March 28, 2017

ENGROSSED
HOUSE BILL No. 1273

DIGEST OF HB 1273 (Updated March 23, 2017 2:27 pm - DI 97)

Citations Affected: IC 25-1; noncode.

Synopsis: Network provider referrals. Specifies notice requirements for network health care providers that make referrals to out of network health care providers. Provides for exceptions to the notice requirements.

Effective: July 1, 2017.

Baird, Heaton, Harris, Schaibley, Austin, Carbaugh

(SENATE SPONSORS — CRIDER, BRAY, GROOMS)

January 10, 2017, read first time and referred to Committee on Insurance.
February 20, 2017, amended, reported — Do Pass.
February 23, 2017, read second time, amended, ordered engrossed.
February 24, 2017, engrossed.
February 27, 2017, read third time, passed. Yeas 93, nays 0.

SENATE ACTION

March 1, 2017, read first time and referred to Committee on Insurance and Financial Institutions.
March 27, 2017, amended, reported favorably — Do Pass.

March 28, 2017

First Regular Session of the 120th General Assembly (2017)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2016 Regular Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1273

A BILL FOR AN ACT to amend the Indiana Code concerning professions and occupations.

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

SECTION 1. IC 25-1-9.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]:

Chapter 9.1. Out of Network Provider Referrals

Sec. 1. (a) This chapter applies to a referral made after December 31, 2017.

(b) This chapter does not apply to the following:

(1) A referral for treatment of an emergency medical condition.

(2) A referral made:

(A) immediately following treatment of an emergency medical condition; and

(B) by the provider that rendered the treatment of the emergency medical condition.

(3) A referral for medically or psychologically necessary therapeutic services rendered to an admitted patient in:

(A) a hospital; or

(B) another facility to which a patient may be admitted for more than twenty-four (24) hours.

Sec. 2. As used in this chapter, "affiliated" refers to a provider that is a member of the same provider group as another provider.

Sec. 3. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 4. As used in this chapter, "emergency medical condition" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(1) place an individual's (including, with respect to a pregnant woman, her unborn child's) health in serious jeopardy;

(2) result in serious impairment to the individual's (including, with respect to a pregnant woman, her unborn child's) bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual (including, with respect to a pregnant woman, her unborn child).

Sec. 5. (a) As used in this chapter, "health plan" means:

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

(2) an individual contract or a group contract with a health maintenance organization under IC 27-13; or

(3) another plan or program that provides payment, reimbursement, or indemnification for the costs of health care items or services;

that conditions the payment of benefits, in whole or in part, on a covered individual's use of providers that have agreed to be part of a network.

(b) The term does not include the following:

(1) Worker's compensation or similar insurance.

(2) Benefits provided under a certificate of exemption issued by the worker's compensation board under IC 22-3-2-5.

(3) Medicaid (IC 12-15).

Sec. 6. As used in this chapter, "network" means a group of two (2) or more providers that have entered into:

(1) an agreement with an insurer under IC 27-8-11-3;

(2) a participating provider contract with a health maintenance organization under IC 27-13; or

(3) an agreement with another person specifying terms and

conditions of the providers' rendering of health care items or services to covered individuals.

Sec. 7. As used in this chapter, "network provider" means a provider described in section 6 of this chapter.

Sec. 8. As used in this chapter, "out of network provider" means a provider that is not described in section 6 of this chapter.

Sec. 9. (a) As used in this chapter, "provider" means a practitioner described in IC 25-1-9-2(1).

(b) The term does not include an individual who holds a license, certification, registration, or permit issued under the following:

(1) IC 25-19.

(2) IC 25-38.1.

(c) The term includes a provider group.

Sec. 10. As used in this chapter, "provider group" means a legal entity:

(1) that is owned by or employs one (1) or more providers; and

(2) through which billing is performed for health care items and services rendered by the providers.

Sec. 11. (a) As used in this chapter, "referral" means a recommendation or direction made by a provider to a covered individual that the covered individual receive a health care item or service rendered by another provider that is not affiliated with the first provider.

(b) The term does not include a recommendation or direction made by a provider to a covered individual that the covered individual receive a health care item or service rendered by another provider that is:

(1) affiliated with; or

(2) not specifically identified by name by;

the first provider.

