Reprinted
March 6, 2001

HOUSE BILL No. 1461

DIGEST OF HB 1461 (Updated March 5, 2001 2:01 PM - DI 104)

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

Synopsis: Insurer and health care provider contracting. States certain information that an insured or enrollee must submit with an insurance claim in order for the claim to be proper and complete. Requires that a complete claim for an evaluation and management code that meets certain requirements be paid to the insured or enrollee not more than 14 days after the claim is submitted. Allows an insurer or health maintenance organization to require a provider to submit additional information for a claim that is not for an evaluation and management code if the request is made within 30 days after the insured or enrollee has submitted the claim. Prohibits an accident and sickness insurer from requiring a provider to provide health care to enrollees of a health maintenance organization as a condition to provide health care to individuals covered under an accident and sickness insurance policy.

Effective: July 1, 2001.

Pelath, Budak, Becker

January 11, 2001, read first time and referred to Committee on Public Health.
February 27, 2001, amended, reported — Do Pass.
March 5, 2001, read second time, amended, ordered engrossed.

Reprinted
March 6, 2001

First Regular Session 112th General Assembly (2001)

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 2000 General Assembly.

HOUSE BILL No. 1461

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

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

SECTION 1. IC 27-8-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 5.7. Payment of Claims

Sec. 1. As used in this chapter, "insured" means an individual who is entitled to the benefits provided by a policy of accident and sickness insurance. The term includes the following:

(1) The policyholder of an individual policy of accident and sickness insurance.

(2) A member of the group covered by a group policy of accident and sickness insurance.

(3) An individual who is entitled to coverage under a policy of accident and sickness insurance as a spouse or dependent of an individual referred to in subdivision (1) or (2).

Sec. 2. As used in this chapter, "insurer" means an entity issuing a policy of accident and sickness insurance.

Sec. 3. As used in this chapter, "policy of accident and sickness

insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 4. (a) An insured who has received services from a provider that provides services, including emergency services, that an insurer is required to pay, is considered to have filed a proper and complete claim if the insured submits the following information:

(1) The name of the insured who received services.

(2) The address of the insured.

(3) The date of service.

(4) The Current Procedural Terminology (CPT) code.

(5) The International Classification of Diseases (ICD) disease classification.

(6) The name and address of the provider.

(7) Information on the insured's benefit card that is specific to the insured.

(8) Tax identification information of the provider.

(b) A claim for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) that meets the requirements under subsection (a) must be paid to the insured not more than fourteen (14) days after the claim is submitted.

(c) If a claim is not for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) the insurer may require the provider to submit information in addition to the information required under subsection (a). However, if a request for additional information under this subsection is not made within thirty (30) days after the insured has submitted a claim, the claim must be paid.

SECTION 2. IC 27-8-11-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 7. An insurer may not require a provider, as a condition of entering into an agreement with the insurer under section 3 of this chapter to provide health care services to individuals who are covered under a policy of accident and sickness insurance (as defined in IC 27-8-5-1), to provide health care services to enrollees (as defined in 27-13-1-12) of a health maintenance organization.**

SECTION 3. IC 27-13-36-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 9.5. (a) An enrollee who receives services from a provider that is not a participating provider and that provides services, including emergency services, that a health maintenance organization or a limited service health maintenance**

organization is required to pay a nonparticipating provider, is considered to have filed a proper and complete claim if the enrollee submits the following information:

(1) The name of the enrollee who received services.

(2) The address of the enrollee.

(3) The date of service.

(4) The Current Procedural Terminology (CPT) code.

(5) The International Classification of Diseases (ICD) disease classification.

(6) The name and address of the provider.

(7) Information on the enrollee's benefit card that is specific to the enrollee.

(8) Tax identification information of the provider.

(b) A claim for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) that meets the requirements under subsection (a) must be paid to the enrollee not more than fourteen (14) days after the claim is submitted.

