CONFERENCE COMMITTEE REPORT
DIGEST FOR EHB 1300

Citations Affected: IC 27-1-3-31; IC 27-8-11-11; IC 27-13-36-12.

Synopsis: Health plan requirements and study. Conference committee report for EHB 1300. Requires certain insurers and health maintenance organizations to submit certain data and information to the insurance commissioner. Requires the insurance commissioner to study the submissions and make certain actuarial determinations and report to the health finance commission. Requires certain insurer and health maintenance organization notice to covered individuals concerning claim payments. Requires the health finance commission to study certain issues during the 2009 interim and report to the legislative council. **(This conference committee report: (1) requires the insurance commissioner to specify data and information and prescribe a format for the data and information submission from insurers and health maintenance organizations; (2) specifies confidentiality requirements; (3) requires notice of possible criminal penalties related to claim payments; and (4) amends certain deadlines.)**

Effective: Upon passage; July 1, 2009.

CONFERENCE COMMITTEE REPORT

MADAM PRESIDENT:

Your Conference Committee appointed to confer with a like committee from the House upon Engrossed Senate Amendments to Engrossed House Bill No. 1300 respectfully reports that said two committees have conferred and agreed as follows to wit:

that the House recede from its dissent from all Senate amendments and that the House now concur in all Senate amendments to the bill and that the bill be further amended as follows:

Delete everything after the enacting clause and insert the following:

SECTION 1. IC 27-1-3-31 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 31. (a) Not later than September 1, 2009, each insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1) and each health maintenance organization shall submit to the commissioner specified data and information in a format prescribed by the commissioner. If data or information from a health care provider is determined to be necessary to complete the study under subsection (b), the health care provider shall submit the data or information to the commissioner.**

(b) The commissioner shall study the data and information submitted under subsection (a) and make actuarial determinations of the savings and costs of implementation of direct reimbursement by the insurers and health maintenance organizations to out-of-network health care providers for health care services rendered to insureds and enrollees.

(c) The commissioner shall specify the data and information to be submitted under subsection (a) to reflect the following:

(1) The costs incurred or savings experienced by the insurer or health maintenance organization in implementing direct

reimbursement to the health care providers.

(2) Operational costs incurred or savings experienced in implementing direct reimbursement to the health care providers.

(3) The number of additional health care providers, by specialty, that would be reimbursed by the insurer or health maintenance organization after the insurer or health maintenance organization implemented direct reimbursement.

(4) Any other costs or savings that an insurer, a health maintenance organization, the commissioner, or the chairperson of the health finance commission established by IC 2-5-23-3 determines to be relevant to direct reimbursement.

(d) The commissioner shall report the results of the study and actuarial determinations made under subsection (b) to the health finance commission in an electronic format under IC 5-14-6 before October 15, 2009.

(e) Data and information submitted, and results of the study and actuarial determinations made, under this section that identify an individual insurer, health maintenance organization, health care provider, or individual are confidential. However, upon request of the chairperson of the health finance commission, the commissioner shall:

(1) remove identifying information from; and

(2) provide, to the legislative services agency and members of the health finance commission;

the data and information submitted under subsection (a).

(f) This section expires December 31, 2009.

SECTION 2. IC 27-8-11-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: **Sec. 11. (a) As used in this section, "noncontracted provider" means a provider that has not entered into an agreement with an insurer under section 3 of this chapter.**

(b) After September 30, 2009, if an insurer makes a payment to an insured for a health care service rendered by a noncontracted provider, the insurer shall include with the payment instrument written notice to the insured that includes the following:

(1) A statement specifying the claims covered by the payment instrument.

(2) The name and address of the provider submitting each claim.

(3) The amount paid by the insurer for each claim.

(4) Any amount of a claim that is the insured's responsibility.

(5) A statement in at least 24 point bold type that:

(A) instructs the insured to use the payment to pay the noncontracted provider if the insured has not paid the noncontracted provider in full;

(B) specifies that paying the noncontracted provider is the insured's responsibility; and

(C) states that the failure to make the payment violates the

law and may result in collection proceedings or criminal penalties.

SECTION 3. IC 27-13-36-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: **Sec. 12. (a) As used in this section, "nonparticipating provider" means a provider that has not entered into an agreement with a health maintenance organization to serve as a participating provider.**

(b) After September 30, 2009, if a health maintenance organization makes a payment to an enrollee for a health care service rendered by a nonparticipating provider, the health maintenance organization shall include with the payment instrument written notice to the enrollee that includes the following:

(1) A statement specifying the claims covered by the payment instrument.

(2) The name and address of the provider submitting each claim.

(3) The amount paid by the health maintenance organization for each claim.

(4) Any amount of a claim that is the enrollee's responsibility.

(5) A statement in at least 24 point bold type that:

(A) instructs the enrollee to use the payment to pay the nonparticipating provider if the enrollee has not paid the nonparticipating provider in full;

(B) specifies that paying the nonparticipating provider is the enrollee's responsibility; and

(C) states that the failure to make the payment violates the law and may result in collection proceedings or criminal penalties.

SECTION 4. [EFFECTIVE UPON PASSAGE] **(a) The health finance commission established by IC 2-5-23-3 shall, during the 2009 interim, study:**

(1) the effect on insurers, health care providers, insureds, and other patients of a provision in an agreement with a health care provider under IC 27-8-11-3 requiring the health care provider to accept as patients more insureds than:

(A) the number of insureds specified in the agreement; or

(B) if there is not a number of insureds specified in the agreement, the number that, in the health care provider's professional judgment, is the greatest number of insureds that the health care provider is able to accept without endangering the health care provider's patients' access to or continuity of care;

(2) the effect on health maintenance organizations, participating providers, enrollees, and other patients of a provision in a contract between a health maintenance organization and a participating provider requiring the participating provider to accept as patients more enrollees than:

(A) the number of enrollees specified in the contract; or

(B) if there is not a number of enrollees specified in the contract, the number that, in the participating provider's professional judgment, is the greatest number of enrollees that the participating provider is able to accept without endangering the participating provider's patients' access to or continuity of care; and

(3) any other issue related to a provision described in subdivision (1) or (2), as determined by the health finance commission or the legislative council.

(b) The health finance commission shall, not later than November 1, 2009, report the health finance commission's findings and recommendations concerning the study conducted under subsection (a) to the legislative council in an electronic format under IC 5-14-6.

(c) The health finance commission shall, during the 2009 interim, study whether an insurer or health maintenance organization described in IC 27-1-3-31, as added by this act, should be required to directly reimburse an out-of-network health care provider for health care services rendered to an insured or enrollee, considering the report of the insurance commissioner's study and actuarial determinations reported to the health finance commission under IC 27-1-3-31, as added by this act.

(d) This SECTION expires December 31, 2009.

SECTION 5. **An emergency is declared for this act.**

(Reference is to EHB 1300 as reprinted March 31, 2009.)

Conference Committee Report
on
Engrossed House Bill 1300

Signed by:

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Representative Welch Chairperson	Senator Gard
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Representative Lehman	Senator Errington
House Conferees	**Senate Conferees**