COMMITTEE REPORT

MADAM PRESIDENT:

The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1004, 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 everything after the enacting clause and insert the following:

SECTION 1. IC 12-7-2-174.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 174.7. (a) "Service facility location", for purposes of IC 12-15-11, means the address where the services of a provider facility or practitioner were provided.**

(b) The term consists of exact address and place of service codes as required on CMS forms 1500 and 1450, including an office, on-campus location of a hospital, and off-campus location of a hospital.

SECTION 2. IC 12-15-11-5, AS AMENDED BY P.L.195-2018, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 5. (a) A provider who participates in the Medicaid program must comply with the enrollment requirements that are established under rules adopted under IC 4-22-2 by the secretary.

(b) A provider who participates in the Medicaid program may be required to ~~use the centralized credentials verification organization established in section 9 of this chapter.~~ **include the address of the service facility location in order to obtain Medicaid reimbursement for a claim for health care services from the office or a managed**

care organization.

(c) The office or a managed care organization is not required to accept a claim for health care services that does not contain the service facility location.

SECTION 3. IC 12-15-11-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 6. **(a)** After a provider signs a provider agreement under this chapter, the office may not exclude the provider from participating in the Medicaid program by entering into an exclusive contract with another provider or group of providers, except as provided under section 7 of this chapter.

(b) The office or a managed care organization contracting with the office may not prohibit a provider from participating in a network of another insurer, managed care organization, or health maintenance organization.

SECTION 4. IC 16-18-2-163.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 163.6. (a) "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-1.**

(b) "Health care services", for purposes of IC 16-51-2, has the meaning set forth in IC 16-51-2-1.

SECTION 5. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 167.8. (a) "Health maintenance organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.**

(b) "Health maintenance organization", for purposes of IC 16-51-2, has the meaning set forth in IC 16-51-2-2.

SECTION 6. IC 16-18-2-188.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 188.4. "Individual provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.**

SECTION 7. IC 16-18-2-190.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.7. "Institutional provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.**

SECTION 8. IC 16-18-2-190.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.8. "Institutional provider form", for purposes of IC 16-51-1, has the meaning set forth in**

IC 16-51-1-5.

SECTION 9. IC 16-18-2-190.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.9. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

(b) "Insurer", for purposes of IC 16-51-2, has the meaning set forth in IC 16-51-2-3.

SECTION 10. IC 16-18-2-254.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 254.7. "Office setting", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**

SECTION 11. IC 16-18-2-288, AS AMENDED BY P.L.96-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 288. (a) "Practitioner", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-5.

(b) "Practitioner", for purposes of IC 16-41-14, has the meaning set forth in IC 16-41-14-4.

(c) "Practitioner", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-3.

(d) "Practitioner", for purposes of IC 16-42-22 and IC 16-42-25, has the meaning set forth in IC 16-42-22-4.5.

(e) "Practitioner", for purposes of IC 16-51-2, has the meaning set forth in IC 16-51-2-4.

SECTION 12. IC 16-18-2-295, AS AMENDED BY P.L.161-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 295. (a) "Provider", for purposes of IC 16-21-8, has the meaning set forth in IC 16-21-8-0.2.

(b) "Provider", for purposes of IC 16-38-5, IC 16-39 (except for IC 16-39-7), and IC 16-41-1 through IC 16-41-9, means any of the following:

(1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:

(A) A physician.

(B) A psychotherapist.

(C) A dentist.

(D) A registered nurse.

(E) A licensed practical nurse.

(F) An optometrist.

(G) A podiatrist.

(H) A chiropractor.

(I) A physical therapist.
(J) A psychologist.
(K) An audiologist.
(L) A speech-language pathologist.
(M) A dietitian.
(N) An occupational therapist.
(O) A respiratory therapist.
(P) A pharmacist.
(Q) A sexual assault nurse examiner.

(2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or described in IC 12-24-1 or IC 12-29.

(3) A health facility licensed under IC 16-28-2.

(4) A home health agency licensed under IC 16-27-1.

(5) An employer of a certified emergency medical technician, a certified advanced emergency medical technician, or a licensed paramedic.

(6) The state department or a local health department or an employee, agent, designee, or contractor of the state department or local health department.

(c) "Provider", for purposes of IC 16-39-7-1, has the meaning set forth in IC 16-39-7-1(a).

(d) "Provider", for purposes of IC 16-48-1, has the meaning set forth in IC 16-48-1-3.

(e) "Provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-8.

SECTION 13. IC 16-18-2-295.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 295.3. "Provider facility", for purposes of IC 16-51-2, has the meaning set forth in IC 16-51-2-5.**

SECTION 14. IC 16-18-2-327.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 327.7. "Service facility location", for purposes of IC 16-51-2, has the meaning set forth in IC 16-51-2-6.**

SECTION 15. IC 16-51 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

ARTICLE 51. HEALTH CARE REQUIREMENTS

Chapter 1. Health Care Provider Billing

Sec. 1. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal

authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 2. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 3. (a) As used in this chapter, "individual provider form" means a medical claim form, including an electronic version of the form, that:

(1) is accepted by the federal Centers for Medicare and Medicaid Services for use by individual providers or groups of providers; and

(2) includes a claim field for disclosure of the site at which the health care services to which the form relates were provided.

(b) The term includes the following:

(1) The CMS-1500 form.

(2) The HCFA-1500 form.

