurance.
(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.
(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.
(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any policy of insurance covering such property through a particular insurance company, insurance producer, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.
(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:
(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.
(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.
(C) Title insurance.

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- 1 (D) Insurance written in connection with an indebtedness and
- 2 intended as a means of repaying such indebtedness in the
- 3 event of the death or disability of the insured.
- 4 (E) Insurance provided by or through motorists service clubs
- 5 or associations.
- 6 (F) Insurance that is provided to the purchaser or holder of an
- 7 air transportation ticket and that:
- 8 (i) insures against death or nonfatal injury that occurs during
- 9 the flight to which the ticket relates;
- 10 (ii) insures against personal injury or property damage that
- 11 occurs during travel to or from the airport in a common
- 12 carrier immediately before or after the flight;
- 13 (iii) insures against baggage loss during the flight to which
- 14 the ticket relates; or
- 15 (iv) insures against a flight cancellation to which the ticket
- 16 relates.
- 17 (14) Refusing, because of the for-profit status of a hospital or
- 18 medical facility, to make payments otherwise required to be made
- 19 under a contract or policy of insurance for charges incurred by an
- 20 insured in such a for-profit hospital or other for-profit medical
- 21 facility licensed by the state department of health.
- 22 (15) Refusing to insure an individual, refusing to continue to issue
- 23 insurance to an individual, limiting the amount, extent, or kind of
- 24 coverage available to an individual, or charging an individual a
- 25 different rate for the same coverage, solely because of that
- 26 individual's blindness or partial blindness, except where the
- 27 refusal, limitation, or rate differential is based on sound actuarial
- 28 principles or is related to actual or reasonably anticipated
- 29 experience.
- 30 (16) Committing or performing, with such frequency as to
- 31 indicate a general practice, unfair claim settlement practices (as
- 32 defined in section 4.5 of this chapter).
- 33 (17) Between policy renewal dates, unilaterally canceling an
- 34 individual's coverage under an individual or group health
- 35 insurance policy solely because of the individual's medical or
- 36 physical condition.
- 37 (18) Using a policy form or rider that would permit a cancellation
- 38 of coverage as described in subdivision (17).
- 39 (19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1
- 40 concerning motor vehicle insurance rates.
- 41 (20) Violating IC 27-8-21-2 concerning advertisements referring
- 42 to interest rate guarantees.

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- 1 (21) Violating IC 27-8-24.3 concerning insurance and health plan
 2 coverage for victims of abuse.
 3 (22) Violating IC 27-8-26 concerning genetic screening or testing.
 4 (23) Violating IC 27-1-15.6-3(b) concerning licensure of
 5 insurance producers.
 6 (24) Violating IC 27-1-38 concerning depository institutions.
 7 (25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning
 8 the resolution of an appealed grievance decision.
 9 (26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired
 10 July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1,
 11 2007, and repealed).
 12 (27) Violating IC 27-2-21 concerning use of credit information.
 13 (28) Violating IC 27-4-9-3 concerning recommendations to
 14 consumers.
 15 (29) Engaging in dishonest or predatory insurance practices in
 16 marketing or sales of insurance to members of the United States
 17 Armed Forces as:
 18 (A) described in the federal Military Personnel Financial
 19 Services Protection Act, P.L.109-290; or
 20 (B) defined in rules adopted under subsection (b).
 21 (30) Violating IC 27-8-19.8-20.1 concerning stranger originated
 22 life insurance.
 23 **(31) Violating IC 27-8-11-12 or IC 27-13-36-5.5 concerning**
 24 **balance bills.**
 25 (b) Except with respect to federal insurance programs under
 26 Subchapter III of Chapter 19 of Title 38 of the United States Code, the
 27 commissioner may, consistent with the federal Military Personnel
 28 Financial Services Protection Act (P.L.109-290), adopt rules under
 29 IC 4-22-2 to:
 30 (1) define; and
 31 (2) while the members are on a United States military installation
 32 or elsewhere in Indiana, protect members of the United States
 33 Armed Forces from;
 34 dishonest or predatory insurance practices.
 35 SECTION 5. IC 27-8-11-1, AS AMENDED BY P.L.26-2005,
 36 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 37 JULY 1, 2011]: Sec. 1. (a) The definitions in this section apply
 38 throughout this chapter.
 39 **(b) "Balance bill" means a noncontracted provider's charge to**
 40 **an insured of the difference between:**
 41 **(1) the noncontracted provider's fee for a health care service**
 42 **rendered to the insured; and**

