February 23, 2007

SENATE BILL No. 152

DIGEST OF SB 152 (Updated February 20, 2007 7:33 pm - DI 104)

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

Synopsis: Assignment of benefits. Specifies requirements concerning health benefit payments under an assignment of benefits.

Effective: July 1, 2007.

Lawson C

January 8, 2007, read first time and referred to Committee on Health and Provider Services.
February 22, 2007, reported favorably — Do Pass.

February 23, 2007

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.

SENATE BILL No. 152

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 27-8-5.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 5.9. Assignment of Benefits

Sec. 1. As used in this chapter, "assignment of benefits" means a written instrument that:

(1) is executed by a covered individual or the authorized representative of a covered individual; and

(2) assigns to a treating health care provider the covered individual's right to receive reimbursement for health care services provided to the covered individual.

Sec. 2. As used in this chapter, "covered individual" means an individual entitled to benefits under a policy.

Sec. 3. As used in this chapter, "insurer" includes the following:

(1) An insurer that issues a policy.

(2) An administrator licensed under IC 27-1-25 that pays or administers claims for benefits under a policy.

Sec. 4. As used in this chapter, "policy" refers to a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

Sec. 5. (a) Except as provided in subsection (b), if:

(1) a policy provides coverage for a health care service;

(2) the health care service is rendered by a provider that has not entered into an agreement with the insurer under IC 27-8-11-3; and

(3) the provider described in subdivision (2):

(A) has an assignment of benefits from a covered individual to whom the health care service is rendered; and

(B) provides written or electronic notification to the insurer that the provider:

(i) has rendered the health care service to the covered individual; and

(ii) has the assignment of benefits;

the insurer shall make a benefit payment directly to the provider for the health care service and send written notice of the payment to the covered individual or the authorized representative of the covered individual.

(b) An insurer is not required to make a benefit payment directly to a provider described in subsection (a)(2) if the provider has been charged with or convicted of fraud.

(c) This section does not require coverage for benefits not covered under the terms of the policy.

Sec. 6. An insurer that does not comply with this chapter shall pay seven percent (7%) interest, compounded daily, accruing from the day after the benefit payment was due, on all amounts that are unpaid thirty (30) days after the insurer receives all documentation reasonably necessary to determine claim payment.

Sec. 7. If:

(1) a provider has an assignment of benefits from a covered individual;

(2) the provider gives notice of the assignment of benefits under section 5 of this chapter to the insurer required to provide benefits to the covered individual under a policy;

(3) the provider renders health care services to the covered individual;

(4) the insurer makes a benefit payment for the health care services referred to in subdivision (3) not directly to the provider but directly to the covered individual or the authorized representative of the covered individual; and

(5) the provider notifies the insurer that the provider has not received the benefit payment to which the provider was entitled for the health care services referred to in subdivision (3);

the insurer, not more than thirty (30) days after receiving notice from the provider under subdivision (5) of the misdirected benefit payment, shall make the benefit payment directly to the provider.

Sec. 8. If:

(1) a provider has an assignment of benefits from a covered individual;

(2) the provider gives notice of the assignment of benefits under section 5 of this chapter to the insurer required to provide benefits to the covered individual under a policy;

(3) the provider renders health care services to the covered individual; and

(4) there is a good faith dispute regarding:

(A) the legitimacy of the claim relating to the services rendered;

(B) the appropriate amount of reimbursement for the claim; or

(C) the authorization for the assignment of benefits;

the insurer, not more than fourteen (14) business days after the insurer receives the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the provider or the provider's authorized representative.

Sec. 9. A provider, by accepting an assignment of benefits under this chapter, does not agree to accept an insurer's fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 10. A provision that:

(1) is contained in an agreement between an insurer and a provider under this chapter; and

(2) violates this chapter;

is void.

SECTION 2. IC 27-13-36.3 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 36.3. Payment to Nonparticipating Providers

Sec. 1. As used in this chapter, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) A person that pays or administers claims on behalf of a

health maintenance organization or limited service health maintenance organization.

Sec. 2. (a) Except as provided in subsection (b), if:

(1) an individual contract or group contract provides coverage for a health care service;

(2) the health care service is rendered by a nonparticipating provider; and

(3) the nonparticipating provider provides written or electronic notification to the health maintenance organization that the nonparticipating provider has rendered the health care service to an enrollee who is covered under the individual contract or group contract;

the health maintenance organization shall make a benefit payment directly to the nonparticipating provider for the health care service and send written notice of the payment to the enrollee or the authorized representative of the enrollee.

(b) A health maintenance organization is not required to make a benefit payment directly to a nonparticipating provider if the nonparticipating provider has been charged with or convicted of fraud.

(c) This section does not require coverage for benefits not covered under the terms of the individual contract or group contract.

Sec. 3. A health maintenance organization that does not make benefit payments as required under section 2 of this chapter shall pay seven percent (7%) interest, compounded daily, accruing from the day after the benefit payment was due, on all amounts that are unpaid thirty (30) days after the health maintenance organization receives all documentation reasonably necessary to determine claim payment.

Sec. 4. If:

(1) a nonparticipating provider provides health care services described in section 2 of this chapter;

(2) the health maintenance organization makes a benefit payment for the health care services referred to in subdivision (1) not directly to the nonparticipating provider but directly to the enrollee or the authorized representative of the enrollee; and

(3) the nonparticipating provider notifies the health maintenance organization that the nonparticipating provider has not received the benefit payment to which the nonparticipating provider was entitled for the health care

services referred to in subdivision (1);

the health maintenance organization, not more than thirty (30) days after receiving notice from the nonparticipating provider under subdivision (3) of the misdirected benefit payment, shall make the benefit payment directly to the nonparticipating provider.

Sec. 5. If:

(1) a nonparticipating provider provides health care services described in section 2 of this chapter; and

(2) there is a good faith dispute regarding:

(A) the legitimacy of the claim relating to the services rendered;

(B) the appropriate amount of reimbursement for the claim; or

(C) the payment of the claim under the terms of the individual contract or group contract;

the health maintenance organization, not more than fourteen (14) business days after the health maintenance organization receives the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the nonparticipating provider or the nonparticipating provider's authorized representative.

Sec. 6. A nonparticipating provider, by providing health care services described in section 2 of this chapter, does not agree to accept the health maintenance organization's fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 7. A contract provision that violates this chapter is void.

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 152, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to Senate Bill 152 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 6, Nays 5.