Sec. 4. As used in this chapter, "institutional provider" means a facility, operated by a hospital licensed under IC 16-21-2, in which both of the following services are provided:

(1) Emergency services.

(2) Inpatient services.

Sec. 5. (a) As used in this chapter, "institutional provider form" means a medical claim form, including an electronic version of the form, that is accepted by the federal Centers for Medicare and Medicaid Services for use by institutional providers.

(b) The term includes the following:

(1) The 837 Institutional form.

(2) The CMS-1450 form.

(3) The UB-04 form.

Sec. 6. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(e).

Sec. 7. As used in this chapter, "office setting" means a location not physically located within the facility of an institutional provider and where a provider routinely provides health examinations and diagnosis and treatment of illness or injury on an ambulatory basis.

Sec. 8. As used in this chapter, "provider" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 9. (a) A bill for health care services provided by a provider in an office setting:

(1) must not be submitted on an institutional provider form;

and

(2) must be submitted on an individual provider form.

(b) An insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services provided by a provider in an office setting is not required to accept a bill for the health care services that is submitted on an institutional provider form.

(c) This section applies only to an institutional provider form or an individual provider form submitted after December 31, 2020.

Sec. 10. Before March 1 of each year an insurer and health maintenance organization shall submit information, specified by the department of insurance, concerning compliance by providers under this chapter.

Sec. 11. The department of insurance shall adopt rules under IC 4-22-2 for the enforcement of this chapter.

Chapter 2. Health Care Service Location Billing

Sec. 1. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 2. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

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

Sec. 4. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 5. As used in this chapter, "provider facility" means any of the following:

(1) A hospital.

(2) A skilled nursing facility.

(3) An end stage renal disease provider.

(4) A home health agency.

(5) A hospice organization.

(6) An outpatient physical therapy, occupational therapy, or speech pathology service provider.

(7) A comprehensive outpatient rehabilitation facility.

(8) A community mental health center.

(9) A critical access hospital.

(10) A federally qualified health center.

(11) A histocompatibility laboratory.

(12) An Indian health service facility.

(13) An organ procurement organization.

(14) A religious nonmedical health care institution.

(15) A rural health clinic.

Sec. 6. As used in this chapter, "service facility location" means the address where the services of a provider facility or practitioner were provided. The term consists of exact address and place of service codes as required on CMS forms 1500 and 1450, including an office, on-campus location of a hospital, and off-campus location of a hospital.

Sec. 7. (a) A provider facility or practitioner shall include the address of the service facility location in order to obtain reimbursement for a commercial claim for health care services from an insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services.

(b) An insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services is not required to accept a bill for health care services that does not contain the service facility location.

Sec. 8. A patient is not liable for any additional payment that is the result of a practitioner or provider facility filing an incorrect form or not including the correct service facility location as required under this chapter.

SECTION 16. IC 25-1-9-23 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 23. (a) As used in this section, "covered individual" means an individual who is entitled to be provided health care services at a cost established according to a network plan.**

(b) As used in this section, "in network practitioner" means a practitioner who is required under a network plan to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

(c) As used in this section, "network plan" means a plan under which facilities and practitioners are required by contract to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

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

(1) An individual licensed under IC 25 who provides professional health care services to individuals in a facility.

(2) An organization:

(A) that consists of practitioners described in subdivision (1); and

(B) through which practitioners described in subdivision (1) provide health care services.

(3) An entity that:

(A) is not a facility; and

(B) employs practitioners described in subdivision (1) to provide health care services.

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

(f) An out of network practitioner who provides health care services to a covered individual may charge more for the health care services than allowed according to the rate or amount of compensation established by the individual's network plan if all of the following conditions are met:

(1) At least five (5) days before the health care services are scheduled to be provided to the covered individual, the practitioner provides to the covered individual, on a form separate from any other form provided to the covered individual by the practitioner, a statement in conspicuous type at least as large as fourteen (14) point type that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of practitioner] intends to charge you more for [name or description of health care services] than allowed according to the rate or amount of compensation established by the network plan applying to your coverage. [Name of practitioner] is not entitled to charge this much for [name or description of health care services] unless you give your written consent to the charge.".

(B) Sets forth the practitioner's good faith estimate of the amount that the practitioner intends to charge for the health care services provided to the covered individual.

(C) Includes a notice reading substantially as follows concerning the good faith estimate set forth under clause (B): "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate of the amount we will charge. If our actual charge for [name or description of health care services] exceeds our

estimate, we will explain to you why the charge exceeds the estimate.".

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

(g) If the charge of a practitioner for health care services provided to a covered individual exceeds the estimate provided to the covered individual under subsection (f)(1)(B), the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

SECTION 17. IC 25-1-9.8 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 9.8. Practitioner Good Faith Estimates

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to be provided health care services according to a health carrier's network plan.

Sec. 1.5. As used in this chapter, "episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.

Sec. 2. As used in this chapter, "good faith estimate" means a reasonable estimate of the price a practitioner anticipates charging for an episode of care for nonemergency health care services that:

(1) is made by a practitioner under this chapter upon the request of:

(A) the individual for whom the nonemergency health care service has been ordered; or

(B) the provider facility in which the nonemergency health care service will be provided; and

(2) is not binding upon the practitioner.

Sec. 3. (a) As used in this chapter, "health carrier" means an entity:

(1) that is subject to IC 27 and the administrative rules adopted under IC 27; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term also includes the following:

(1) An insurer, as defined in IC 27-1-2-3(x), that issues a policy of accident and sickness insurance, as defined in IC 27-8-5-1(a).

