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New Surprise Bill Legislation Proposed in Indiana

Overview

Currently, new legislation is under discussion in the state of Indiana regarding surprise billing. Both the Senate and the House have proposed their own bills (SB 3 and HB 1004) with overlapping recommendations regarding how best to advance legislation targeting surprise bills and looking to achieve fair protocol for determining rates. If passed, this legislation will likely have widespread impact on both the health care and insurance industries.

Background

In January of 2018, Indiana enacted legislation (HB 1273) to address concerns with surprise billing. This bill required providers to give advance written notice to patients when a referral includes out-of-network services. The written notice must state the following:

- That an out-of-network provider may be called upon during treatment
- That an out-of-network provider is not bound by the payment limitations of the network provider under the insured's health plan
- That an insured may consult their insurance provider before accepting out-of-network services

The bill also identifies the following circumstances as exceptions where no notification is required:

- A referral is made for emergency medical conditions
- A referral is made for medically or psychologically necessary therapeutic services provided to an admitted patient in a hospital or another facility to which a patient may be admitted for more than twenty-four hours
- For a patient covered by Medicaid, Workers' Compensation insurance, or who is uninsured

New Developments

Committees in the House and Senate both heard proposals recently advocating new legislation targeting surprise billing in Indiana. Each bill (House Bill 1004 and Senate Bill 3) attempts to eliminate surprise bills for patients while determining a fair process for setting rates of services rendered. The major highlights of these bills are as follows:

- Prohibits patient from being billed more than in-network rates when provided at in-network facilities
- Allows greater than in-network rates if a patient signs a notification agreeing to pay out-of-network rates
- Requires at least 5 days advance notice that 1) Practitioner intends to charge more than in-network rates and 2) Provides a good faith estimate of the cost
- Requires a patient to sign a consent form agreeing to pay out-of-network rates

For HB 1004, there are also some controversial stipulations regarding sight of service. These are as follows:

- Requires provider to include the service facility location to obtain Medicaid reimbursement
- Requires health care providers to include the address of the service facility location on submitted reimbursement forms

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Hospitals have threatened wide-spread cuts if this legislation is passed. As a result, the Senate has agreed to amend this aspect of the legislation in their bill.

Notably, both HB 1004 and SB 3 propose a requirement stipulating a patient must be provided at least 5 days advance written notice to warn them of potential out-of-network charges, as well as a good faith cost estimate. This would prove very difficult, if not impossible, from a logistical perspective as patient contact is quite limited for many specialists. As a result of these concerns and others, hundreds of hospital representatives from around the state gathered around the Statehouse to protest.

Many of those who testified in the dispute regarding the arbitration and resolution process support the measures suggested in both bills. Most parties involved agree patients should not receive surprise out-of-network bills, but the discrepancy arises in determining fair reimbursement procedures. In general, providers prefer an arbitration process to avoid health insurance companies dictating rates of service. Health insurance companies, in turn, argue that arbitration will result in higher rates and ultimately higher insurance premiums for patients. Alternative methods of pricing have been suggested, such as doubling the Medicare rates, but no definitive answer has yet been determined. Failing to settle on an appropriate and fair method of rate setting could result in increased health care costs, inability to recruit emergency physicians and specialists in the state, and potential harm to rural hospitals.

Discussions of these legislative actions are ongoing, and APS will continue to monitor all developments that may affect your practice's compliance and reimbursement. If you have further questions on your state's regulation on balance billing, please contact your Practice Manager.