February 18, 1998

ENGROSSED
SENATE BILL No. 364

DIGEST OF SB 364 (Updated February 17, 1998 2:39 pm - DI 88)

Citations Affected: IC 27-13; noncode.

Synopsis: Health maintenance organization patient protection. Requires a health maintenance organization to do the following: (1) Provide enrollees with full and timely access to participating providers. (2) Employ medical directors and doctors to develop treatment policies, protocols, and quality assurance activities, and to make utilization review decisions. (3) Provide enrollees with continuation of care and referrals to out of network providers as necessary. (4) Provide coverage for emergency services under a prudent layperson standard. (5) Offer adequate choice among health care providers that are accessible and

(Continued next page)

Effective: July 1, 1998.

Lawson, Simpson, Miller, Gard, Wolf, Breaux, Landske, Dempsey, Worman, Antich, Randolph, R. Young

(HOUSE SPONSORS — CROSBY, BUDAK)

January 8, 1998, read first time and referred to Committee on Health and Environmental Affairs.
January 26, 1998, amended, reported favorably — Do Pass.
January 30, 1998, read second time, amended, ordered engrossed.
February 2, 1998, engrossed.
February 3, 1998, read third time, passed. Yeas 35, nays 15.

HOUSE ACTION

February 10, 1998, read first time and referred to Committee on Public Health.
February 17, 1998, amended, reported — Do Pass.

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qualified. (6) Offer a point-of-service option to each purchaser of a group contract or individual contract. (7) Distribute to participating providers drug and device formularies if developed, and establish a procedure to allow enrollees to obtain nonformulary drugs if medically necessary and appropriate. (8) Develop and implement a procedure to evaluate whether to provide coverage for new medical technologies and new applications of existing medical technologies. (9) Provide comparison sheets that clearly explain the services offered by the health maintenance organization. Adds additional reporting requirements for health maintenance organizations. Requires limited service health maintenance organizations to comply with provisions concerning reporting, hold harmless clauses in contracts, referrals to out of network providers, continuation of care, and comparison sheets. Requires the department of insurance to annually review health plan employer data and information set (HEDIS) data submitted by each health maintenance organization and to develop a compilation of the data that allows for comparative analysis.

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February 18, 1998

Second Regular Session 110th General Assembly (1998)

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 1997 General Assembly.

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ENGROSSED
SENATE BILL No. 364

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 27-13-1-11.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 11.3. "Department" refers to the department of insurance.**

SECTION 2. IC 27-13-1-11.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 11.7. "Emergency" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:**

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of

the individual.

SECTION 3. IC 27-13-1-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 13.5. "Experimental treatment" means medical technology or a new application of existing medical technology, including medical procedures, drugs, and devices for treating a medical condition, illness, or diagnosis that:**

(1) is not generally accepted by informed health care professionals in the United States as effective; or

(2) has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

SECTION 4. IC 27-13-1-27.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 27.5. "Primary care provider" means a provider under contract with a health maintenance organization who is designated by the health maintenance organization to coordinate, supervise, or provide ongoing care to an enrollee.**

SECTION 5. IC 27-13-1-28.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 28.5. "Quality assurance" means the ongoing evaluation of the quality of health care services provided to enrollees.**

SECTION 6. IC 27-13-8-2, AS AMENDED BY P.L.191-1997, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:

(1) Audited financial statements of the health maintenance organization for the preceding calendar year.

(2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.

(3) A description of the grievance procedure of the health maintenance organization, the total number of grievances handled through the procedure during the preceding calendar year, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

(4) The percentage of providers credentialed by the health maintenance organization according to standards, if any,

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developed by the National Committee on Quality Assurance or a successor organization.

(5) The health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data.

(b) The information required by subsection (a)(2) ~~and (a)(3)~~ **through (a)(4)** must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be filed with the commissioner on or before June 1 of each year. **The health maintenance organization's HEDIS data required by subsection (a)(5) must be filed with the commissioner on or before July 1 of each year.** The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a)(3) **through (a)(5)** that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

SECTION 7. IC 27-13-9-1, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. Upon:

(1) the enrollment; and

(2) each reenrollment;

of a subscriber, a health maintenance organization must provide to the subscriber a list of providers who provide health care services through the health maintenance organization. **The health maintenance organization must also provide the list of providers to a potential enrollee upon request.**

SECTION 8. IC 27-13-9-4, AS AMENDED BY P.L.191-1997, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 4. A health maintenance organization shall provide to each enrollee and subscriber:

(1) information on:

(A) how services can be obtained;

(B) where additional information on access to services can be obtained; ~~and~~

(C) how to file a grievance under IC 27-13-10; ~~and~~

(D) the health maintenance organization's:

(i) structure;

(ii) health care benefits and exclusions; and

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(iii) criteria for denying coverage; and

(E) costs for which the enrollee or subscriber is responsible; and

(2) a toll free telephone number through which the enrollee can contact the health maintenance organization at no cost to the enrollee to obtain information and to file grievances.

The information under this section must be provided to a potential enrollee of the health maintenance organization upon request.

SECTION 9. IC 27-13-23-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 7. (a) Beginning July 1, 1999, the commissioner shall review each health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data on an annual basis.**

(b) The commissioner may contract with an appropriate entity to conduct the reviews required under this section.

SECTION 10. IC 27-13-24-1, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) The commissioner may suspend or revoke a certificate of authority issued under this article or deny an application submitted under this article if the commissioner finds that any of the following conditions exists:

(1) The health maintenance organization is operating:

(A) significantly in contravention of its basic organizational document; or

(B) in a manner contrary to that described in any other information submitted under IC 27-13-2;

unless amendments to the basic organizational document or other submissions that are consistent with the operations of the organization have been filed with and approved by the commissioner.

(2) The health maintenance organization:

(A) issues an evidence of coverage;

(B) enters into a contract with a participating provider; or

(C) uses a schedule of charges for health care services;

that does not comply with the requirements of IC 27-13-7, IC 27-13-15, and IC 27-13-20.

(3) The health maintenance organization does not provide or arrange for basic health care services.

(4) The commissioner determines that the health maintenance organization is unable to fulfill its obligations to furnish health care coverage.

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(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(6) The health maintenance organization has failed to correct, within the time prescribed by section 2 of this chapter, any deficiency occurring due to the impairment of the prescribed minimum net worth of the health maintenance organization.

(7) The health maintenance organization has failed to implement the grievance procedures required by IC 27-13-10 in a reasonable manner to resolve valid complaints.

(8) The health maintenance organization or any person acting on behalf of the organization has intentionally advertised or merchandised the services of the organization in an untrue, a misrepresentative, a misleading, a deceptive, or an unfair manner.

(9) The continued operation of the health maintenance organization would be hazardous to the enrollees of the organization.

(10) The health maintenance organization fails to comply with the requirements provided under IC 27-13-36 through IC 27-13-40.

~~(10)~~ **(11)** The health maintenance organization has otherwise failed substantially to comply with this article.

(b) The commissioner, in a proceeding under IC 4-21.5-3-8, may impose a civil penalty of not more than twenty-five thousand dollars ($25,000) against a health maintenance organization for each cause listed in subsection (a). The civil penalties may not exceed one hundred thousand dollars ($100,000) for any one (1) health maintenance organization in one (1) calendar year. The penalty may be imposed in addition to or instead of a suspension or revocation of the certificate of authority of the health maintenance organization.

SECTION 11. IC 27-13-28-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 7. This article does not preclude the department from investigating complaints, grievances, or appeals on behalf of enrollees or providers.**

SECTION 12. IC 27-13-34-12, AS AMENDED BY P.L.191-1997, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 12. A limited service health maintenance organization operated under this chapter is subject to the following:

(1) IC 27-13-8, except for IC 27-13-8-2(a)(5) concerning reports.

~~(1)~~ **(2)** IC 27-13-10-1 through IC 27-13-10-3 concerning

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grievance procedures.

~~(2)~~ **(3)** IC 27-13-11 concerning investments.

(4) IC 27-13-15 concerning hold harmless clauses in contracts.

~~(3)~~ **(5)** IC 27-13-21 concerning producers.

~~(4)~~ **(6)** IC 27-13-29 concerning statutory construction and relationship to other laws.

~~(5)~~ **(7)** IC 27-13-30 concerning public records.

~~(6)~~ **(8)** IC 27-13-31 concerning confidentiality of medical information and limitation of liability.

(9) IC 27-13-36-5 and IC 27-13-36-6 concerning referrals to out-of-network providers and continuation of care.