(2) A health maintenance organization, as defined in IC 27-13-1-19.

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined by IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

Sec. 4. As used in this chapter, "in network", when used in reference to a practitioner, means that the health care services provided by the practitioner are subject to a health carrier's network plan.

Sec. 5. (a) As used in this chapter, "network" means a group of provider facilities and practitioners that:

(1) provide health care services to covered individuals; and

(2) have agreed to, or are otherwise subject to, maximum limits on the prices for the health care services to be provided to the covered individuals.

(b) The term includes the following:

(1) A network described in subsection (a) that is established pursuant to a contract between an insurer providing coverage under a group health policy and:

(A) individual provider facilities and practitioners;

(B) a preferred provider organization; or

(C) an entity that employs or represents providers, including:

(i) an independent practice association; and

(ii) a physician-hospital organization.

(2) A health maintenance organization, as defined in IC 27-13-1-19.

Sec. 6. As used in this chapter, "network plan" means a plan of a health carrier that:

(1) requires a covered person to receive; or

(2) creates incentives, including financial incentives, for a covered person to receive;

health care services from one (1) or more providers that are under contract with, managed by, or owned by the health carrier.

Sec. 7. As used in this chapter, "nonemergency health care

service" means a discrete service or series of services ordered by a practitioner for an episode of care for the:

(1) diagnosis;

(2) prevention;

(3) treatment;

(4) cure; or

(5) relief;

of a physical, mental, or behavioral health condition, illness, injury, or disease that is not provided on an emergency or urgent care basis.

Sec. 8. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 8.5. As used in this chapter, "price" means the negotiated rate between the:

(1) provider facility and practitioner; and

(2) covered individual's primary health carrier.

Sec. 9. As used in this chapter, "provider" means:

(1) a provider facility; or

(2) a practitioner.

Sec. 10. As used in this chapter, "provider facility"means any of the following:

(1) A hospital licensed under IC 16-21-2.

(2) An ambulatory outpatient surgery center licensed under IC 16-21-2.

(3) An abortion clinic licensed under IC 16-21-2.

(4) A birthing center licensed under IC 16-21-2.

(5) Except for an urgent care facility (as defined by IC 27-1-46-10.5), a facility that provides diagnostic services to the medical profession or the general public.

(6) A laboratory where clinical pathology tests are carried out on specimens to obtain information about the health of a patient.

(7) A facility where radiologic and electromagnetic images are made to obtain information about the health of a patient.

(8) An infusion center that administers intravenous medications.

Sec. 11. (a) This section does not apply to an individual who is a Medicaid recipient.

(b) An individual for whom a nonemergency health care service has been ordered may request from the practitioner who may provide the nonemergency health care service a good faith estimate

of the total price the practitioner will charge for providing the nonemergency health care service.

(c) A practitioner who receives a request from a patient under subsection (b) shall, not more than five (5) business days after receiving all the relevant information from the individual, provide to the individual a good faith estimate of the price that the practitioner will charge for providing the nonemergency health care service.

(d) A practitioner must ensure that a good faith estimate provided to an individual under this section is accompanied by a notice stating that:

(1) an estimate provided under this section is not binding on the practitioner;

(2) the price the practitioner charges the individual may vary from the estimate based on the individual's medical needs; and

(3) the estimate provided under this section is only valid for thirty (30) days.

(e) A practitioner may not charge an individual for information provided under this section.

Sec. 12. (a) If:

(1) the individual who requests a good faith estimate from a practitioner under this chapter is a covered individual with respect to a network plan; and

(2) the practitioner from which the individual requests the good faith estimate is in network with respect to the same network plan;

the good faith estimate that the practitioner provides to the individual under this chapter must be based on the negotiated price to which the practitioner has agreed as an in network provider.

(b) If the individual who requests a good faith estimate from a practitioner under this chapter:

(1) is not a covered individual with respect to any network plan; or

(2) is not a covered individual with respect to a network plan with respect to which the practitioner is in network;

the good faith estimate that the practitioner provides to the individual under this chapter must be based on the price that the practitioner charges for the nonemergency health care service in the absence of any network plan.

Sec. 13. A practitioner may provide a good faith estimate to an individual under this chapter:

(1) in a writing delivered to the individual;

(2) by electronic mail; or

(3) through a mobile application or other Internet web based method, if available;

according to the preference expressed by the individual.

Sec. 14. (a) A good faith estimate provided by a practitioner to an individual under this chapter must meet the following requirements:

(1) Provide a summary of the services and material items that the good faith estimate is based on.

(2) Include:

(A) the price that the provider facility in which the health care service will be performed will charge for:

(i) the use of the provider facility to care for the individual for the nonemergency health care service;

(ii) the services rendered by the staff of the provider facility in connection with the nonemergency health care service; and

(iii) medication, supplies, equipment, and material items to be provided to or used by the individual while the individual is present in the provider facility in connection with the nonemergency health care service;

(B) the price charged for the services of all practitioners, support staff, and other persons who provide professional health services:

(i) who may provide services to or for the individual during the individual's presence in the provider facility for the nonemergency health care service; and

(ii) for whose services the individual will be charged separately from the charge of the provider facility;

for imaging, laboratory services, diagnostic services, therapy, observation services, and other services expected to be provided to the individual for the episode of care.