Sec. 12. (a) This section does not apply to a referral made by a provider that has confirmed that the provider to which a covered individual is referred is a network provider with respect to the covered individual's health plan.

(b) A provider that makes a referral shall provide to the covered individual an electronic or paper copy of written notice that states all the following:

(1) That an out of network provider may be called upon to render health care items or services to the covered individual during the course of treatment.

(2) That an out of network provider described in subdivision

(1) is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.

(3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out of network provider described in subdivision (1):

(A) to obtain a list of network providers that may render the health care items or services; and

(B) for additional assistance.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1273, 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:

Delete the title and insert the following:

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

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1273 as introduced.)

CARBAUGH

Committee Vote: yeas 10, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1273 be amended to read as follows:

Page 3, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 2. IC 5-10-8.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]:

Chapter 8.2. Government Employee Health Plans; Out of Network Health Care Services

Sec. 1. As used in this chapter, "administrator" means the following:

(1) For purposes of a state employee health plan:

(A) the state personnel department; or

(B) an entity with which the state contracts to administer the health coverage.

(2) For purposes of a local unit health plan:

(A) the executive (as defined in IC 36-1-2-5) of the local unit; or

(B) an entity with which the local unit contracts to administer the health coverage.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a government

employee health plan.

Sec. 3. As used in this chapter, "emergency" has the meaning set forth in IC 27-8-11-1.

Sec. 4. As used in this chapter, "government employee health plan" means the following:

(1) A state employee health plan.

(2) A local unit health plan.

Sec. 5. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

Sec. 6. As used in this chapter, "independent data base" means a data base that is approved by the commissioner under IC 27-1-3-34.

Sec. 7. As used in this chapter, "in network" refers to a provider that has entered into an agreement to be part of a network that applies to coverage under a covered individual's government employee health plan.

Sec. 8. As used in this chapter, "local unit health plan" means a self-insurance program established or maintained under IC 5-10-8-2.2(d)(2) or IC 5-10-8-2.6(b)(2) to provide group health coverage.

Sec. 9. As used in this chapter, "network" means a group of two (2) or more providers that, individually or through a third party representative, have entered into an agreement to provide health care services to a covered individual.

Sec. 10. As used in this chapter, "out of network" refers to a provider that has not entered into an agreement to be part of a network that applies to coverage under a covered individual's government employee health plan.

Sec. 11. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 12. As used in this chapter, "state employee health plan" means a self-insurance program established or maintained under IC 5-10-8-7(b) to provide group health coverage.

Sec. 13. (a) This section applies to a government employee health plan:

(1) that is established, amended, or renewed after June 30, 2017; and

(2) to which a network applies.

(b) As used in this section, "care obtained in an emergency" means, with respect to a covered individual, covered health care services that are:

(1) rendered by a provider within the scope of the provider's

license and as otherwise authorized under law; and

(2) needed to evaluate or stabilize an individual in an emergency.

(c) As used in this section, "stabilize" means to render medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(1) The discharge of the individual from an emergency department or other care setting where emergency health care services are rendered to the individual.

(2) The transfer of the individual:

(A) from an emergency department or other care setting where emergency health care services are rendered to the individual; and

(B) to another health care facility.

(3) The transfer of the individual:

(A) from a hospital emergency department or other hospital care setting where emergency health care services are rendered to the individual; and

(B) to the hospital's inpatient setting.

(d) As described in subsection (e), a government employee health plan shall cover and reimburse expenses for care obtained in an emergency by a covered individual without:

(1) prior authorization; or

(2) regard to whether the provider who rendered the health care services to the covered individual in an emergency is in network or out of network;

in a situation where a prudent lay person could reasonably believe that the covered individual's condition required immediate medical attention. The emergency care obtained by a covered individual under this section includes care for the alleviation of severe pain, which is a symptom of an emergency.

(e) A government employee health plan shall cover and reimburse expenses for emergency health care services at a rate equal to the lesser of the following:

(1) In accordance with an independent data base, the usual, customary, and reasonable charge in the government employee health plan's service area for health care services rendered during the emergency.