(10) IC 27-13-40 concerning comparison sheets of services provided by a limited service health maintenance organization.

SECTION 13. IC 27-13-34-15, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 15. All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment basis or other basis must contain, or shall be construed to contain, the following terms and conditions:

(1) If the limited service health maintenance organization fails to pay for limited health services for any reason whatsoever, including insolvency or breach of this contract, the enrollees shall not be liable to the provider for any sums owed to the provider under this contract.

(2) No provider or agent, trustee, representative, or assignee of a provider may maintain an action at law or attempt to collect from the enrollee sums that the limited service health maintenance organization owes to the provider.

(3) These provisions do not prohibit the collection of:

(A) uncovered charges consented to by enrollees; or

(B) copayments;

from enrollees.

(4) The contract may not provide for a financial or other penalty to a primary care provider for making a referral permitted under IC 27-13-36-5(a), but may provide for reasonable cost sharing between the primary care provider and the limited service health maintenance organization for the additional costs incurred as a result of service provided by an out of network provider.

~~(4)~~ **(5)** These provisions survive the termination of this contract, regardless of the reason for the termination.

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~~(5)~~ **(6)** For not more than ninety (90) days after the termination of this contract, the provider must complete procedures in progress on an enrollee receiving treatment for a specific condition, at the same schedule of copayment or other applicable charge that is in effect on the effective date of termination of the contract.

~~(6)~~ **(7)** An amendment to the provisions of this contract set forth in subdivisions (1) through ~~(5)~~ **(6)** must be:

(A) submitted to; and

(B) approved by;

the commissioner before it becomes effective.

SECTION 14. IC 27-13-36 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:

Chapter 36. Patient Protection; Clinical Decision Making; Access to Personnel and Facilities

Sec. 1. (a) Each health maintenance organization shall appoint a medical director who has an unlimited license to practice medicine under IC 25-22.5 or an equivalent license issued by another state.

(b) The medical director is responsible for oversight of treatment policies, protocols, quality assurance activities, and utilization management decisions of the health maintenance organization.

(c) A health maintenance organization shall contract with or employ at least one (1) individual who holds an unlimited license to practice medicine under IC 25-22.5 to do the following:

(1) Participate in the development of the health maintenance organization's treatment policies, protocols, and quality assurance activities.

(2) Consult with the treating provider before an adverse utilization review decision is made.

Sec. 2. Beginning July 1, 1999, each health maintenance organization shall include a sufficient number and type of primary care providers and other appropriate providers throughout the health maintenance organization's service area to:

(1) meet the needs of; and

(2) provide a choice of primary care providers and other appropriate providers to;

subscribers of the health maintenance organization. Compliance with the most current guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.

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Sec. 3. (a) The provisions of this section do not apply until July 1, 1999.

(b) Each health maintenance organization shall demonstrate to the department that the health maintenance organization offers an adequate number of:

(1) acute care hospital services;

(2) primary care providers; and

(3) other appropriate providers;

that are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with the most current guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.

(c) If a health maintenance organization provides coverage for:

(1) specialty medical services, including physical therapy, occupational therapy, and rehabilitation services;

(2) mental and behavioral care services; or

(3) pharmacy services;

the health maintenance organization shall demonstrate to the department that the offered services are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with the most current guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.

Sec. 4. Beginning July 1, 1999, primary care providers shall include licensed physicians who practice in one (1) or more of the following areas:

(1) Family practice.

(2) General practice.

(3) Internal medicine.

(4) As a woman's health care provider, in compliance with IC 27-8-24.7.

(5) Pediatrics.

Sec. 5. (a) The provisions of the section do not apply until July 1, 1999.

(b) When an enrollee's primary care provider determines that the enrollee needs a particular health care service and the health maintenance organization determines that the type of health care service needed by the enrollee to treat a specific condition:

(1) is a covered service; and

(2) is not available from the health maintenance

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organization's network of participating providers;

the primary care provider and the health maintenance organization shall refer the enrollee to an appropriate provider who is not a participating provider within a reasonable amount of time and within a reasonable proximity of the enrollee.

(c) When an enrollee receives health care services from a provider to whom the enrollee was referred as described in subsection (b), the health maintenance organization shall pay the out of network provider the lesser of the following:

(1) The usual, customary, and reasonable charge in the health maintenance organization's service area for the health care services provided by the out of network provider.

(2) An amount agreed to between the health maintenance organization and the out of network provider.

The enrollee's treating provider may collect from the enrollee only the deductible or copayment, if any, that the enrollee would be responsible to pay if the health care services had been provided by a participating provider. The enrollee may not be billed by the health maintenance organization or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the health maintenance organization to the out of network provider as provided in this subsection.

(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a determination allowed under subsection (b).

Sec. 6. (a) A health maintenance organization shall include provisions in the health maintenance organization's contracts with providers to provide for continuation of care in the event that a provider's contract with the health maintenance organization is terminated, provided that the termination is not due to a quality of care issue.

(b) The contract provisions under subsection (a) shall require that the provider, upon the request of the enrollee, continue to treat the enrollee for up to sixty (60) days following the termination of the provider's contract with the health maintenance organization or, in the case of a pregnant enrollee in the third trimester of pregnancy, throughout the term of the enrollee's pregnancy. If the provider is a hospital, the contract shall provide for continuation of treatment until the earlier of the following:

(1) Sixty (60) days following the termination of the provider's contract with the health maintenance organization.

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(2) The enrollee is released from inpatient status at the hospital.

(c) During a continuation period under this section, the provider:

(1) shall agree to continue accepting the contract terms and conditions, together with applicable deductibles and copayments, as payment in full; and

(2) is prohibited from billing the enrollee for any amounts in excess of the enrollee's applicable deductible or copayment.

Sec. 7. Each health maintenance organization shall provide the following:

(1) Telephone access to the health maintenance organization during business hours to ensure enrollee access for routine care.

(2) Twenty-four (24) hour telephone access to either:

(A) a representative of the health maintenance organization; or

(B) a participating provider;

for authorization for care.

Sec. 8. (a) Each health maintenance organization shall establish guidelines for establishing reasonable periods of time within which an enrollee must be given an appointment with a participating provider, except as provided in section 9 of this chapter regarding emergency services.

(b) The guidelines described in subsection (a) must include appointment scheduling guidelines based on the type of health care services most often requested, including the following:

(1) Prenatal care appointments.

(2) Well-child visits and immunizations.

(3) Routine physicals.

(4) Adult preventive services.

(5) Urgent visits.

Sec. 9. (a) As used in this section, "care obtained in an emergency" means, with respect to an enrollee, covered services that are:

(1) furnished by a provider within the scope of the provider's license and as otherwise authorized under law; and

(2) needed to evaluate or stabilize an individual in an emergency.

(b) As used in this section, "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material

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deterioration of the individual's condition is not likely to result from or during any of the following:

(1) The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual.

(2) The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility.

(3) The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient setting.

(c) As described in subsection (d), each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency by an enrollee without:

(1) prior authorization; or

(2) regard to the contractual relationship between:

(A) the provider who provided health care services to the enrollee in an emergency; and

(B) the health maintenance organization;

in a situation where a prudent lay person could reasonably believe that the enrollee's condition required immediate medical attention. The emergency care obtained by an enrollee under this section includes care for the alleviation of severe pain, which is a symptom of an emergency as provided in IC 27-13-1-11.7.

(d) Each health maintenance organization shall cover and reimburse expenses for emergency services at a rate equal to the lesser of the following:

(1) The usual, customary, and reasonable charge in the health maintenance organization's service area for health care services provided during the emergency.

(2) An amount agreed to between the health maintenance organization and the out of network provider.

A provider that provides emergency services to an enrollee under this section may not charge the enrollee except for an applicable copayment or deductible. Care and treatment provided to an enrollee once the enrollee is stabilized is not care obtained in an emergency.

Sec. 10. Each health maintenance organization shall demonstrate to the commissioner that the health maintenance organization has developed an access plan to meet the needs of the health maintenance organization's enrollees, including vulnerable

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and underserved enrollees and enrollees from major population groups who speak a primary language other than English.

Sec. 11. The health maintenance organization shall develop standards for continuity of care following enrollment, including sufficient information on how to access care within the health maintenance organization.

SECTION 15. IC 27-13-37 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:

Chapter 37. Patient Protection; Choice of Health Care Professional

Sec. 1. (a) A health maintenance organization shall allow each enrollee of the health maintenance organization to choose the enrollee's own primary care provider from a list of participating primary care providers within the health maintenance organization.