(3) Include a total figure that is a sum of the estimated prices referred to in subdivisions (1) and (2).

(b) Subsection (a) does not prohibit a practitioner from providing to an individual a good faith estimate that indicates how much of the total figure stated under subsection (a)(2) will be the individual's out-of-pocket expense after the health carrier's payment of charges.

(c) A health carrier must provide a practitioner with the information needed by the practitioner to comply with the

requirements under this chapter not more than two (2) business days after receiving the request.

(d) A practitioner is not subject to the penalties under section 18 of this chapter if:

(1) a health carrier or provider facility fails to provide the practitioner with the information as required under subsection (c);

(2) the practitioner provides the individual with a good faith estimate based on any information that the practitioner has; and

(3) the practitioner provides the individual with an updated good faith estimate after the health carrier or provider facility has provided the information required under subsection (c).

Sec. 15. If:

(1) a practitioner is expected to provide a nonemergency health care service to an individual in a provider facility; and

(2) the provider facility receives a request from an individual for a good faith estimate under IC 27-1-46;

the practitioner, upon request from the provider facility, shall provide to the provider facility a good faith estimate of the practitioner's price for providing the nonemergency health care service to enable the provider facility to comply with IC 27-1-46-11.

Sec. 16. (a) A practitioner that has ordered the individual for a nonemergency health care service shall provide to the individual an electronic or paper copy of a written notice that states the following, or words to the same effect: "A patient may at any time ask a health care provider for an estimate of the price the health care providers and health facility will charge for providing a nonemergency medical service. The law requires that the estimate be provided within 5 business days.".

(b) The state department may adopt rules under IC 4-22-2 to establish requirements for practitioners to provide additional charging information under this section.

Sec. 17. If:

(1) a practitioner receives a request for a good faith estimate under this chapter; and

(2) the patient is eligible for Medicare coverage;

the practitioner shall provide a good faith estimate to the patient within five (5) business days based on available Medicare rates.

Sec. 18. The appropriate board (as defined in IC 25-1-9-1) may take action against a practitioner:

(1) under IC 25-1-9-9(a)(3) or IC 25-1-9-9(a)(4) for an initial violation or isolated violations of this chapter; or

(2) under IC 25-1-9-9(a)(6) for repeated or persistent violations of this chapter;

concerning the providing of a good faith estimate to an individual for whom a nonemergency health care service has been ordered or the providing of notice in the practitioner's office or on the practitioner's Internet web site that a patient may at any time ask for an estimate of the price that the patient will be charged for a medical service.

SECTION 18. IC 25-1-9.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 9.9. Practitioner Employment Contracts And Non-Compete Agreements

Sec. 1. This chapter applies to an employment contract entered into, modified, renewed, or extended after June 30, 2020.

Sec. 2. As used in this chapter, "employee" means a practitioner (as defined in IC 25-1-9-2) employed by an employer for wages or salary. The term includes an individual who has received an offer of employment from a prospective employer.

Sec. 3. As used in this chapter, "employer" means an individual, corporation, partnership, limited liability company, or any other legal entity that has at least one (1) employee and is legally doing business in Indiana.

Sec. 4. As used in this chapter, "non-compete agreement" means a contractual provision by which an employer attempts to limit an employee's ability to seek future employment or engage in future business activity after the employment relationship has terminated.

Sec. 5. An employment contract entered into by an employer and employee may not contain a non-compete agreement.

Sec. 6. A non-compete agreement in an employment contract in violation of this chapter is unenforceable and void.

SECTION 19. IC 25-22.5-17 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 17. Physician's Patient Information

Sec. 1. If a physician licensed under this article leaves the employment of an employer, the following apply:

(1) The employer of the physician must provide the physician with a copy of any notice that:

(A) concerns the physician's departure from the employer;

and

(B) was sent to any patient seen or treated by the physician during the two (2) year period preceding the termination of the physician's employment or the expiration of the physician's contract. However, the patient names and contact information must be redacted from the copy of the notice provided from the employer of the physician to the physician.

(2) The physician's employer must, in good faith, provide the physician's last known or current contact and location information to a patient who:

(A) requests updated contact and location information for the physician; and

(B) was seen or treated by the physician during the two (2) year period preceding the termination of the physician's employment or the expiration of the physician's contract.

(3) The physician's employer must provide the physician with:

(A) access to; or

(B) copies of;

any medical record associated with a patient described in subdivision (1) or (2) upon receipt of the patient's consent.

(4) The physician's employer may not provide patient medical records to a requesting physician in a format that materially differs from the format used to create or store the medical record during the routine or ordinary course of business, unless a different format is mutually agreed upon by the parties. Paper or portable document format copies of the medical records satisfy the formatting provisions of this chapter.

Sec. 2. A person or entity required to create, copy, or transfer a patient medical record for a reason specified in this chapter may charge a reasonable fee for the service as permitted under applicable state or federal law.

SECTION 20. IC 27-1-3-7, AS AMENDED BY P.L.278-2013, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 7. (a) The department may promulgate rules and regulations for any of the following enumerated purposes:

(1) For the conduct of the work of the department.

(2) Prescribing the methods and standards to be used in making the examinations and prescribing the forms of reports of the several insurance companies to which IC 27-1 is applicable.

(3) Defining what is a safe or an unsafe manner and a safe or an

unsafe condition for conducting business by any insurance company to which IC 27-1 is applicable.

