



February 11, 2011

SENATE BILL No. 416

DIGEST OF SB 416 (Updated February 9, 2011 4:14 pm - DI 104)

Citations Affected: IC 4-13; IC 16-21; IC 27-8; IC 27-13.

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.
February 10, 2011, amended, reported favorably — Do Pass.

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SB 416—LS 6527/DI 97+



February 11, 2011

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)~~).

SB 416—LS 6527/DI 97+



- 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, "nonparticipating provider" means
 23 a provider or group of providers that is not part of a provider
 24 network.**

25 **(c) As used in this section, "participating provider" means a
 26 provider or group of providers that is part of a provider network.**

27 **(d) As used in this section, "provider network" means a group
 28 of two (2) or more providers that is represented by a person for
 29 purposes of negotiations with third parties.**

30 **(e) A facility shall provide to patients for nonemergency health
 31 care services, before admission or when a patient is initially treated
 32 at the facility, a conspicuous written disclosure that informs the
 33 patient that if:**

- 34 **(1) the facility is a participating provider; and**
- 35 **(2) a nonparticipating provider renders a health care service
 36 to the patient at the facility;**

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

39 **(f) A violation of this chapter by a facility is grounds for
 40 disciplinary action under this article.**

41 SECTION 3. IC 27-8-11-1, AS AMENDED BY P.L.26-2005,
 42 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

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1 JULY 1, 2011]: Sec. 1. (a) The definitions in this section apply
 2 throughout this chapter.
 3 **(b) "Balance bill" means a noncontracted provider's charge to**
 4 **an insured of the difference between:**
 5 **(1) the noncontracted provider's fee for a health care service**
 6 **rendered to the insured; and**
 7 **(2) the sum of:**
 8 **(A) the payments made by the insurer to the noncontracted**
 9 **provider; plus**
 10 **(B) the insured's cost sharing amounts;**
 11 **for the health care service under the terms of the insured's**
 12 **policy.**
 13 ~~(b)~~ **(c) "Credentialing" means a process through which an insurer**
 14 **makes a determination:**
 15 **(1) based on criteria established by the insurer; and**
 16 **(2) concerning whether a provider is eligible to:**
 17 **(A) provide health care services to an insured; and**
 18 **(B) receive reimbursement for the health care services;**
 19 **under an agreement entered into between the provider and the**
 20 **insurer under section 3 of this chapter.**
 21 **(d) "Contracted provider" means a provider that has entered**
 22 **into an agreement with an insurer under section 3 of this chapter.**
 23 **(e) "Facility" means an entity that is licensed under IC 16-21.**
 24 **(f) "Facility based provider" means an individual provider:**
 25 **(1) to whom a facility has granted clinical privileges; and**
 26 **(2) who renders health care services to patients who are**
 27 **treated at the facility.**
 28 **The term includes a group of individual providers.**
 29 ~~(f)~~ **(g) "Health care services":**
 30 **(1) means health care related services or products rendered or**
 31 **sold by a provider within the scope of the provider's license or**
 32 **legal authorization; and**
 33 **(2) includes hospital, medical, surgical, dental, vision, and**
 34 **pharmaceutical services or products.**
 35 ~~(f)~~ **(h) "Insured" means an individual entitled to reimbursement for**
 36 **expenses of health care services under a policy issued or administered**
 37 **by an insurer.**
 38 ~~(f)~~ **(i) "Insurer" means an insurance company authorized in this state**
 39 **to issue policies that provide reimbursement for expenses of health care**
 40 **services.**
 41 **(j) "Noncontracted provider" means a provider that has not**
 42 **entered into an agreement with an insurer under section 3 of this**

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chapter.

~~(f)~~ **(k)** "Person" means an individual, an agency, a political subdivision, a partnership, a corporation, an association, or any other entity.

~~(g)~~ **(l)** "Preferred provider plan" means an undertaking to enter into agreements with providers relating to terms and conditions of reimbursements for the health care services of insureds, members, or enrollees relating to the amounts to be charged to insureds, members, or enrollees for health care services.