(b) The list described in subsection (a) shall be updated semiannually and must include a sufficient number of primary care providers that accept new enrollees. The list must be:

(1) provided to each enrollee annually; and

(2) sent to an enrollee at the enrollee's request.

Sec. 2. (a) Each health maintenance organization shall develop a system to allow an enrollee to use an appropriate participating provider to manage the enrollee's medical condition when the enrollee's primary care provider determines that the use of another appropriate participating provider is warranted by the enrollee's medical condition.

(b) A primary care provider who makes the required determination under subsection (a) shall refer the enrollee to a participating provider whom the primary care provider determines is appropriate.

(c) A health maintenance organization shall provide coverage under this section for treatment received by an enrollee from an appropriate participating provider when the enrollee is referred to the participating provider as provided in this section for as long as the treatment is appropriate for the medical condition, subject to the terms and conditions of the enrollee's contract with the health maintenance organization.

(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a referral allowed under this section.

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Sec. 3. Beginning July 1, 1999, each health maintenance organization shall provide continuity of care and referral to appropriate participating providers when specialty care is warranted, including the following:

(1) Enrollees have access to appropriate participating providers on a timely basis.

(2) Enrollees have a choice of appropriate participating providers when a referral is made.

Sec. 4. Beginning July 1, 1999, each health maintenance organization shall offer to each purchaser of a group contract or individual contract a point-of-service product to the extent permitted by IC 27-13-13-8.

Sec. 5. Each health maintenance organization shall allow an enrollee who has received a medical opinion from a participating provider to obtain a second medical opinion from an appropriate participating provider concerning the enrollee's medical condition at the enrollee's request.

SECTION 16. IC 27-13-38 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]:

Chapter 38. Patient Protection; Drugs and Devices; Drug Utilization Review Program

Sec. 1. (a) A health maintenance organization may apply a formulary to the prescription drug and devices benefits provided by the health maintenance organization if the formulary is developed, reviewed, and updated:

(1) in consultation with; and

(2) with the approval of;

a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.

(b) If a health maintenance organization maintains one (1) or more drug and devices formularies, the health maintenance organization shall do the following:

(1) Disseminate to participating providers and pharmacists the complete drug and devices formulary or formularies maintained by the health maintenance organization, including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(2) Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty

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or additional cost sharing beyond that provided for in the enrollee's covered benefits with the health maintenance organization, coverage for a specific, medically necessary and appropriate nonformulary drug or device if the participating provider documents and certifies in the enrollee's medical records that:

(A) the formulary drug or device is ineffective in treating the enrollee's disease or condition; or

(B) the participating provider believes that the formulary drug or device causes or is reasonably expected to cause a harmful outcome or a less than reasonably optimal outcome to the enrollee.

(c) A health maintenance organization may not:

(1) void a contract; or

(2) refuse to renew a contract;

between the health maintenance organization and a participating provider because the participating provider has prescribed a medically necessary and appropriate nonformulary drug or device as provided in subsection (b)(2).

Sec. 2. Subject to section 1(b)(2) of this chapter, a prescribing provider who prescribes drugs or devices shall determine the appropriate drug therapy or device for an enrollee. A generic substitution for a prescribed drug or device may be made only in compliance with IC 16-42-22.

Sec. 3. Each health maintenance organization that has a prescription drug benefit shall establish and operate, or cause to be established and operated, a drug utilization review program that includes the following:

(1) Retrospective review of prescription drugs furnished to enrollees.

(2) Education of physicians, enrollees, and pharmacists regarding the appropriate use of prescription drugs.

(3) Ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees.

(4) Clinically relevant criteria and standards for drug therapy.

(5) Nonproprietary criteria and standards, developed and revised through an open, professional consensus process.

(6) Interventions that focus on improving therapeutic outcomes, including prospective drug utilization review programs that monitor for possible prescription drug

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problems or complications, including drug to disease interactions, drug to drug interactions, or therapeutic duplication.

Sec. 4. The primary emphasis of the drug utilization review program established under section 3 of this chapter is to enhance quality of care for enrollees by assuring appropriate drug therapy.

Sec. 5. The name of an enrollee that is discovered in the course of the drug utilization review program shall remain confidential.

Sec. 6. The commissioner, with input and assistance from the state health commissioner, may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 17. IC 27-13-39 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]:

Chapter 39. Patient Protection; Experimental Treatments

Sec. 1. (a) A health maintenance organization shall develop and implement a procedure to evaluate whether to provide coverage for new medical technologies and new applications of existing medical technologies, including medical procedures, drugs, and devices.

(b) A health maintenance organization shall maintain the procedure required under subsection (a) in writing. The written procedure shall describe the process used to determine whether the health maintenance organization will provide coverage for new medical technologies and new uses of existing medical technologies.

(c) The procedure required under this section shall include a review of information from appropriate governmental regulatory bodies and published scientific literature about new medical technologies and new uses of existing medical technologies.

(d) A health maintenance organization shall include appropriate professionals in the decision making process to determine whether new medical technologies and new uses of existing medical technologies qualify for coverage.

Sec. 2. (a) A health maintenance organization that limits coverage for experimental services must clearly state the limitations in any contract, policy, agreement, or certificate of coverage.

(b) The disclosure required under subsection (a) must include the following:

(1) A description of the process used to make the determination regarding a limitation under subsection (a).

(2) A description of the criteria the health maintenance

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organization uses to determine whether a service is experimental, as provided in section 1 of this chapter.

Sec. 3. (a) If a health maintenance organization denies coverage for a treatment, procedure, drug, or device on the grounds that the treatment, procedure, drug, or device is experimental, the health maintenance organization shall provide the enrollee with a written explanation that includes the following:

(1) The basis for the denial.

(2) The enrollee's right to appeal the health maintenance organization's decision as provided in IC 27-8-16-8, IC 27-8-17-12, and IC 27-13-10.

(3) The telephone number of:

(A) an individual employed by the health maintenance organization whom; or

(B) a department of the health maintenance organization that;

the enrollee may contact for assistance in initiating an appeal of the health maintenance organization's decision.

(b) An enrollee is entitled to a review that takes not more than seventy-two (72) hours if the enrollee's health situation is life threatening or is an emergency.

SECTION 18. IC 27-13-40 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:

Chapter 40. Patient Protection; Health Maintenance Organization Comparison Sheets Managed Care Plan Descriptions

Sec. 1. Beginning January 1, 2000, each health maintenance organization shall make available a health maintenance organization comparison sheet for each policy or contract that either covers or is marketed to an Indiana resident or the resident's employer.

Sec. 2. (a) The comparison sheet required under section 1 of this chapter must include information of general interest to:

(1) purchasers of group contracts and individual contracts; and

(2) individuals covered by each group contract or individual contract.

(b) The comparison sheet must be designed to facilitate comparison of different health maintenance organizations.

Sec. 3. A health maintenance organization shall provide a completed health maintenance organization comparison sheet to the following:

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(1) Upon request, to an individual covered by the health maintenance organization or to the individual's employer.

(2) As part of the health maintenance organization's marketing materials, to a person or an employer that may be interested in purchasing or obtaining coverage under a group contract or individual contract offered by the health maintenance organization.

SECTION 19. [EFFECTIVE JULY 1, 1998] **(a) Not later than January 1, 1999, the commissioner of the department of insurance shall adopt rules under IC 4-22-2 regarding the format for and elements of the health maintenance organization comparison sheet required under IC 27-13-40-1, as added by this act.**

(b) This SECTION expires January 1, 2000.

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SENATE MOTION

Mr. President: I move that Senator Wolf be added as coauthor of Senate Bill 364.

LAWSON

SENATE MOTION

Mr. President: I move that Senator Breaux be added as coauthor of Senate Bill 364.

LAWSON

SENATE MOTION

Mr. President: I move that Senator Landske be added as coauthor of Senate Bill 364.

LAWSON

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Environmental Affairs, to which was referred Senate Bill 364, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 14.

Delete pages 2 through 6.

Page 7, delete lines 1 through 30.

Page 8, line 4, delete "care is" and insert "**coverage for a particular service or treatment has been**".

Page 8, line 5, after "that the" insert "**level of**".

Page 8, line 5, delete "received by the enrollee" and insert "**authorized by the enrollee's managed care plan**".

Page 8, line 11, delete "means an amount, or a percentage of the" and insert "**has the meaning set forth in IC 27-13-1-8.**".

Page 8, delete lines 12 through 13.

Page 8, line 22, delete "the sudden onset of" and insert "**a medical condition that arises suddenly and unexpectedly and manifests itself by acute**".

Page 8, line 23, delete "sufficient".