(4) For the establishment of safe and sound methods for the transaction of business by such insurance companies and for the purpose of safeguarding the interests of policyholders, creditors, and shareholders respecting the withdrawal or payment of funds by any life insurance company in times of emergency. Any rule or regulation promulgated under this subdivision may apply to one (1) or more insurance companies as the department may determine.

(5) For the administration and termination of the affairs of any such insurance company which is in involuntary liquidation or whose business and property have been taken possession of by the department for the purpose of rehabilitation, liquidation, conservation, or dissolution under IC 27-1.

(6) For the regulation of the solicitation or use of proxies, in general and as they concern consents or authorizations, in respect of securities issued by any domestic stock company for the purpose of protecting investors by prescribing the form of proxies, including such consents or authorizations, and by requiring adequate disclosure of information relevant to such proxies, including such consents or authorizations, and relevant to the business to be transacted at any meeting of shareholders with respect to which such proxies, including such consents or authorizations, may be used, which regulations may, in general, conform to those prescribed by the National Association of Insurance Commissioners.

(7) For regulation related to a health benefit exchange established under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and operating in Indiana.

(b) The department may adopt a rule under IC 4-22-2 to provide reasonable simplification of the terms and coverage of individual and group Medicare supplement accident and sickness insurance policies and individual and group Medicare supplement subscriber contracts in order to facilitate public understanding and comparison and to eliminate provisions contained in those policies or contracts which may be misleading or confusing in connection either with the purchase of those coverages or with the settlement of claims and to provide for full disclosure in the sale of those coverages.

(c) The department shall adopt rules concerning the

enforcement of health care billing requirements in IC 16-51-1.

SECTION 21. IC 27-1-45 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 45. Health Facility Compensation

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to be provided health care services at a cost established according to a network plan.

Sec. 2. As used in this chapter, "facility" means an institution in which health care services are provided to individuals. The term includes:

(1) hospitals and other licensed ambulatory surgical centers; and

(2) ambulatory outpatient surgical centers.

Sec. 3. As used in this chapter, "in network provider" means a provider that is required under a network plan to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

Sec. 4. As used in this chapter, "network plan" means a plan under which providers are required by contract to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

Sec. 5. As used in this chapter, "practitioner" means the following:

(1) An individual licensed under IC 25 who provides professional health care services to individuals in a facility.

(2) An organization:

(A) that consists of practitioners described in subdivision (1); and

(B) through which practitioners described in subdivision (1) provide health care services.

(3) An entity that:

(A) is not a facility; and

(B) employs practitioners described in subdivision (1) to provide health care services.

Sec. 6. As used in this chapter, "provider" means:

(1) a facility; or

(2) a practitioner.

Sec. 7. (a) When a covered individual receives health care services in a facility that is an in network provider, neither:

(1) the facility; nor

(2) a practitioner who provides health care services in the

facility;

may charge more for the health care services provided to the covered individual than allowed according to the rate or amount of compensation established by the individual's network plan.

(b) A facility that is an out of network provider or a practitioner who provides health care services in the facility may charge more for the health care services provided to the covered individual than allowed according to the rate or amount of compensation established by the individual's network plan if all of the following conditions are met:

(1) At least five (5) days before the health care services are scheduled to be provided to the covered individual, the facility or practitioner provides to the covered individual, on a form separate from any other form provided to the covered individual by the facility or practitioner, a statement in conspicuous type at least as large as fourteen (14) point type that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of facility or practitioner] intends to charge you more for [name or description of health care services] than allowed according to the rate or amount of compensation established by the network plan applying to your coverage. [Name of facility or practitioner] is not entitled to charge this much for [name or description of health care services] unless you give your written consent to the charge.".

(B) Sets forth the facility's or practitioner's good faith estimate of the amount that the facility or practitioner intends to charge for the health care services provided to the covered individual.

(C) Includes a notice reading substantially as follows concerning the good faith estimate set forth under clause (B): "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate of the amount we will charge.".

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

(c) If the charge of a facility or practitioner for health care services provided to a covered individual exceeds the estimate

provided to the covered individual under subsection (b)(1)(B), the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

Sec. 8. (a) The insurance commissioner may, after notice and hearing under IC 4-21.5, impose on the provider facility a civil penalty of not more than one thousand dollars ($1,000) for each violation of this chapter.

(b) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

SECTION 22. IC 27-1-46 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 46. Provider Facility Good Faith Estimates

Sec. 0.5. Nothing in this chapter prohibits:

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); or

(2) a self-insurance program established to provide group health coverage as described in IC 5-10-8-7(b), or a contract for health services as described in IC 5-10-8-7(c);

from providing information requested by a practitioner or provider facility under this chapter.

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to be provided health care services according to a health carrier's network plan.

Sec. 1.5. As used in this chapter, "episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.

Sec. 2. As used in this chapter, "good faith estimate" means a reasonable estimate of the price a provider anticipates charging for an episode of care for nonemergency health care services that:

(1) is made by a provider under this chapter upon the request of the individual for whom the nonemergency health care service has been ordered; and

(2) is not binding upon the provider.

Sec. 3. (a) As used in this chapter, "health carrier" means an entity:

(1) that is subject to IC 27 and the administrative rules adopted under IC 27; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term also includes the following:

(1) An insurer, as defined in IC 27-1-2-3(x), that issues a policy of accident and sickness insurance, as defined in IC 27-8-5-1(a).