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- 1 **(2) the sum of:**
- 2 **(A) the payments made by the insurer to the noncontracted**
- 3 **provider; plus**
- 4 **(B) the insured's cost sharing amounts;**
- 5 **for the health care service under the terms of the insured's**
- 6 **policy.**
- 7 ~~(b)~~ **(c) "Credentialing" means a process through which an insurer**
- 8 **makes a determination:**
- 9 (1) based on criteria established by the insurer; and
- 10 (2) concerning whether a provider is eligible to:
- 11 (A) provide health care services to an insured; and
- 12 (B) receive reimbursement for the health care services;
- 13 under an agreement entered into between the provider and the
- 14 insurer under section 3 of this chapter.
- 15 **(d) "Contracted provider" means a provider that has entered**
- 16 **into an agreement with an insurer under section 3 of this chapter.**
- 17 **(e) "Facility" means an entity that is licensed under IC 16-21.**
- 18 **(f) "Facility based provider" means an individual provider:**
- 19 **(1) to whom a facility has granted clinical privileges; and**
- 20 **(2) who renders health care services to patients who are**
- 21 **treated at the facility.**
- 22 **The term includes a group of individual providers.**
- 23 ~~(e)~~ **(g) "Health care services":**
- 24 (1) means health care related services or products rendered or
- 25 sold by a provider within the scope of the provider's license or
- 26 legal authorization; and
- 27 (2) includes hospital, medical, surgical, dental, vision, and
- 28 pharmaceutical services or products.
- 29 ~~(d)~~ **(h) "Insured" means an individual entitled to reimbursement for**
- 30 **expenses of health care services under a policy issued or administered**
- 31 **by an insurer.**
- 32 ~~(e)~~ **(i) "Insurer" means an insurance company authorized in this state**
- 33 **to issue policies that provide reimbursement for expenses of health care**
- 34 **services.**
- 35 **(j) "Noncontracted provider" means a provider that has not**
- 36 **entered into an agreement with an insurer under section 3 of this**
- 37 **chapter.**
- 38 ~~(f)~~ **(k) "Person" means an individual, an agency, a political**
- 39 **subdivision, a partnership, a corporation, an association, or any other**
- 40 **entity.**
- 41 ~~(g)~~ **(l) "Preferred provider plan" means an undertaking to enter into**
- 42 **agreements with providers relating to terms and conditions of**

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1 reimbursements for the health care services of insureds, members, or
 2 enrollees relating to the amounts to be charged to insureds, members,
 3 or enrollees for health care services.

4 ~~(h)~~ **(m)** "Provider" means an individual or entity duly licensed or
 5 legally authorized to provide health care services.

6 **(n) "Provider network" means a group of providers that have**
 7 **entered into one (1) or more agreements with an insurer under**
 8 **section 3 of this chapter.**

9 SECTION 6. IC 27-8-11-11, AS ADDED BY P.L.144-2009,
 10 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 11 JULY 1, 2011]: Sec. 11. ~~(a)~~ As used in this section, "noncontracted
 12 provider" means a provider that has not entered into an agreement with
 13 an insurer under section 3 of this chapter.

14 ~~(b)~~ After September 30, 2009, if an insurer makes a payment to an
 15 insured for a health care service rendered by a noncontracted provider,
 16 the insurer shall include with the payment instrument written notice to
 17 the insured that includes the following:

- 18 (1) A statement specifying the claims covered by the payment
 19 instrument.
- 20 (2) The name and address of the provider submitting each claim.
- 21 (3) The amount paid by the insurer for each claim.
- 22 (4) Any amount of a claim that is the insured's responsibility.
- 23 (5) A statement in at least 24 point bold type that:
 24 (A) instructs the insured to use the payment to pay the
 25 noncontracted provider if the insured has not paid the
 26 noncontracted provider in full;
 27 (B) specifies that paying the noncontracted provider is the
 28 insured's responsibility; and
 29 (C) states that the failure to make the payment violates the law
 30 and may result in collection proceedings or criminal penalties.