Page 8, line 33, after "process" insert "**under IC 27-8-17 or IC 27-13-10**".

Page 8, line 34, delete "less" and insert "**not more than**".

Page 8, line 35, delete "treatment that, while" and insert "**new medical technology or a new application of existing medical technology, including medical procedures, drugs, and devices for treatment of an illness or injury.**".

Page 8, delete lines 36 through 39.

Page 8, line 40, delete "written".

Page 9, delete lines 3 through 15.

Page 9, line 16, delete "14. (a)" and insert "**13**".

Page 9, line 16, delete "means" and insert "**has the meaning set forth in IC 27-13-1-18.**".

Page 9, delete lines 17 through 30.

Page 9, line 31, delete "15" and insert "**14**".

Page 9, line 31, delete "means a person" and insert "**has the meaning set forth in IC 27-13-1-19.**".

Page 9, delete lines 32 through 34.

Page 9, line 35, delete "16" and insert "**15**".

Page 10, line 3, delete "17" and insert "**16**".

Page 10, line 5, delete "18" and insert "**17**".

C o p y

Page 10, delete lines 6 through 7, begin a new line block indented and insert:

"**(1) a provider sponsored organization (as defined in 42 U.S.C. 1395w-25d); or**".

Page 10, line 8, delete "(3)" and insert "**(2)**".

Page 10, line 8, delete "or limited service" and insert "**(as defined in IC 27-13-1-19);**".

Page 10, delete lines 9 through 12.

Page 10, line 14, before "provides" delete "health care".

Page 10, line 16, delete "19" and insert "**18**".

Page 10, line 17, after "that" insert "**does the following:**".

Page 10, line 17, delete "provides" begin a new line block indented and insert:

"**(1) Provides**".

Page 10, line 18, delete "The term".

Page 10, delete lines 19 through 21, begin a new line block indented and insert:

"**(2) Requires an enrollee to receive a referral to obtain health care services other than primary care.**

(3) Requires an enrollee to select a primary care provider.".

Page 10, line 22, delete "20" and insert "**19**".

Page 10, line 24, delete "health care".

Page 10, line 32, delete "21" and insert "**20**".

Page 10, line 32, delete "health care".

Page 10, line 40, delete "22" and insert "**21**".

Page 10, line 40, delete "includes the following:" and insert "**has the meaning set forth in IC 27-13-1-25.**".

Page 10, delete lines 41 through 42.

Page 11, delete lines 1 through 4.

Page 11, line 5, delete "23" and insert "**22**".

Page 11, line 5, delete "means a product that covers" and insert "**has the meaning set forth in IC 27-13-1-26.**".

Page 11, delete lines 6 through 8.

Page 11, line 9, delete "24" and insert "**23**".

Page 11, line 9, delete "health care".

Page 11, between lines 12 and 13, begin a new paragraph and insert:

"**Sec. 24. "Provider" has the meaning set forth in IC 27-13-1-28.**".

Page 11, line 25, after "IC 25-22.5" insert "**or an equivalent license issued by another state**".

Page 11, line 26, after "for" insert "**oversight of**".

Page 11, between lines 28 and 29, begin a new paragraph and insert:

C o p y

"**(c) A managed care entity shall employ at least one (1) individual who holds an unlimited license to practice medicine under IC 25-22.5 to:**

(1) develop treatment policies, protocols, and quality assurance activities; and

(2) make utilization management decisions;

of a managed care plan operated by the managed care entity.".

Page 11, line 33, delete "meaningful".

Page 11, line 41, delete "and".

Page 11, line 42, after ";" insert "**and**".

Page 11, after line 42, begin a new line double block indented and insert:

"**(D) pharmacy services, if the managed care entity offers pharmacy services;**".

Page 12, line 1, delete "distance or travel time" and insert "**proximity**".

Page 12, line 3, delete ":".

Page 12, line 4, delete "(A)".

Page 12, line 5, after "," delete "and".

Page 12, line 5, delete ";" and insert "**,**".

Page 12, line 5, after "and" insert "**mental and behavioral care services.**".

Page 12, run in lines 3 through 5.

Page 12, delete lines 6 through 7.

Page 12, line 13, delete "Obstetrics or gynecology" and insert "**As a woman's health care provider, in compliance with IC 27-8-24.7**".

Page 12, line 15, after "5." insert "**(a)**".

Page 12, line 15, after "When" insert "**an enrollee's primary care provider determines that**".

Page 12, line 17, delete "an enrollee is entitled to access" and insert "**the primary care provider shall refer the enrollee**".

Page 12, line 18, delete "a health care" and insert "**an appropriate**".

Page 12, line 18, delete "who" and insert "**that**".

Page 12, line 19, after "network" insert "**for treatment that is not available within the managed care plan's network**".

Page 12, between lines 19 and 20, begin a new paragraph and insert:

"**(b) A managed care plan shall pay a medical specialist who provides health care services as described in subsection (a) the usual, customary, and reasonable charge in the managed care plan's service area for the health care services provided by the medical specialist for the treatment.**

(c) A contract between a managed care plan and a primary care

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provider may not provide for a financial or other penalty to a primary care provider for making a referral permitted under subsection (a).".

Page 12, line 20, after "6." insert "**(a)**".

Page 12, line 20, delete "allow an enrollee, at no" and insert "**include provisions in the managed care plan's contracts with providers to provide for continuation of care in the event that a provider's contract with the managed care plan is terminated, provided that the termination is not due to a quality of care issue.**".

Page 12, delete lines 21 through 24, begin a new paragraph and insert:

"**(b) The contract provisions under subsection (a) shall require that the provider, upon the request of the managed care plan and the enrollee, continue to treat the enrollee for up to sixty (60) days following the termination of the provider's contract with the managed care plan. If the provider is a hospital, the contract shall provide for continuation of treatment until the earlier of the following:**

(1) Sixty (60) days following the termination of the provider's contract with the managed care plan.

(2) The enrollee is released from inpatient status at the hospital.

(c) During a continuation period under this section, the provider:

(1) shall agree to continue accepting the contract rate, together with applicable deductibles and copayments, as payment in full; and

(2) is prohibited from billing the enrollee for any amounts in excess of the enrollee's applicable deductible or copayment.".

Page 12, line 27, delete "and evening".

Page 13, line 7, delete "health care".

Page 13, line 8, delete "health care".

Page 13, line 31, delete "health care".

Page 13, line 37, delete "management" and insert "**alleviation**".

Page 13, delete lines 38 through 41.

Page 13, line 42, delete "(a)".

Page 14, line 2, after "," insert "**including enrollees from major population groups who speak a primary language other than English,**".

Page 14, delete lines 4 through 7.

Page 14, line 11, delete "hold harmless enrollees" and insert "**require that a participating provider hold enrollees harmless for**

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covered health services, except for applicable deductibles and copayments, as provided in IC 27-13-15-1(4).".

Page 14, delete lines 12 through 13.

Page 14, line 22, after "participating" insert "**primary care**".

Page 14, line 29, delete "A" and insert "**To the greatest extent possible, a**".

Page 14, line 30, delete "that is adequate".

Page 14, line 35, delete "enrollees" and insert "**an enrollee**".

Page 14, line 35, delete "as the enrollee's" and insert "**to treat the enrollee's medical condition**".

Page 14, line 36, delete "primary care provider".

Page 14, line 36, after "when" insert "**the enrollee's primary care provider determines that the**".

Page 14, line 37, delete "conditions" and insert "**condition**".

Page 14, delete lines 38 through 40, begin a new paragraph and insert:

"**(b) A primary care provider who makes the required determination under subsection (a) shall refer the enrollee to a medical specialist whom the primary care provider determines is appropriate.**

(c) A managed care plan shall provide coverage under this section for treatment received by an enrollee from a medical specialist when the enrollee is referred to the medical specialist as provided in this section for as long as the treatment is appropriate for the medical condition.".

Page 15, line 6, delete "plan" and insert "**entity**".

Page 15, line 6, after "offer" insert "**to each purchaser of a managed care plan**".

Page 15, line 7, delete "plan" and insert "**product**".

Page 15, line 8, delete "The point-of-service plan may require that an enrollee in the" and insert "**A managed care entity is liable to pay a provider that provides health care services to an enrollee of the managed care entity under a point-of-service product the same amount that the managed care entity would pay to a participating provider that provides the same health care services.**".

Page 15, delete lines 9 through 10, begin a new paragraph and insert:

"**(c) A provider that provides health care services to an enrollee of a managed care entity under a point-of-service product may charge the enrollee for an amount equal to the remainder of:**

(1) the provider's charges for the health care services; minus

(2) the amount paid by the enrollee's managed care plan

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under subsection (b).".