(2) A health maintenance organization, as defined in IC 27-13-1-19.

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined by IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

Sec. 4. As used in this chapter, "in network", when used in reference to a provider, means that the health care services provided by the provider are subject to a health carrier's network plan.

Sec. 5. (a) As used in this chapter, "network" means a group of provider facilities and practitioners that:

(1) provide health care services to covered individuals; and

(2) have agreed to, or are otherwise subject to, maximum limits on the prices for the health care services to be provided to the covered individuals.

(b) The term includes the following:

(1) A network described in subsection (a) that is established pursuant to a contract between an insurer providing coverage under a group health policy and:

(A) individual provider facilities and practitioners;

(B) a preferred provider organization; or

(C) an entity that employs or represents providers, including:

(i) an independent practice association; and

(ii) a physician-hospital organization.

(2) A health maintenance organization, as defined in IC 27-13-1-19.

Sec. 6. As used in this chapter, "network plan" means a plan of a health carrier that:

(1) requires a covered person to receive; or

(2) creates incentives, including financial incentives, for a covered person to receive;

health care services from one (1) or more providers that are under contract with, managed by, or owned by the health carrier.

Sec. 7. As used in this chapter, "nonemergency health care service" means a discrete service or series of services ordered by a practitioner for an episode of care for the purpose of:

(1) diagnosis;

(2) prevention;

(3) treatment;

(4) cure; or

(5) relief;

of a physical, mental, or behavioral health condition, illness, injury, or disease that is not provided on an emergency or urgent care basis.

Sec. 8. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 8.5. As used in this chapter, "price" means the negotiated rate between the:

(1) provider facility and practitioner; and

(2) covered individual's primary health carrier.

Sec. 9. As used in this chapter, "provider" means:

(1) a provider facility; or

(2) a practitioner.

Sec. 10. As used in this chapter, "provider facility"means any of the following:

(1) A hospital licensed under IC 16-21-2.

(2) An ambulatory outpatient surgery center licensed under IC 16-21-2.

(3) An abortion clinic licensed under IC 16-21-2.

(4) A birthing center licensed under IC 16-21-2.

(5) Except for an urgent care facility, a facility that provides diagnostic services to the medical profession or the general public, including outpatient facilities.

(6) A laboratory where clinical pathology tests are carried out on specimens to obtain information about the health of a patient.

(7) A facility where radiologic and electromagnetic images are made to obtain information about the health of a patient.

(8) An infusion center that administers intravenous medications.

Sec. 10.5. (a) As used in this chapter, "urgent care facility" means a freestanding health care facility that offers episodic,

walk-in care for the treatment of acute, but not life threatening, health conditions.

(b) The term does not include an emergency department of a hospital or a nonprofit or government operated health clinic.

Sec. 11. (a) This section does not:

(1) apply to a individual who is a Medicaid recipient; or

(2) limit the authority of a legal representative of the patient.

(b) An individual for whom a nonemergency health care service has been ordered may request from the provider facility in which the health care service will be provided a good faith estimate of the price that will be charged as a result of the nonemergency health care service.

(c) A provider facility that receives a request from an individual under subsection (b) shall, not more than five (5) business days after receiving all the relevant information from the individual, provide to the individual a good faith estimate of:

(1) the price that the provider facility in which the health care service will be performed will charge for:

(A) the use of the provider facility to care for the individual for the nonemergency health care service;

(B) the services rendered by the staff of the provider facility in connection with the nonemergency health care service; and

(C) medication, supplies, equipment, and material items to be provided to or used by the individual while the individual is present in the provider facility in connection with the nonemergency health care service; and

(2) the price charged for the services of all practitioners, support staff, and other persons who provide professional health services:

(A) who may provide services to or for the individual during the individual's presence in the provider facility for the nonemergency health care service; and

(B) for whose services the individual will be charged separately from the charge of the provider facility.

(d) The price that must be included in a good faith estimate under this section includes all services under subsection (c)(1) or (c)(2) for imaging, laboratory services, diagnostic services, therapy, observation services, and other services expected to be provided to the individual for the episode of care.

(e) A provider facility shall ensure that a good faith estimate states that:

(1) an estimate provided under this section is not binding on the provider facility;

(2) the price the provider facility charges the individual may vary from the estimate based on the individual's medical needs; and

(3) the estimate provided under this section is only valid for thirty (30) days.

(f) A provider facility may not charge a patient for information provided under this section.

Sec. 12. (a) If:

(1) the individual who requests a good faith estimate from a provider facility under this chapter and has been verified as a covered individual with respect to a network plan; and

(2) the provider facility from which the individual requests the good faith estimate is in network with respect to the same network plan;

the good faith estimate that the provider facility provides to the individual under this chapter must be based on the price to which the provider facility and any practitioners referred to in section 11(c)(2) of this chapter have agreed as in network providers.

(b) If the individual who requests a good faith estimate from a provider facility under this chapter:

(1) is not a covered individual with respect to any network plan; or

(2) is not a covered individual with respect to a network plan with respect to which the provider facility is in network;

the good faith estimate that the provider facility provides to the individual under this chapter must be based on the price that the provider facility and any practitioners referred to in section 11(c)(2) of this chapter charge for the nonemergency health care services in the absence of any network plan.

Sec. 13. A provider facility may provide a good faith estimate to an individual under this chapter:

(1) in a writing delivered to the individual;

(2) by electronic mail; or

(3) through a mobile application or other Internet web based method, if available;

according to the preference expressed by the individual.