31 SECTION 7. IC 27-8-11-12 IS ADDED TO THE INDIANA CODE
 32 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 33 1, 2011]: Sec. 12. **(a) An insurer that uses a provider network shall**
 34 **provide notice to insureds of the following:**

- 35 **(1) A facility based provider or other provider may not be a**
 36 **contracted provider.**
- 37 **(2) A noncontracted provider may charge the insured a**
 38 **balance bill for amounts not paid under the insured's policy.**

39 **(b) The notice required by subsection (a) must meet the**
 40 **following requirements:**

- 41 **(1) The notice must be provided in writing to each insured as**
 42 **follows:**

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(A) Be included in any materials sent to the insured in conjunction with issuance or renewal of the insured's policy.

(B) Be included in an explanation of payment summary, or another document describing policy benefits, that is provided to the insured.

(C) Be conspicuously displayed on a policy related Internet web site that an insured is reasonably expected to access.

(2) The notice must include any additional requirements prescribed by the commissioner.

(3) The notice must be in substantially the following form:
"NOTICE: ALTHOUGH NONEMERGENCY HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A FACILITY THAT IS PART OF THE PROVIDER NETWORK USED BY YOUR POLICY, OTHER PROFESSIONAL SERVICES MAY BE PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE NOT PART OF THE PROVIDER NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR POLICY."

(c) A policy must clearly identify facility based providers who are contracted providers. A facility based provider identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or Internet web site directory.

(d) With any explanation of benefits that:

- (1) is sent to an insured; and
- (2) contains a remark code indicating that a payment has been made to a noncontracted provider at the policy's allowable or usual and customary amount;

the insurer must include the telephone number for the department of insurance consumer protection division for complaints regarding the payment.

(e) An insurer shall, upon request for a health care service or supply and not later than forty-eight (48) hours after a health care service or supply is preauthorized, provide to an insured, by electronic or written means, the following:

- (1) Information concerning whether a facility based provider or other provider is a contracted provider.

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- 1 **(2) Information concerning whether proposed nonemergency**
- 2 **care is covered under the insured's policy.**
- 3 **(3) Information concerning the extent of the insured's**
- 4 **personal responsibility for payment of applicable copayments,**
- 5 **deductibles, or other cost sharing amounts.**
- 6 **(4) Information concerning the extent of any coinsurance**
- 7 **owed based on the:**
 - 8 **(A) contracted provider's payment rate; or**
 - 9 **(B) insurer's usual and customary payment rate for**
 - 10 **noncontracted providers;**
 - 11 **whichever is applicable.**
 - 12 **(f) A violation of this chapter by an insurer is an unfair and**
 - 13 **deceptive act in the business of insurance under IC 27-4-1-4.**
 - 14 SECTION 8. IC 27-13-36-5.5 IS ADDED TO THE INDIANA
 - 15 CODE AS A NEW SECTION TO READ AS FOLLOWS
 - 16 [EFFECTIVE JULY 1, 2011]: **Sec. 5.5. (a) This section does not**
 - 17 **apply to health care services rendered as described in section 5 of**
 - 18 **this chapter.**
 - 19 **(b) As used in this section, "balance bill" means a**
 - 20 **nonparticipating provider's charge to an enrollee of the difference**
 - 21 **between:**
 - 22 **(1) the nonparticipating provider's fee for a health care**
 - 23 **service rendered to the enrollee; and**
 - 24 **(2) the sum of:**
 - 25 **(A) the payments made to the nonparticipating provider by**
 - 26 **the health maintenance organization; plus**
 - 27 **(B) the enrollee's cost sharing amounts;**
 - 28 **for the health care service under the terms of the enrollee's**
 - 29 **individual contract or group contract.**
 - 30 **(c) As used in this section, "facility" means an entity that is**
 - 31 **licensed under IC 16-21.**
 - 32 **(d) As used in this section, "facility based provider" means an**
 - 33 **individual provider:**
 - 34 **(1) to whom a facility has granted clinical privileges; and**
 - 35 **(2) who renders health care services to patients who are**
 - 36 **treated at the facility.**
 - 37 **The term includes a group of individual providers.**
 - 38 **(e) A health maintenance organization shall provide notice to**
 - 39 **enrollees of the following:**
 - 40 **(1) A facility based provider or other provider may not be a**
 - 41 **participating provider.**
 - 42 **(2) A provider who is not a participating provider may charge**