Page 15, line 12, after "second" insert "**medical**".

Page 15, line 16, delete "An employment contract or a" and insert "**A**".

Page 15, line 16, delete "for services".

Page 15, line 17, delete "the" and insert "**health care services**".

Page 15, line 18, delete "managed care plan".

Page 15, line 21, delete "to an enrollee of the managed care plan".

Page 15, line 26, delete "treatment options".

Page 15, line 33, before "contract" insert "**policy or**".

Page 15, line 38, delete "health care".

Page 15, line 40, delete "health care".

Page 16, line 6, delete "a" and insert "**the**".

Page 16, line 6, after "from" insert "**the subscriber or**".

Page 16, line 12, after "against" insert "**a subscriber or**".

Page 16, line 13, delete "entity" and insert "**plan**".

Page 16, line 18, after "1." insert "**(a)**".

Page 16, between lines 24 and 25, begin a new paragraph and insert:

"**(b) This section does not do any of the following:**

(1) Require coverage for any drug when the federal Food and Drug Administration has determined the drug's use to be contraindicated.

(2) Require coverage for an experimental drug not approved for any indication by the federal Food and Drug Administration.

(3) Alter any other law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration.

(c) A managed care plan may not:

(1) void a contract; or

(2) refuse to renew a contract;

between the managed care plan and a participating provider because the participating provider determines that a drug or device is medically necessary and appropriate for an enrollee's condition, as provided in subsection (a).".

Page 17, line 10, after "drugs" insert "**(as provided in IC 16-42-22)**".

Page 17, between lines 13 and 14, begin a new paragraph and insert:

"**Sec. 1. (a) A managed care plan shall develop and implement a procedure to evaluate whether to provide coverage for new medical technologies and new applications of existing medical technologies, including medical procedures, drugs, and devices.**

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(b) A managed care plan shall maintain the procedure required under subsection (a) in writing. The written procedure shall describe the process used to determine whether the managed care plan will provide coverage for new medical technologies and new uses of existing medical technologies.

(c) The procedure required under this section shall include a review of information from appropriate governmental regulatory bodies and published scientific literature about new medical technologies and new uses of existing medical technologies.

(d) A managed care plan shall include appropriate professionals in the decision making process to determine whether new medical technologies and new uses of existing medical technologies qualify for coverage.".

Page 17, line 14, delete "1" and insert "**2**".

Page 17, line 15, delete ":" and insert "**clearly state the limitations in any contract, policy, agreement, or certificate of coverage.**".

Page 17, delete lines 16 through 18.

Page 17, line 24, after "experimental" insert "**, as provided in section 1 of this chapter**".

Page 17, delete lines 25 through 38, begin a new paragraph and insert:

"**Sec. 3. (a) If a managed care plan denies coverage for a treatment, procedure, drug, or device on the grounds that the treatment, procedure, drug, or device is experimental, the managed care plan shall provide the enrollee with a letter in writing that includes an explanation of:**

(1) the basis for the denial; and

(2) the enrollee's right to appeal the managed care plan's decision as provided in IC 27-8-17-12, IC 27-8-16-8, and IC 27-13-10.

(b) An enrollee is entitled to an expedited review if the enrollee's health situation is life threatening or is an emergency.".

Page 17, line 41, after "enrollees" insert "**and subscribers**".

Page 18, between lines 1 and 2, begin a new paragraph and insert:

"**Sec. 2. The commissioner may examine the grievance procedures of a managed care plan.**".

Page 18, line 2, delete "2" and insert "**3**".

Page 18, line 7, delete "3" and insert "**4**".

Page 18, line 8, delete "in writing".

Page 18, line 8, after "enrollee" insert "**or subscriber**".

Page 18, delete lines 10 through 15.

Page 18, line 16, delete "(c)" and insert "**(b)**".

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Page 18, line 17, after "enrollees" insert "**and subscribers**".
Page 18, line 17, delete "where" and insert "**at which**".
Page 18, line 19, delete "(d)" and insert "**(c)**".
Page 18, line 19, after "enrollee's" insert "**or subscriber's**".
Page 18, delete lines 23 through 33.
Page 18, line 34, after "enrollee" insert "**or a subscriber**".
Page 18, line 35, after "enrollees" insert "**and subscribers**".
Page 18, line 42, delete "all" and insert "**the**".
Page 18, line 42, delete "spoken by" and insert "**of**".
Page 19, line 3, delete "by the managed care plan".
Page 19, line 6, after "enrollees" insert "**and subscribers**".
Page 19, line 7, after "enrollee" insert "**or a subscriber**".
Page 19, line 8, after "enrollee" insert "**or subscriber**".
Page 19, line 9, delete "procedure".
Page 19, line 14, after "grievance," insert "**orally or**".
Page 19, line 15, after "enrollee" insert "**or subscriber**".
Page 19, line 20, after "enrollee" insert "**or subscriber**".
Page 19, line 23, after "enrollees" insert "**and subscribers**".
Page 19, line 24, delete "grievance" and insert "**complaint**".
Page 19, line 27, delete "grievance" and insert "**complaint**".
Page 19, line 34, after "enrollee" insert "**or subscriber**".
Page 19, line 38, after "enrollee" insert "**or subscriber**".
Page 20, line 3, after "enrollee's" insert "**or subscriber's**".
Page 20, line 5, delete "of".
Page 20, line 6, delete "the managed care plan".
Page 20, delete lines 8 through 21.
Page 20, line 33, after "enrollees" insert "**or subscribers**".
Page 20, line 34, after "enrollee" insert "**or subscriber**".
Page 20, line 37, after "enrollees" insert "**or subscribers**".
Page 21, line 5, delete "entity" and insert "**plan**".
Page 21, line 16, delete "participating".
Page 21, line 22, delete "thirty (30)" and insert "**forty-five (45)**".
Page 21, line 24, after "enrollee" insert "**or a subscriber**".
Page 21, line 26, after "enrollee" insert "**or subscriber**".
Page 21, line 28, after "enrollee" insert "**or subscriber**".
Page 21, line 35, after "enrollee's" insert "**or subscriber's**".
Page 21, line 38, delete "of".
Page 21, line 39, delete "the managed care plan".
Page 22, line 1, after "enrollee" insert "**or a subscriber**".
Page 22, line 3, delete "commissioner" and insert "**department**".
Page 22, line 25, delete "commissioner shall" and insert "**department may**".

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Page 23, line 42, delete "Each" and insert "**A**".

Page 24, line 10, after "body," insert "**participating**".

Page 24, line 21, delete "individual".

Page 24, line 37, delete "Before March 2" and insert "**Not later than March 1 of**".

Page 25, line 17, after "enrollees" insert "**or subscribers**".

Page 25, line 25, delete "before March 2" and insert "**not later than March 1**".

Page 25, line 27, delete "on or before" and insert "**not later than**".

Page 26, line 5, delete "Any" and insert "**Notwithstanding IC 27-13-30, any**".

Page 26, line 7, delete "plan" and insert "**entity**".

Page 26, line 11, delete "plan" and insert "**entity**".

Page 26, line 21, delete "plan" and insert "**entity**".

Page 26, line 23, delete "plan" and insert "**entity**".

Page 26, line 26, delete "plan" and insert "**entity**".

Page 26, between lines 26 and 27, begin a new paragraph and insert:

"**Sec. 3. (a) As used in this section, "in good faith and without malice", when used to describe an action taken or a decision or recommendation made, means that:**

(1) a reasonable effort has been taken to obtain the facts of the matter;

(2) a reasonable belief exists that the action, decision, or recommendation is warranted by the facts known; and

(3) if the action is described in IC 34-4-12.6-2(g), the action is made in compliance with IC 34-4-12.6-2(g).

(b) As used in this section, "health care review committee" means a peer review committee under IC 34-4-12.6-1(c).

(c) In all actions to which this section applies, good faith shall be presumed and malice shall be required to be proven by the person aggrieved.

(d) A person who, in good faith and without malice:

(1) takes an action or makes a decision or recommendation as a member, an agent, or an employee of a health care review committee; or

(2) furnishes any record, information, or assistance to a health care review committee;

is not subject to liability for damages in any legal action in consequence of that action.

(e) Neither:

(1) the managed care entity that established the health care review committee; nor

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(2) the officers, directors, employees, or agents of the managed care entity;

are liable for damages in any civil action for the activities of a person that, in good faith and without malice, takes an action or makes a decision or recommendation as a member, an agent, or an employee of a health care review committee, or furnishes any record, information, or assistance to a health care review committee.