Sec. 14. (a) A good faith estimate provided by a provider facility to an individual under this chapter must:

(1) provide a summary of the services and material items that the good faith estimate is based on; and

(2) include a total figure that is a sum of the estimated prices referred to in subdivision (1).

(b) Subsection (a) does not prohibit a provider facility from providing to an individual a good faith estimate that indicates how much of the total figure stated under subsection (a)(2) will be the individual's out-of-pocket expense after the health carrier's payment of charges.

(c) A health carrier or practitioner must provide a provider facility with the information needed by the provider facility to comply with the requirements under this chapter not more than two (2) business days after receiving the request.

(d) A provider facility is not subject to the penalties under section 17 of this chapter if:

(1) a health carrier or practitioner fails to provide the provider facility with the information as required under subsection (c);

(2) the provider facility provides the individual with a good faith estimate based on any information that the provider facility has; and

(3) the provider facility provides the individual with an updated good faith estimate after the health carrier or practitioner has provided the information required under subsection (c).

Sec. 15. (a) As used in this section, "waiting room" means a space in a building used by a provider facility in which people check in or register to:

(1) be seen by practitioners; or

(2) meet with members of the staff of the provider facility.

(b) A provider facility shall ensure that each waiting room of the provider facility includes at least one (1) printed notice that:

(1) is designed, lettered, and positioned within the waiting room so as to be conspicuous to and readable by any individual with normal vision who visits the waiting room; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in this facility. The law requires that an estimate be provided within 5 business days.".

(c) If a provider facility maintains an Internet web site, the provider facility shall ensure that the Internet web site includes at least one (1) printed notice that:

(1) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site; and

(2) states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in our facility. The law requires that an estimate be provided within 5 business days.".

Sec. 16. If:

(1) a provider facility receives a request for a good faith estimate under this chapter; and

(2) the patient is eligible for Medicare coverage;

the provider facility shall provide a good faith estimate to the patient within five (5) business days based on available Medicare rates.

Sec. 17. (a) If a provider facility fails or refuses:

(1) to provide a good faith estimate as required by this chapter; or

(2) to provide notice on the provider facility's Internet web site as required under this chapter;

the insurance commissioner may, after notice and hearing under IC 4-21.5, impose on the provider facility a civil penalty of not more than one thousand dollars ($1,000) for each violation.

(b) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

SECTION 23. IC 27-2-25 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 25. Health Carrier Good Faith Estimates

Sec. 1. As used in this chapter, "coverage" means the right of an individual to receive:

(1) health care services; or

(2) payment or reimbursement for health care services;

from a health carrier.

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

Sec. 2.5. As used in this chapter, "episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.

Sec. 3. As used in this chapter, "good faith estimate" means a health carrier's reasonable estimate of:

(1) the amount of the cost of a nonemergency health care

service that the health carrier will:

(A) pay for; or

(B) reimburse to;

a covered individual; or

(2) the applicable benefit limitations of the nonemergency health care service a covered individual is entitled to receive;

that a health carrier provides upon request to a covered individual for whom a nonemergency health care service has been ordered.

Sec. 4. (a) As used in this chapter, "health carrier" means an entity:

(1) that is subject to this title and the administrative rules adopted under this title; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term also includes the following:

(1) An insurer, as defined in IC 27-1-2-3(x), that issues a policy of accident and sickness insurance, as defined in IC 27-8-5-1(a).

(2) A health maintenance organization, as defined in IC 27-13-1-19.

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined by IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

Sec. 5. As used in this chapter, "in network", when used in reference to a practitioner, means that the health care services provided by the practitioner are subject to a health carrier's network plan.

Sec. 6. (a) As used in this chapter, "network" means a group of provider facilities and practitioners that:

(1) provide health care services to covered individuals; and

(2) have agreed to, or are otherwise subject to, maximum limits on the prices for the health care services to be provided to the covered individuals.

(b) The term includes the following:

(1) A network described in subsection (a) that is established

pursuant to a contract between an insurer providing coverage under a group health policy and:

(A) individual provider facilities and practitioners;

(B) a preferred provider organization; or

(C) an entity that employs or represents providers, including:

(i) an independent practice association; and

(ii) a physician-hospital organization.

(2) A health maintenance organization, as defined in IC 27-13-1-19.

Sec. 7. As used in this chapter, "network plan" means a plan of a health carrier that:

(1) requires a covered person to receive; or

(2) creates incentives, including financial incentives, for a covered person to receive;

health care services from one (1) or more providers that are under contract with, managed by, or owned by the health carrier.

Sec. 8. As used in this chapter, "nonemergency health care service" means a discrete service or series of services ordered by a practitioner for an episode of care for the:

(1) diagnosis;

(2) prevention;

(3) treatment;

(4) cure; or

(5) relief;

of a physical, mental, or behavioral health condition, illness, injury, or disease that is not provided on an emergency or urgent care basis.

Sec. 9. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 9.5. As used in this chapter, "price" means the negotiated rate between the:

(1) provider facility and practitioner; and

(2) covered individual's primary health carrier;

minus the amount that the health carrier will pay.

Sec. 10. As used in this chapter, "provider" means:

(1) a provider facility; or

(2) a practitioner.

Sec. 11. As used in this chapter, "provider facility"means any of the following:

(1) A hospital licensed under IC 16-21-2.