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

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

SECTION 4. IC 27-8-11-11, AS ADDED BY P.L.144-2009, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 11. ~~(a)~~ As used in this section, "noncontracted provider" means a provider that has not entered into an agreement with an insurer under section 3 of this chapter.

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

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

SECTION 5. IC 27-8-11-12 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 12. (a) An insurer that uses a provider network shall provide notice to insureds of the following:**

- (1) A facility based provider or other provider may not be a contracted provider.**

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

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

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

7 (2) Information concerning whether proposed nonemergency
8 care is covered under the insured's policy.

9 (3) Information concerning the extent of the insured's
10 personal responsibility for payment of applicable copayments,
11 deductibles, or other cost sharing amounts.

12 (4) Information concerning the extent of any coinsurance
13 owed based on the:

14 (A) contracted provider's payment rate; or

15 (B) insurer's usual and customary payment rate for
16 noncontracted providers;

17 whichever is applicable.

18 (f) A violation of this chapter by an insurer is an unfair and
19 deceptive act in the business of insurance under IC 27-4-1-4.

20 SECTION 6. IC 27-13-36-5.5 IS ADDED TO THE INDIANA
21 CODE AS A NEW SECTION TO READ AS FOLLOWS
22 [EFFECTIVE JULY 1, 2011]: Sec. 5.5. (a) This section does not
23 apply to health care services rendered as described in section 5 of
24 this chapter.

25 (b) As used in this section, "balance bill" means a
26 nonparticipating provider's charge to an enrollee of the difference
27 between:

28 (1) the nonparticipating provider's fee for a health care
29 service rendered to the enrollee; and

30 (2) the sum of:

31 (A) the payments made to the nonparticipating provider by
32 the health maintenance organization; plus

33 (B) the enrollee's cost sharing amounts;

34 for the health care service under the terms of the enrollee's
35 individual contract or group contract.

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

38 (d) As used in this section, "facility based provider" means an
39 individual provider:

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

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

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The term includes a group of individual providers.

(e) A health maintenance organization shall provide notice to enrollees of the following:

(1) A facility based provider or other provider may not be a participating provider.

(2) A provider who is not a participating provider may charge the enrollee a balance bill for amounts not paid under the enrollee's individual contract or group contract.

(f) The notice required by subsection (e) must meet the following requirements:

(1) The notice must be provided in writing to each enrollee as follows:

(A) Be included in any materials sent to the enrollee in conjunction with issuance or renewal of the enrollee's individual contract or group contract.

(B) Be included in an explanation of payment summary, or another document describing individual contract or group contract benefits, that is provided to the enrollee.

(C) Be conspicuously displayed on an individual contract related or group contract related Internet web site that an enrollee 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 HEALTH MAINTENANCE ORGANIZATION, 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 HEALTH MAINTENANCE ORGANIZATION CONTRACT."

(g) An individual contract or a group contract must clearly identify facility based providers who are participating providers. A facility based provider identified under this subsection must be identified in a separate and conspicuous manner in any

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

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COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 416, 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 3, delete lines 22 through 27.

Page 3, line 28, delete "(c)" and insert "**(b)**".

Page 3, line 31, delete "(d)" and insert "**(e)**".

Page 3, line 33, delete "(e)" and insert "**(d)**".

Page 3, line 36, delete "(f)" and insert "**(e)**".

Page 3, line 36, delete "implement written policies related to billing" and insert "**provide to**".

Page 3, line 37, delete "services as follows:" and insert "**services,**".

Page 3, line 38, delete "(1) A policy for,".

Page 3, run in lines 37 and 38.

Page 3, line 39, delete "provision of".

Page 3, line 40, delete "patient:" and insert "**patient that if:**

(1) the facility is a participating provider; and

(2) 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."

Page 3, delete lines 41 through 42.

Page 4, delete lines 1 through 18.

Page 4, line 19, delete "(g)" and insert "**(f)**".

Page 4, delete lines 21 through 42.

Delete pages 5 through 11.

Page 12, delete lines 1 through 34.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 416 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 8, Nays 0.

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