(f) This section does not relieve a person of liability arising from treatment of a patient or an enrollee, or from a determination of the reimbursement to be provided under the terms of an insurance policy, a managed care plan contract, or another benefit program providing payment, reimbursement, or indemnification for health care costs based on the appropriateness of health care services delivered to an enrollee.

(g) A health care review committee shall comply with IC 34-4-12.6-1(c).

Sec. 4. (a) Notwithstanding IC 27-13-30, the information considered by a health care review committee and the record of the actions and proceedings of the committee are confidential for purposes of IC 5-14-3-4 and not subject to subpoena or order to produce, except:

(1) in proceedings before the appropriate state licensing or certifying agency; and

(2) in an appeal, if permitted, from the finding or recommendation of the health care review committee.

(b) If information considered by a health care review committee or records of the actions and proceedings of a health care review committee are used under subsection (a) by a state licensing or certifying agency or in an appeal, the information or records:

(1) shall be kept confidential; and

(2) are subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

Sec. 5. To fulfill its obligations under IC 27-14-9 concerning the quality management program of the managed care entity, a managed care entity is entitled to access to treatment records and other information pertaining to the diagnosis, treatment, and health status of an enrollee during the period of time the enrollee is covered by the managed care entity.".

Page 27, between lines 6 and 7, begin a new paragraph and insert:

C o p y

"**Chapter 13. Limited Service Health Maintenance Organizations and Preferred Provider Organizations**

Sec. 1. A limited service health maintenance organization shall comply with the following:

(1) IC 27-14-3-5.

(2) IC 27-14-3-6.

(3) IC 27-14-5.

(4) IC 27-14-10, except for IC 27-14-10-2(a)(1) and IC 27-14-10-2(a)(2).

(5) IC 27-14-11.

(6) IC 27-14-12.

Sec. 2. A preferred provider organization shall comply with the following:

(1) IC 27-14-3-5.

(2) IC 27-14-3-6.

(3) IC 27-14-5.

(4) IC 27-14-10.

(5) IC 27-14-11.

(6) IC 27-14-12.".

Page 27, line 7, delete "13" and insert "**14**".

Page 27, delete lines 25 through 26.

Page 27, delete line 29.

Page 27, line 30, delete "providers, and managed care entities,".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 364 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 8, Nays 1.

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SENATE MOTION

Mr. President: I move that Senators Dempsey and Worman be added as coauthors of Senate Bill 364.

LAWSON

SENATE MOTION

Mr. President: I move that Senators Antich and Randolph be added as coauthors of Senate Bill 364.

LAWSON

SENATE MOTION

Mr. President: I move that Senate Bill 364 be amended to read as follows:

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

"SECTION 1. IC 27-13-8-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 1.5. (a) The report required by section 1 of this chapter must include specific data for each health maintenance organization, including the following:**

(1) Gross outpatient and hospital utilization data.

(2) Enrollee clinical outcome data.

(3) The number, amount, and disposition of malpractice claims resolved during the year by:

(A) the health maintenance organization; and

(B) any participating provider of the health maintenance organization.

(b) The information required under subsection (a) shall be made available to the public on a timely basis.

SECTION 2. IC 27-13-8-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 3. Each health maintenance organization shall provide information on the health maintenance organization's:**

(1) structure;

(2) decision making process;

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(3) health care benefits and exclusions;
(4) cost and cost sharing requirements;
(5) list of participating providers; and
(6) grievance and appeals procedures;

to all potential enrollees, to all enrollees covered by the health maintenance organization, and to the department of insurance.

SECTION 3. IC 27-13-8-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 4. The commissioner may require additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article and under IC 27-14.**

SECTION 4. IC 27-13-34-12, AS AMENDED BY P.L.191-1997, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 12. A limited service health maintenance organization operated under this chapter is subject to the following:

(1) IC 27-13-8, except for IC 27-13-8-1.5(a)(1) and IC 27-13-8-1.5(a)(2) concerning reports.

~~(1)~~ **(2)** IC 27-13-10-1 through IC 27-13-10-3 concerning grievance procedures.

~~(2)~~ **(3)** IC 27-13-11 concerning investments.

(4) IC 27-13-15 concerning hold harmless clauses in contracts.

~~(3)~~ **(5)** IC 27-13-21 concerning producers.

~~(4)~~ **(6)** IC 27-13-29 concerning statutory construction and relationship to other laws.

~~(5)~~ **(7)** IC 27-13-30 concerning public records.

~~(6)~~ **(8)** IC 27-13-31 concerning confidentiality of medical information and limitation of liability.

(9) IC 27-14-3-5 and IC 27-14-3-6 concerning referrals to out-of-network providers and continuation of care.

(10) IC 27-14-7 concerning descriptions of services provided by a limited service health maintenance organization.".

Page 3, delete lines 14 through 15.
Page 3, line 16, delete "17" and insert "**16**".
Page 3, line 24, delete "18" and insert "**17**".
Page 3, line 31, delete "19" and insert "**18**".
Page 3, line 41, delete "20" and insert "**19**".
Page 4, line 7, delete "21" and insert "**20**".
Page 4, line 8, delete "22" and insert "**21**".
Page 4, line 10, delete "23" and insert "**22**".
Page 4, line 14, delete "24" and insert "**23**".
Page 4, line 15, delete "25" and insert "**24**".
Page 4, line 17, delete "26" and insert "**25**".

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Page 4, line 39, delete "specialists" and insert "**other appropriate providers**".

Page 4, line 42, delete "specialists" and insert "**other appropriate providers**".

Page 5, line 3, after "3." insert "**(a)**".

Page 5, line 5, delete "the following" and insert "**an adequate number of**".

Page 5, delete lines 6 through 16, begin a new line block indented and insert:

"**(1) acute care hospital services;**

(2) primary care providers; and

(3) other appropriate providers;

that are located within a reasonable proximity of enrollees of the managed care plan.

(b) If a managed care entity offers a managed care plan that provides coverage for:

(1) specialty medical services, including physical therapy, occupational therapy, and rehabilitation services;

(2) mental and behavioral care services; or

(3) pharmacy services;

the managed care entity shall demonstrate to the department that the offered services are located within a reasonable proximity of enrollees of the managed care plan.".

Page 5, line 26, delete "medical specialist needed" and insert "**health care service needed by an enrollee**".

Page 5, line 27, delete "represented in" and insert "**available from**".

Page 5, line 29, delete "does not participate in the" and insert "**is not a participating provider for treatment.**".

Page 5, delete lines 30 through 31.

Page 5, line 32, delete "A managed care plan shall pay a medical specialist who" and insert "**When an enrollee receives health care services from a provider to which the enrollee was referred**".

Page 5, line 33, delete "provides health care services".

Page 5, line 33, after "(a)" insert "**, the managed care entity shall indemnify the enrollee for the lesser of the following:**".

Page 5, line 33, delete "the", begin a new line block indented and insert:

"**(1) The**".

Page 5, between lines 36 and 37, begin a new line block indented and insert:

"**(2) The payment that the provider agrees to accept for the health care services provided by the provider for the**

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treatment.

The amount in subdivision (1) or (2) must be reduced by the deductibles and copayments, if any, that the enrollee would be responsible to pay if the health care services had been provided by a participating provider.".

Page 5, line 37, delete "plan" and insert "**entity**".

Page 5, line 38, after "to" delete "a" and insert "**the**".

Page 5, line 40, after "(a)" insert "**, but may provide for reasonable sharing between the primary care provider and the managed care entity for the additional costs incurred as a result of services provided by an out of network provider**".

Page 7, line 22, delete "Each" and insert "**As described in subsection (d), each**".

Page 7, line 26, delete "an" and insert "**the**".

Page 7, line 31, after "The" insert "**emergency**".

Page 7, line 32, after "pain" insert "**, which is a symptom of an emergency as provided in IC 27-14-1-8**".

Page 7, between lines 32 and 33, begin a new paragraph and insert:

"**(d) Each managed care plan shall cover and reimburse expenses for emergency services at the rate the enrollee's in-plan covered emergency services would be paid. A provider that provides emergency services to an enrollee under this section may not charge the enrollee except for an applicable copayment or deductible.**".

Page 8, line 26, delete "a medical specialist" and insert "**an appropriate provider**".

Page 8, line 32, delete "medical specialist whom" and insert "**provider that**".

Page 8, line 35, delete "a medical" and insert "**an appropriate provider**".

Page 8, line 36, before "when" delete "specialist".