(2) An ambulatory outpatient surgery center licensed under IC 16-21-2.

(3) An abortion clinic licensed under IC 16-21-2.

(4) A birthing center licensed under IC 16-21-2.

(5) Except for an urgent care facility (as defined by IC 27-1-46-10.5), a facility that provides diagnostic services to the medical profession or the general public.

(6) A laboratory where clinical pathology tests are carried out on specimens to obtain information about the health of a patient.

(7) A facility where radiologic and electromagnetic images are made to obtain information about the health of a patient.

(8) An infusion center that administers intravenous medications.

Sec. 12. (a) A covered individual for whom a nonemergency health care service has been ordered may request from the health carrier a good faith estimate of:

(1) the amount of the cost of the nonemergency health care service that the health carrier will:

(A) pay for; or

(B) reimburse to;

the covered individual; or

(2) the applicable benefit limitations of the ordered nonemergency health care service a covered individual is entitled to receive from the health carrier.

(b) If:

(1) a health carrier provides coverage to a covered individual through a network plan; and

(2) the health carrier receives a request for a good faith estimate from a covered individual for whom a nonemergency health care service has been ordered;

the health carrier shall inform the covered individual whether the provider facility in which the nonemergency health care service will be provided is in network and whether each scheduled practitioner who may provide the nonemergency health care service is in network.

(c) A health carrier that receives a request from a covered individual patient under subsection (b) shall, not more than five (5) business days after receiving all the relevant information, provide to the individual a good faith estimate as described in section 14 of this chapter.

(d) A health carrier must ensure that a good faith estimate

states that the estimate provided under this section is only valid for thirty (30) days and that:

(1) the amount that the health carrier will:

(A) pay; or

(B) reimburse;

for or to the covered individual for the nonemergency health care services the individual receives; and

(2) the applicable benefit limitations of the nonemergency health care services the individual will receive;

may vary from the health carrier's good faith estimate based on the individual's medical needs.

(e) A health carrier may not charge an individual for information provided under this section.

(f) A practitioner and provider facility shall provide a health carrier with the information needed by the health carrier to comply with the requirements under this chapter not more than two (2) business days after receiving the request.

Sec. 13. A health carrier may provide a good faith estimate to an individual under this chapter:

(1) in a writing delivered to the individual;

(2) by electronic mail; or

(3) through a mobile application or other Internet web based method, if available;

according to the preference expressed by the individual.

Sec. 14. (a) A good faith estimate provided by a health carrier to an individual under this chapter must:

(1) in the case of an insurer or another health carrier that pays or reimburses the cost of health care services:

(A) provide a summary of the services and material items that the good faith estimate is based on;

(B) include a total figure that is a sum of the amounts referred to in clause (A); and

(C) state the out-of-pocket costs the covered individual will incur, if any, beyond the amount that the health carrier will pay or reimburse; and

(2) in the case of a health maintenance organization or another health carrier that provides health care services:

(A) provide a summary of the applicable benefit limitations of the health care services to which the covered individual is entitled; and

(B) state the out-of-pocket costs the covered individual will incur, if any, beyond being provided the health care

services referred to in clause (A).

(b) A practitioner and provider facility shall provide a health carrier with the information needed by the health carrier to comply with the requirements under this chapter not more than two (2) business days after receiving the request.

(c) A health carrier is not subject to the penalties under section 16 of this chapter if:

(1) a provider facility or practitioner fails to provide the health carrier with the information as required under subsection (b);

(2) the health carrier provides the individual with a good faith estimate based on any information that the health carrier has; and

(3) the health carrier provides the individual with an updated good faith estimate after the provider facility or practitioner has provided the information required under subsection (b).

Sec. 15. A health carrier that provides an Internet web site for the use of its covered individuals shall ensure that the Internet web site includes a printed notice that:

(1) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site; and

(2) states the following, or words to the same effect: "A covered individual may at any time ask the health carrier for an estimate of the amount the health carrier will pay for or reimburse to a covered individual for nonemergency health care services that have been ordered for the covered individual or the applicable benefit limitations of the ordered nonemergency health care services a covered individual is entitled to receive from the health carrier. The law requires that an estimate be provided within 5 business days.".

Sec. 16. (a) If a health carrier fails or refuses:

(1) to provide a good faith estimate as required by this chapter; or

(2) to provide notice on the health carrier's Internet web site as required by section 15 of this chapter;

the insurance commissioner may, after notice and hearing under IC 4-21.5, impose on the health carrier a civil penalty of not more than one thousand dollars ($1,000) for each day of noncompliance.

(b) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

SECTION 24. [EFFECTIVE JULY 1, 2020] **(a) As used in this**

SECTION, "department" refers to the department of insurance.

(b) The following shall submit, before September 1, 2021, a report described in this SECTION to the department and the general assembly in an electronic format under IC 5-14-6:

(1) An insurer (as defined in IC 27-1-2-3) that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(2) A health maintenance organization (as defined in IC 27-13-1-19).

(c) The report must include an estimate of the total reduction in reimbursement for health service claims that were appropriately billed as being provided in an office setting under IC 16-51-1-9, as added by this act, instead of being billed as being provided in an institutional setting.

(d) This SECTION expires December 31, 2021.

(Reference is to HB 1004 as printed January 24, 2020.)

and when so amended that said bill do pass .

Committee Vote: Yeas 8, Nays 4.

Senator Charbonneau, Chairperson

611064.10779 - Senator Charbonneau