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- 1 the enrollee a balance bill for amounts not paid under the
- 2 enrollee's individual contract or group contract.
- 3 (f) The notice required by subsection (e) must meet the following
- 4 requirements:
- 5 (1) The notice must be provided in writing to each enrollee as
- 6 follows:
- 7 (A) Be included in any materials sent to the enrollee in
- 8 conjunction with issuance or renewal of the enrollee's
- 9 individual contract or group contract.
- 10 (B) Be included in an explanation of payment summary, or
- 11 another document describing individual contract or group
- 12 contract benefits, that is provided to the enrollee.
- 13 (C) Be conspicuously displayed on an individual contract
- 14 related or group contract related Internet web site that an
- 15 enrollee is reasonably expected to access.
- 16 (2) The notice must include any additional requirements
- 17 prescribed by the commissioner.
- 18 (3) The notice must be in substantially the following form:
- 19 "NOTICE: ALTHOUGH NONEMERGENCY HEALTH
- 20 CARE SERVICES MAY BE PROVIDED TO YOU AT A
- 21 FACILITY THAT IS PART OF THE PROVIDER
- 22 NETWORK USED BY YOUR HEALTH
- 23 MAINTENANCE ORGANIZATION, OTHER
- 24 PROFESSIONAL SERVICES MAY BE PROVIDED AT
- 25 OR THROUGH THE FACILITY BY PHYSICIANS AND
- 26 OTHER HEALTH CARE PROVIDERS WHO ARE NOT
- 27 PART OF THE PROVIDER NETWORK. YOU MAY BE
- 28 RESPONSIBLE FOR PAYMENT OF ALL OR PART OF
- 29 THE FEES FOR THOSE PROFESSIONAL SERVICES
- 30 THAT ARE NOT PAID OR COVERED BY YOUR
- 31 HEALTH MAINTENANCE ORGANIZATION
- 32 CONTRACT."
- 33 (g) An individual contract or a group contract must clearly
- 34 identify facility based providers who are participating providers.
- 35 A facility based provider identified under this subsection must be
- 36 identified in a separate and conspicuous manner in any
- 37 participating provider directory or Internet web site directory.
- 38 (h) With any explanation of benefits that:
- 39 (1) is sent to an enrollee; and
- 40 (2) contains a remark code indicating that a payment has been
- 41 made to a nonparticipating provider at the individual
- 42 contract's or group contract's allowable or usual and

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1 **customary amount;**
2 **the health maintenance organization must include the telephone**
3 **number for the department of insurance consumer protection**
4 **division for complaints regarding the payment.**
5 **(i) A health maintenance organization shall, upon request for a**
6 **health care service or supply and not later than forty-eight (48)**
7 **hours after a health care service or supply is preauthorized,**
8 **provide to an enrollee, by electronic or written means, the**
9 **following:**
10 **(1) Information concerning whether a facility based provider**
11 **or other provider is a participating provider.**
12 **(2) Information concerning whether proposed nonemergency**
13 **care is covered under the enrollee's individual contract or**
14 **group contract.**
15 **(3) Information concerning the extent of the enrollee's**
16 **personal responsibility for payment of applicable copayments,**
17 **deductibles, or other cost sharing amounts.**
18 **(4) Information concerning the extent of any coinsurance**
19 **owed based on:**
20 **(A) the participating provider's payment rate; or**
21 **(B) the health maintenance organization's usual and**
22 **customary payment rate for nonparticipating providers;**
23 **whichever is applicable.**
24 **(j) A violation of this chapter by a health maintenance**
25 **organization is an unfair and deceptive act in the business of**
26 **insurance under IC 27-4-1-4.**

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