Page 8, line 36, delete "medical specialist" and insert "**provider**".

Page 8, line 40, delete "specialists" and insert "**appropriate providers**".

Page 8, line 42, delete "medical specialists" and insert "**appropriate providers**".

Page 9, line 2, delete "specialists" and insert "**appropriate providers**".

Page 9, delete lines 22 through 42.

Page 10, delete lines 1 through 23.

Page 10, line 24, delete "6" and insert "**5**".

Page 11, line 39, delete "7" and insert "**6**".

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Page 12, delete lines 36 through 42.

Delete pages 13 through 21.

Page 22, delete lines 1 through 19.

Page 22, line 20, delete "12" and insert "**7**".

Page 22, line 21, delete "Each" and insert "**Beginning January 1, 2000, each**".

Page 22, delete line 42, begin a new paragraph and insert:

"**Chapter 8. Miscellaneous Provisions**

Sec. 1. A managed care entity operated under this article is subject to the following:

(1) IC 27-13-6 concerning quality management programs.

(2) IC 27-13-8 concerning annual reports.

(3) IC 27-13-10 concerning grievance procedures.

(4) IC 27-13-15 concerning hold harmless provisions in contracts.

(5) IC 27-13-31 concerning confidentiality of medical information and limitations of liability.".

Page 23, delete lines 1 through 18.

Page 23, line 19, delete "14" and insert "**9**".

Page 23, line 38, delete "insurance," and insert "**insurance**".

Page 23, line 41, delete "IC 27-14-12-1" and insert "**IC 27-14-7-1**".

Renumber all SECTIONS consecutively.

(Reference is to Senate Bill 364 as printed January 27, 1998.)

LAWSON

SENATE MOTION

Mr. President: I move that Senate Bill 364 be amended to read as follows:

Page 10, delete lines 26 through 42, begin a new paragraph and insert:

"**Sec. 1. (a) A managed care plan that provides prescription drug benefits shall do the following:**

(1) Develop a formulary:

(A) in consultation with; and

(B) with the approval of;

a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.

(2) If the managed care plan maintains one (1) or more drug

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formularies, disseminate to participating providers and pharmacists the complete drug formulary or formularies maintained by the managed care plan, including a list of the prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug is preferred over other drugs.

(3) Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost sharing beyond that provided for formulary drugs in the enrollee's contract with the managed care plan, coverage of a specific nonformulary prescription drug if the prescribing provider determines that the nonformulary alternative is medically necessary or appropriate to treat a covered condition or disease.".

Page 11, line 1, delete "(c)" and insert "**(b)**".

Page 11, line 6, delete "and" and insert "**or**".

Page 11, line 9, after "operate" insert "**, or cause to be established and operated,**".

Page 11, line 23, after "outcomes" insert "**, including prospective drug utilization review programs that monitor for possible prescription drug problems or complications, including drug to disease interactions, drug to drug interactions, or therapeutic duplication**".

Page 11, delete lines 29 through 36.

Page 11, line 37, delete "7" and insert "**5**".

Page 11, line 37, after "commissioner" insert "**, with input and assistance from the state health commissioner,**".

(Reference is to Senate Bill 364 as printed January 27, 1998.)

LAWSON

C o p y

SENATE MOTION

Mr. President: I move that Senator R. Young be added as coauthor of Senate Bill 364.

LAWSON

Copy

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 364, 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, delete lines 1 through 15, begin a new paragraph and insert:

"SECTION 1. IC 27-13-1-11.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 11.3. "Department" refers to the department of insurance.**

SECTION 2. IC 27-13-1-11.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 11.7. "Emergency" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:**

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

SECTION 3. IC 27-13-1-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 13.5. "Experimental treatment" means medical technology or a new application of existing medical technology, including medical procedures, drugs, and devices for treating a medical condition, illness, or diagnosis that:**

(1) is not generally accepted by informed health care professionals in the United States as effective; or

(2) has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

SECTION 4. IC 27-13-1-27.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 27.5. "Primary care provider" means a provider under contract with a health maintenance organization who is designated by the health maintenance organization to coordinate, supervise, or provide ongoing care to an enrollee.**

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SECTION 5. IC 27-13-1-28.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 28.5. "Quality assurance" means the ongoing evaluation of the quality of health care services provided to enrollees.**

SECTION 6. IC 27-13-8-2, AS AMENDED BY P.L.191-1997, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:

(1) Audited financial statements of the health maintenance organization for the preceding calendar year.

(2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.

(3) A description of the grievance procedure of the health maintenance organization, the total number of grievances handled through the procedure during the preceding calendar year, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

(4) The percentage of providers credentialed by the health maintenance organization according to standards, if any, developed by the National Committee on Quality Assurance or a successor organization.

(5) The health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data.

(b) The information required by subsection (a)(2) ~~and (a)(3)~~ **through (a)(4)** must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be filed with the commissioner on or before June 1 of each year. **The health maintenance organization's HEDIS data required by subsection (a)(5) must be filed with the commissioner on or before July 1 of each year.** The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a)(3) **through (a)(5)** that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

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SECTION 7. IC 27-13-9-1, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. Upon:

(1) the enrollment; and

(2) each reenrollment;

of a subscriber, a health maintenance organization must provide to the subscriber a list of providers who provide health care services through the health maintenance organization. **The health maintenance organization must also provide the list of providers to a potential enrollee upon request.**

SECTION 8. IC 27-13-9-4, AS AMENDED BY P.L.191-1997, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 4. A health maintenance organization shall provide to each enrollee and subscriber:

(1) information on:

(A) how services can be obtained;

(B) where additional information on access to services can be obtained; ~~and~~

(C) how to file a grievance under IC 27-13-10; ~~and~~

(D) the health maintenance organization's:

(i) structure;

(ii) health care benefits and exclusions; and

(iii) criteria for denying coverage; and

(E) costs for which the enrollee or subscriber is responsible; and

(2) a toll free telephone number through which the enrollee can contact the health maintenance organization at no cost to the enrollee to obtain information and to file grievances.

The information under this section must be provided to a potential enrollee of the health maintenance organization upon request.

SECTION 9. IC 27-13-23-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 7. (a) Beginning July 1, 1999, the commissioner shall review each health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data on an annual basis.**

(b) The commissioner may contract with an appropriate entity to conduct the reviews required under this section.

SECTION 10. IC 27-13-24-1, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) The commissioner may suspend or revoke a certificate of authority issued under this article or deny an application

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submitted under this article if the commissioner finds that any of the following conditions exists:

(1) The health maintenance organization is operating:

(A) significantly in contravention of its basic organizational document; or

(B) in a manner contrary to that described in any other information submitted under IC 27-13-2;

unless amendments to the basic organizational document or other submissions that are consistent with the operations of the organization have been filed with and approved by the commissioner.

(2) The health maintenance organization:

(A) issues an evidence of coverage;

(B) enters into a contract with a participating provider; or

(C) uses a schedule of charges for health care services;

that does not comply with the requirements of IC 27-13-7, IC 27-13-15, and IC 27-13-20.

(3) The health maintenance organization does not provide or arrange for basic health care services.

(4) The commissioner determines that the health maintenance organization is unable to fulfill its obligations to furnish health care coverage.

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(6) The health maintenance organization has failed to correct, within the time prescribed by section 2 of this chapter, any deficiency occurring due to the impairment of the prescribed minimum net worth of the health maintenance organization.

(7) The health maintenance organization has failed to implement the grievance procedures required by IC 27-13-10 in a reasonable manner to resolve valid complaints.

(8) The health maintenance organization or any person acting on behalf of the organization has intentionally advertised or merchandised the services of the organization in an untrue, a misrepresentative, a misleading, a deceptive, or an unfair manner.

(9) The continued operation of the health maintenance organization would be hazardous to the enrollees of the organization.

(10) The health maintenance organization fails to comply with the requirements provided under IC 27-13-36 through IC 27-13-40.

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~~(10)~~ **(11)** The health maintenance organization has otherwise failed substantially to comply with this article.

(b) The commissioner, in a proceeding under IC 4-21.5-3-8, may impose a civil penalty of not more than twenty-five thousand dollars ($25,000) against a health maintenance organization for each cause listed in subsection (a). The civil penalties may not exceed one hundred thousand dollars ($100,000) for any one (1) health maintenance organization in one (1) calendar year. The penalty may be imposed in addition to or instead of a suspension or revocation of the certificate of authority of the health maintenance organization.

SECTION 11. IC 27-13-28-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 7. This article does not preclude the department from investigating complaints, grievances, or appeals on behalf of enrollees or providers.**".