(c) If a claim is not for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) the health maintenance organization or the limited service health maintenance organization may require the provider to submit information in addition to the information required under subsection (a). However, if a request for additional information under this subsection is not made within thirty (30) days after the enrollee has submitted a claim, the claim must be paid.

SECTION 4. [EFFECTIVE JULY 1, 2001] **(a) IC 27-8-11-7, as added by this act, applies to agreements with providers that are entered into, amended, or renewed after June 30, 2001.**

(b) This SECTION expires June 30, 2006.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1461, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, line 3, delete "(a) As used in this section, "all services contract"" and insert "**An insurer may not require a provider, as a condition of entering into an agreement with the insurer under section 3 of this chapter to provide health care services to individuals who are covered under a policy of accident and sickness insurance (as defined in IC 27-8-5-1), to provide health care services to enrollees (as defined in 27-13-1-12) of a health maintenance organization.**".

Page 1, delete lines 4 through 17.

Page 2, delete lines 1 through 8.

Page 2, line 9, delete "3." and insert "2.".

Page 2, line 9, delete "and" and insert "**,**".

Page 2, line 10, delete "IC 27-13-36-12, both".

Page 2, line 10, delete "apply" and insert "applies".

Page 2, line 10, delete "contracts" and insert "**agreements**".

and when so amended that said bill do pass.

(Reference is to HB 1461 as introduced.)

BROWN C, Chair

Committee Vote: yeas 9, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1461 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-8-5.7 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 5.7. Payment of Claims

Sec. 1. As used in this chapter, "insured" means an individual who is entitled to the benefits provided by a policy of accident and sickness insurance. The term includes the following:

(1) The policyholder of an individual policy of accident and sickness insurance.

(2) A member of the group covered by a group policy of accident and sickness insurance.

(3) An individual who is entitled to coverage under a policy of accident and sickness insurance as a spouse or dependent of an individual referred to in subdivision (1) or (2).

Sec 2. As used in this chapter, "insurer" means an entity issuing a policy of accident and sickness insurance.

Sec. 3. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 4. (a) An insured who has received services from a provider that provides services, including emergency services, that an insurer is required to pay, is considered to have filed a proper and complete claim if the insured submits the following information:

(1) The name of the insured who received services.

(2) The address of the insured.

(3) The date of service.

(4) The Current Procedural Terminology (CPT) code.

(5) The International Classification of Diseases (ICD) disease classification.

(6) The name and address of the provider.

(7) Information on the insured's benefit card that is specific to the insured.

(8) Tax identification information of the provider.

(b) A claim for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) that meets the requirements under subsection (a) must be paid to the insured not more than fourteen (14) days after the claim is submitted.

(c) If a claim is not for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) the insurer may require the provider to submit information in addition to the information required under subsection (a). However, if a request for additional information under this subsection is not made within thirty (30) days after the insured has submitted a claim, the claim must be paid.".

Page 1, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 3. IC 27-13-36-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 9.5. (a) An enrollee who receives services from a provider that is not a participating provider and that provides services, including emergency services, that a health maintenance organization or a limited service health maintenance organization is required to pay a nonparticipating provider, is considered to have filed a proper and complete claim if the enrollee submits the following information:**

(1) The name of the enrollee who received services.

(2) The address of the enrollee.

(3) The date of service.

(4) The Current Procedural Terminology (CPT) code.

(5) The International Classification of Diseases (ICD) disease classification.

(6) The name and address of the provider.

(7) Information on the enrollee's benefit card that is specific to the enrollee.

(8) Tax identification information of the provider.

(b) A claim for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) that meets the requirements under subsection (a) must be paid to the enrollee not more than fourteen (14) days after the claim is submitted.

(c) If a claim is not for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) the health maintenance organization or the limited service health maintenance organization may require the provider to submit information in addition to the information required under subsection (a). However, if a request for additional information under this subsection is not made within thirty (30) days after the enrollee has submitted a claim, the claim must be paid.".

Renumber all SECTIONS consecutively.

(Reference is to hb 1461 as printed February 28, 2001.)

BROWN T