(2) An amount agreed to between the administrator and the out of network provider.

A provider that renders emergency health care services to a covered individual under this section may not charge the covered individual except for an applicable copayment, coinsurance, or deductible. Care and treatment rendered to a covered individual once the covered individual is stabilized is not care obtained in an emergency.

Sec. 14. (a) This section applies to a government employee health plan:

(1) that is established, amended, or renewed after June 30, 2017; and

(2) to which a network applies.

(b) A government employee health plan:

(1) must provide for direct payment to an out of network provider described in IC 16-21-2.5-5(2)(B) or IC 25-1-9.1-6(2)(B) an amount equal to or less than the payments to providers:

(A) of the same specialty; and

(B) for the same health care services;

at the sixtieth percentile in the same geographic area according to an independent data base that is available for the geographic area in which the health care services described in IC 16-21-2.5-5(2) or IC 25-1-9.1-6(2) are provided; and

(2) may not require a covered individual to pay to an out of network provider described in IC 16-21-2.5-5(2)(B) or IC 25-1-9.1-6(2)(B) an amount that exceeds the coinsurance, deductible, copayment, or other out of pocket part:

(A) of the amount payable on a claim under subdivision (1); and

(B) that is the covered individual's responsibility under the government employee health plan.

(c) An administrator shall provide for mediation of a dispute between the administrator and an out of network provider as follows:

(1) The amount in controversy on a disputed claim must be at least five hundred dollars ($500) per billing code net of:

(A) the government employee health plan's out of network payment amount; and

(B) the covered individual's out of pocket amount;

under the government employee health plan.

(2) The out of network provider alleges that the amount payable under subsection (b) does not properly recognize:

(A) the out of network provider's training, qualifications,

and length of time in practice;

(B) the nature of the health care services;

(C) usual and customary charges for providers practicing in the same geographic area; and

(D) other aspects of the out of network provider's practice that are relevant to the value of the health care services.

(3) The out of network provider may initiate mediation by providing written notice of the dispute to the administrator.

(4) A single mediation may consider more than one (1) dispute between the out of network provider and the administrator if the claims are similar or involve common questions of fact or law.

(5) Upon receipt of a notice under subdivision (3), the administrator shall:

(A) select a different mediator for each mediation initiated under this section from the list of mediators approved by the commissioner under IC 27-1-3-34; and

(B) rotate the choice of a mediator among all approved mediators before repeating a selection.

(6) Mediation resolution must occur less than thirty (30) days after the date the notice described in subdivision (3) is received by the administrator.

(7) The mediator must accept either the out of network provider's or the administrator's reimbursement proposal.

(8) The physician fee schedule that applies to Medicare (42 U.S.C. 1395 et seq.) may not be used as a reference for the mediation process.

(d) Subsection (c) does not waive any rights of a covered individual or out of network provider to file a civil action or an administrative complaint:

(1) for alleged regulatory noncompliance of an administrator; or

(2) if the amount in controversy is less than the amount described in subsection (c)(1).".

Page 5, line 13, after "patient's" insert "**government employee health plan under IC 5-10-8.2-14 or**".

Page 6, line 24, after "by" insert "**IC 5-10-8.2-14 or**".

Page 8, line 3, after "patient's" insert "**government employee health plan under IC 5-10-8.2-14 or**".

Page 9, line 12, after "by" insert "**IC 5-10-8.2-14 or**".

Page 9, line 30, after "by" insert "**administrators under IC 5-10-8.2-14 and**".

Page 9, delete lines 36 through 39, begin a new line block indented and insert:

"**(1) approve, for use by:**

(A) administrators and out of network providers under IC 5-10-8.2-14; and

(B) insurers and out of network providers under IC 27-8-11-3;

in mediating disputes, at least one (1) mediator that meets criteria (including an appropriate mediation process) determined by the commissioner; and".

Renumber all SECTIONS consecutively.

(Reference is to HB 1273 as printed February 20, 2017.)

CARBAUGH

COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred House Bill No. 1273, 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:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning professions and occupations.

Page 1, delete lines 1 through 17.

Delete pages 2 through 10.

Page 11, delete lines 1 through 11.

