HOUSE BILL No. 1772

DIGEST OF INTRODUCED BILL

Citations Affected: IC 16-18-2; IC 16-21.

Synopsis: Hospital and outpatient surgical center charges. Requires hospitals and ambulatory outpatient surgical centers to: (1) establish a self-pay program that provides reduced cost of care to eligible individuals and alternative payment options to other individuals; (2) provide billing information to patients and the public; and (3) establish an appeal procedure for disputed patient bills. Requires the state department of health to investigate violations of these requirements, and specifies action that may be taken by the state department for a violation.

Effective: July 1, 2007.

Ripley

January 26, 2007, read first time and referred to Committee on Insurance.

Introduced

First Regular Session 115th General Assembly (2007)

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 2006 Regular Session of the General Assembly.

HOUSE BILL No. 1772

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

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

SECTION 1. IC 16-18-2-12.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 12.5. "Alternative payment arrangement", for purposes of IC 16-21-10, has the meaning set forth in IC 16-21-10-1.**

SECTION 2. IC 16-18-2-52.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 52.3. "Charge master", for purposes of IC 16-21-11, has the meaning set forth in IC 16-21-11-1.**

SECTION 3. IC 16-18-2-52.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 52.5. (a) "Charity care", for purposes of:

(1) IC 16-21-6 and IC 16-21-9, means the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services:

~~(1)~~ **(A)** to a person classified by the hospital as financially

indigent or medically indigent on an inpatient or outpatient basis; and

~~(2)~~ **(B)** to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations; **and**

(2) IC 16-21-10, has the meaning set forth in IC 16-21-10-2.

(b) As used in this section, "financially indigent" means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's financial criteria and procedure used to determine if a patient is eligible for charity care. The criteria and procedure must include income levels and means testing indexed to the federal poverty guidelines. A hospital may determine that a person is financially or medically indigent under the hospital's eligibility system after health care services are provided.

(c) As used in this section, "medically indigent" means a person whose medical or hospital bills after payment by third party payors exceed a specified percentage of the patient's annual gross income as determined in accordance with the hospital's eligibility system, and who is financially unable to pay the remaining bill.

SECTION 4. IC 16-18-2-122 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 122. "Facility", for purposes of:

(1) IC 16-21-10, has the meaning set forth in IC 16-21-10-3.

(2) IC 16-21-11, has the meaning set forth in IC 16-21-11-2.

(3) IC 16-41-11, has the meaning set forth in IC 16-41-11-2.

SECTION 5. IC 16-18-2-326.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 326.4. "Self-pay patient", for purposes of IC 16-21-10, has the meaning set forth in IC 16-21-10-4.**

SECTION 6. IC 16-18-2-326.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION6976 TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 326.6. "Self-pay program", for purposes of IC 16-21-10, has the meaning set forth in IC 16-21-10-5.**

SECTION 7. IC 16-21-10 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 10. Self-Pay Program

Sec. 1. As used in this chapter, "alternative payment arrangement" means a method of payment that allows an

individual to pay for a billed charge in a manner other than a lump sum basis or a delayed basis.

Sec. 2. As used in this chapter, "charity care" means health care services that are provided to a self-pay patient at no cost or at a reduced cost.

Sec. 3. As used in this chapter, "facility" refers to the following:

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

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

Sec. 4. As used in this chapter, "self-pay patient" means an individual who does not:

(1) have health care coverage; or

(2) qualify for coverage under any of the following:

(A) The federal Medicare program (42 U.S.C. 1395 et seq.).

(B) The Medicaid program under IC 12-15.

(C) An association policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(D) Any other state or federal assistance program that provides coverage for health care services.

The term includes charity care patients.

Sec. 5. As used in this chapter, "self-pay program" means a program developed by a facility that includes the following:

(1) Reduced charges for health care services to a self-pay patient who has an income of not more than two hundred fifty percent (250%) of the federal income poverty level.

(2) Reduced charges based on a percentage of the amount reimbursed under the federal Medicare program for the service.

(3) Alternative payment arrangements for a self-pay patient who has an income of more than two hundred fifty percent (250%) of the federal income poverty level.

Sec. 6. A facility shall establish a self-pay program and shall provide a self-pay patient with information on the facility's self-pay program:

(1) upon the patient's admission to the facility for nonemergency health care services; or

(2) as soon as reasonably practicable for a patient receiving emergency health care services.

Sec. 7. A facility shall do the following:

(1) Develop and implement procedures for a self-pay patient to apply for an alternative payment arrangement or reduced

charges.

(2) Develop the application form and procedures to apply for the self-pay program in a manner that encourages self-pay patients to participate in the self-pay program.

(3) Make available to the public on the facility's Internet web site a copy of the facility's self-pay program in a format that can be downloaded.

(4) Conspicuously post a sign:

(A) in the area in which patients are admitted;

(B) in the reception area that is open to the public; and

(C) in the billing office;

to notify patients of the facility's self-pay program and that an individual may obtain a copy of the self-pay program upon request.

Sec. 8. (a) A facility shall file a quarterly report with the state department indicating the following concerning the self-pay program:

(1) The number of patients that applied for the self-pay program.

(2) The number of patients that were approved to participate in the self-pay program.

(b) The state department shall post a report submitted by a facility under subsection (a) on the state department's Internet web site.