Page 11, line 12, delete "6." and insert "1.".

Page 11, line 15, delete "Providers" and insert "**Provider Referrals**".

Page 11, line 16, delete "health care service rendered" and insert "**referral made after December 31, 2017.**".

Page 11, delete line 17.

Page 11, delete lines 19 through 42, begin a new line block indented and insert:

"**(1) A referral for treatment of an emergency medical condition.**

(2) A referral made:

(A) immediately following treatment of an emergency

medical condition; and

(B) by the provider that rendered the treatment of the emergency medical condition.

(3) A referral for medically or psychologically necessary therapeutic services rendered to an admitted patient in:

(A) a hospital; or

(B) another facility to which a patient may be admitted for more than twenty-four (24) hours.".

Delete pages 12 through 13.

Page 14, delete lines 1 through 30, begin a new paragraph and insert:

"**Sec. 2. As used in this chapter, "affiliated" refers to a provider that is a member of the same provider group as another provider.**

Sec. 3. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 4. As used in this chapter, "emergency medical condition" means a medical condition that arises".

Page 14, line 36, after "individual's" insert "**(including, with respect to a pregnant woman, her unborn child's)**".

Page 14, line 37, after "individual's" insert "**(including, with respect to a pregnant woman, her unborn child's)**".

Page 14, line 40, delete "." and insert "**(including, with respect to a pregnant woman, her unborn child).**".

Page 14, delete lines 41 through 42, begin a new paragraph and insert:

"**Sec. 5. (a) As used in this chapter, "health plan" means:**

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

(2) an individual contract or a group contract with a health maintenance organization under IC 27-13; or

(3) another plan or program that provides payment, reimbursement, or indemnification for the costs of health care items or services;

that conditions the payment of benefits, in whole or in part, on a covered individual's use of providers that have agreed to be part of a network.

(b) The term does not include the following:

(1) Worker's compensation or similar insurance.

(2) Benefits provided under a certificate of exemption issued by the worker's compensation board under IC 22-3-2-5.

(3) Medicaid (IC 12-15).

Sec. 6. As used in this chapter, "network" means a group of two

(2) or more providers that have entered into:

(1) an agreement with an insurer under IC 27-8-11-3;

(2) a participating provider contract with a health maintenance organization under IC 27-13; or

(3) an agreement with another person specifying terms and conditions of the providers' rendering of health care items or services to covered individuals.

Sec. 7. As used in this chapter, "network provider" means a provider described in section 6 of this chapter.

Sec. 8. As used in this chapter, "out of network provider" means a provider that is not described in section 6 of this chapter.

Sec. 9. (a) As used in this chapter, "provider" means a practitioner described in IC 25-1-9-2(1).

(b) The term does not include an individual who holds a license, certification, registration, or permit issued under the following:

(1) IC 25-19.

(2) IC 25-38.1.

(c) The term includes a provider group.

Sec. 10. As used in this chapter, "provider group" means a legal entity:

(1) that is owned by or employs one (1) or more providers; and

(2) through which billing is performed for health care items and services rendered by the providers.

Sec. 11. (a) As used in this chapter, "referral" means a recommendation or direction made by a provider to a covered individual that the covered individual receive a health care item or service rendered by another provider that is not affiliated with the first provider.

(b) The term does not include a recommendation or direction made by a provider to a covered individual that the covered individual receive a health care item or service rendered by another provider that is:

(1) affiliated with; or

(2) not specifically identified by name by;

the first provider.

Sec. 12. (a) This section does not apply to a referral made by a provider that has confirmed that the provider to which a covered individual is referred is a network provider with respect to the covered individual's health plan.

(b) A provider that makes a referral shall provide to the covered individual an electronic or paper copy of written notice that states

all the following:

(1) That an out of network provider may be called upon to render health care items or services to the covered individual during the course of treatment.

(2) That an out of network provider described in subdivision (1) is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.

(3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out of network provider described in subdivision (1):

(A) to obtain a list of network providers that may render the health care items or services; and

(B) for additional assistance.".

Delete pages 15 through 18.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1273 as reprinted February 24, 2017.)

HOLDMAN, Chairperson

Committee Vote: Yeas 7, Nays 1.