Sec. 9. (a) Beginning March 1, 2008, and before March 1 of any following year, the state department shall annually issue a report to the legislative council in an electronic format under IC 5-14-6 and to the governor that includes the following information:

(1) The number of individuals who applied to participate in a self-pay program established under section 6 of this chapter.

(2) The number of investigations conducted by the state department for violations of this chapter.

(3) The number of violations confirmed by the state department.

(4) The name of a facility that has violated this chapter and the actions taken by the state department against the facility as allowed under section 10(a) of this chapter.

(b) The state department shall make the report required under subsection (a) available to the public upon request and without charge.

Sec. 10. (a) The state department may take the following action against a facility that violates this chapter:

(1) Suspend the facility's license.

(2) Revoke the facility's license.

(3) Impose a civil penalty on the facility of not more than five thousand dollars ($5,000) for each violation.

(b) An individual may file with the state department a complaint alleging that a facility has violated this chapter. The state department shall investigate the complaint and report the state department's findings to the complainant and any action that will be taken under subsection (a).

(c) Any action taken by the state department under this section does not preclude any other remedy available to an individual, a health insurance plan, or another party that is available under contract or any other law.

SECTION 8. IC 16-21-11 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 11. Charges for Services and Right to Appeal Charges

Sec. 1. As used in this chapter, "charge master" means a uniform schedule of charges published by a facility as the facility's gross billed charge for a given service or treatment, regardless of payor type.

Sec. 2. As used in this chapter, "facility" refers to the following:

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

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

Sec. 3. (a) A facility may not require a patient or a patient's representative to do the following:

(1) Enter into an agreement that requires the patient to be financially liable for an unspecified amount for the provision of services by the facility.

(2) Waive the patient's right to appeal charges billed to the patient by the facility.

(b) A facility may require the patient or a patient's representative to make a financial commitment for nonemergency services if the facility provides the patient or the patient's representative with an estimate of the charges that:

(1) the facility;

(2) a contractor of the facility; or

(3) a physician licensed under IC 25-22.5 who provides services at the facility;

generally charges for the services needed to treat the patient's condition.

(c) The facility shall notify the patient or the patient's representative of any changes in an estimate provided under subsection (b) in a timely manner.

(d) Except as provided in section 5 of this chapter, if the facility revises the estimated charges provided under subsection (b) by the lesser of either:

(1) twenty percent (20%); or

(2) one thousand dollars ($1,000);

of the original estimate, the financial commitment entered into by the patient or the patient's representative is void.

Sec. 4. A facility may not provide nonemergency services to a patient until the facility has provided the patient with written notice advising the patient of the availability of the facility's charge master from the state department.

Sec. 5. If an unanticipated complication or an unforeseen circumstance occurs in the nonemergency treatment of a patient, the facility may charge the patient or a third party payor for the additional services or supplies resulting from the complication or unforeseen circumstance if the charges are itemized on the patient's billing statement.

Sec. 6. (a) A facility shall provide a patient with the following information concerning a service received by the patient at the facility:

(1) The cost for each service provided to the patient.

(2) The amount of reimbursement for the service under the federal Medicare program, including any cost sharing requirement.

(b) Subsection (a)(2) does not include supplemental payments required under the federal Medicare program.

Sec. 7. A facility may not condition the provision of services to an individual on a waiver of the patient's rights under this chapter.

Sec. 8. (a) An individual who receives services from a facility has the right to appeal any charges billed by:

(1) the facility;

(2) a contractor of the facility; or

(3) a physician licensed under IC 25-22.5 who provides services at the facility.

(b) A facility's billing statement must notify the individual of the individual's right to appeal a charge on the billing statement. The notice on the billing statement must meet the following conditions:

(1) Be in at least 12 point type.

(2) Be in bold face type.

(3) Be in capitalized letters.

(4) Be conspicuously displayed at the bottom of the billing statement.

Sec. 9. (a) A facility shall establish an independent method for reviewing a billing appeal that includes the following:

(1) The review of the charges by an individual who was not involved in the initial billing of the patient.

(2) A written decision with a clear explanation of the grounds for the decision concerning the billing appeal not later than thirty (30) days after the facility receives the request for appeal.

(b) A facility shall maintain a record of the following regarding a billing appeal filed under this chapter:

(1) The name of the patient or the patient's representative who requested the appeal.

(2) The basis for the appeal.

(3) The total amount of billing charges.

(4) The amount of billing charges under appeal.

(5) The disposition of the appeal and the basis for the disposition.

Sec. 10. (a) A facility shall annually report to the state department the following information concerning appeals at the facility:

(1) The number of appeals filed in the calendar year.

(2) The total amount of billing charges subject to appeal.

(3) A summary of the disposition of each appeal.

(b) The state department shall post a report submitted by a facility under subsection (a) on the state department's Internet web site.

Sec. 11. (a) The state department may take the following action against a facility that violates this chapter:

(1) Suspend the facility's license.

(2) Revoke the facility's license.

(3) Impose a civil penalty on the facility of not more than five thousand dollars ($5,000) for each violation.

(b) An individual may file with the state department a complaint alleging that a facility has violated this chapter. The state department shall investigate the complaint and report the state department's findings to the complainant and any action that will be taken under subsection (a).

(c) Any action taken by the state department under this section does not preclude any other remedy available to an individual, a

health insurance plan, or another party that is available under contract or any other law.