Page 2, delete lines 1 through 16.

Page 2, line 21, delete "IC 27-13-8-1.5(a)(1) and" and insert "**IC 27-13-8-2(a)(5)**".

Page 2, line 22, delete "IC 27-13-8-1.5(a)(2)".

Page 2, line 33, delete "IC 27-14-3-5 and IC 27-14-3-6" and insert "**IC 27-13-36-5 and IC 27-13-36-6**".

Page 2, line 35, delete "IC 27-14-7 concerning descriptions" and insert "**IC 27-13-40 concerning comparison sheets**".

Page 2, delete lines 37 through 42, begin a new paragraph and insert:

"SECTION 13. IC 27-13-34-15, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 15. All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment basis or other basis must contain, or shall be construed to contain, the following terms and conditions:

(1) If the limited service health maintenance organization fails to pay for limited health services for any reason whatsoever, including insolvency or breach of this contract, the enrollees shall not be liable to the provider for any sums owed to the provider under this contract.

(2) No provider or agent, trustee, representative, or assignee of a provider may maintain an action at law or attempt to collect from the enrollee sums that the limited service health maintenance organization owes to the provider.

(3) These provisions do not prohibit the collection of:

(A) uncovered charges consented to by enrollees; or

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(B) copayments;

from enrollees.

(4) The contract may not provide for a financial or other penalty to a primary care provider for making a referral permitted under IC 27-13-36-5(a), but may provide for reasonable cost sharing between the primary care provider and the limited service health maintenance organization for the additional costs incurred as a result of service provided by an out of network provider.

~~(4)~~ **(5)** These provisions survive the termination of this contract, regardless of the reason for the termination.

~~(5)~~ **(6)** For not more than ninety (90) days after the termination of this contract, the provider must complete procedures in progress on an enrollee receiving treatment for a specific condition, at the same schedule of copayment or other applicable charge that is in effect on the effective date of termination of the contract.

~~(6)~~ **(7)** An amendment to the provisions of this contract set forth in subdivisions (1) through ~~(5)~~ **(6)** must be:

(A) submitted to; and

(B) approved by;

the commissioner before it becomes effective.".

Delete pages 3 through 4.

Page 5, delete lines 1 through 29, begin a new paragraph and insert:

"SECTION 14. IC 27-13-36 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:".

Page 5, line 30, delete "3." and insert "**36. Patient Protection;**".

Page 5, line 32, delete "managed care plan" and insert "**health maintenance organization**".

Page 5, line 37, delete "managed care plan" and insert "**health maintenance organization**".

Page 5, line 38, delete "managed care entity shall employ" and insert "**health maintenance organization shall contract with or employ**".

Page 5, line 40, after "to" insert "**do the following**".

Page 5, line 41, delete "develop" and insert "**Participate in the development of the health maintenance organization's**".

Page 5, line 42, delete "; and" and insert "**.**".

Page 6, line 1, delete "make utilization management decisions;" and insert "**Consult with the treating provider before an adverse utilization review decision is made.**".

Page 6, delete line 2.

Page 6, line 3, delete "Each managed care plan" and insert

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"**Beginning July 1, 1999, each health maintenance organization**".

Page 6, line 5, delete "managed care plan's" and insert "**health maintenance organization's**".

Page 6, delete line 9 and insert "**subscribers of the health maintenance organization. Compliance with the most current guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.**".

Page 6, line 10, after "(a)" insert "**The provisions of this section do not apply until July 1, 1999.**

Page 6, line 10, delete "A managed care entity", begin a new paragraph and insert:

"**(b) Each health maintenance organization**".

Page 6, line 11, delete "each managed care plan operated by the managed" and insert "**the health maintenance organization**".

Page 6, line 12, delete "care entity".

Page 6, line 16, delete "enrollees of the" and insert "**subscribers of the health maintenance organization. Compliance with the most current guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.**".

Page 6, delete line 17.

Page 6, line 18, delete "(b) If a managed care entity offers a managed care plan that" and insert "**(c) If a health maintenance organization**".

Page 6, line 24, delete "managed care entity" and insert "**health maintenance organization**".

Page 6, line 25, after "of" insert "**subscribers of the health maintenance organization. Compliance with the most current guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.**".

Page 6, delete line 26.

Page 6, line 27, delete "Primary" and insert "**Beginning July 1, 1999, primary**".

Page 6, line 35, after "(a)" insert "**The provisions of the section do not apply until July 1, 1999.**".

Page 6, line 35, before "When," begin a new paragraph and insert:

"**(b)**".

Page 6, line 36, after "the" insert "**enrollee needs a particular health care service and the health maintenance organization determines that the**".

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Page 6, line 36, delete "an" and insert "**the**".

Page 6, line 37, delete "is" and insert "**:**

(1) is a covered service; and

(2) is".

Page 6, line 37, delete "a managed care plan's" and insert "**the health maintenance organization's**".

Page 6, line 38, delete "," and insert "**;**".

Page 6, line 38, before "the" begin a new line blocked left.

Page 6, line 38, after "provider" insert "**and the health maintenance organization**".

Page 6, line 39, delete "that" and insert "**who**".

Page 6, line 40, delete "for treatment" and insert "**within a reasonable amount of time and within a reasonable proximity of the enrollee**".

Page 6, line 41, delete "(b)" and insert "**(c)**".

Page 6, line 42, delete "which" and insert "**whom**".

Page 7, line 1, delete "(a), the managed care plan shall indemnify the enrollee" and insert "**(b), the health maintenance organization shall pay the out of network provider**".

Page 7, line 2, delete "for".

Page 7, line 4, delete "managed care plan's" and insert "**health maintenance organization's**".

Page 7, line 5, delete "medical specialist for the treatment" and insert "**out of network provider**".

Page 7, line 6, delete "The payment that the provider agrees to accept for the" and insert "**An amount agreed to between the health maintenance organization and the out of network provider.**".

Page 7, delete lines 7 through 9.

Page 7, line 10, delete "deductibles and copayments," and insert "**The enrollee's treating provider may collect from the enrollee only the deductible or copayment,**".

Page 7, line 12, after "." insert "**The enrollee may not be billed by the health maintenance organization or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the health maintenance organization to the out of network provider as provided in this subsection.**".

Page 7, line 13, delete "(c)" and insert "**(d)**".

Page 7, line 13, delete "managed care entity" and insert "**health maintenance organization**".

Page 7, line 15, delete "referral permitted" and insert "**determination allowed**".

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Page 7, line 16, delete "(a), but may provide for reasonable sharing between the" and insert "**(b).**".

Page 7, delete lines 17 through 19.

Page 7, line 20, delete "managed care plan" and insert "**health maintenance organization**".

Page 7, line 21, delete "managed care plan's" and insert "**health maintenance organization's**".

Page 7, line 23, delete "managed care plan" and insert "**health maintenance organization**".

Page 7, line 26, delete "the managed care plan and".

Page 7, line 29, delete "managed care plan" and insert "**health maintenance organization or, in the case of a pregnant enrollee in the third trimester of pregnancy, throughout the term of the enrollee's pregnancy**".

Page 7, line 33, delete "managed care plan" and insert "**health maintenance organization**".

Page 7, line 38, delete "rate" and insert "**terms and conditions**".

Page 8, line 1, delete "managed care plan" and insert "**health maintenance organization**".

Page 8, line 2, delete "managed care plan" and insert "**health maintenance organization**".

Page 8, line 5, delete "managed care plan" and insert "**health maintenance organization**".

Page 8, line 7, delete "emergency care or".

Page 8, line 8, delete "managed care plan" and insert "**health maintenance organization**".

Page 8, line 8, delete "standards" and insert "**guidelines**".

Page 8, line 13, delete "standards" and insert "**guidelines**".

Page 8, line 19, delete "Follow-up appointments for chronic conditions." and insert "**Adult preventive services.**".

Page 8, line 20, delete "care" and insert "**visits**".

Page 8, line 22, delete "in a managed care" and insert "**,**".

Page 8, line 23, delete "plan, covered inpatient and outpatient" and insert "**covered**".

Page 9, line 1, delete "managed care plan" and insert "**health maintenance organization**".

Page 9, line 5, after "between" delete "the".

Page 9, line 6, after "(A)" insert "**the**".

Page 9, line 8, delete "managed care plan" and insert "**the health maintenance organization**".

Page 9, line 10, after "attention" insert "**.**".

Page 9, line 11, delete "at the nearest facility.".

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Page 9, line 13, delete "IC 27-14-1-8" and insert "**IC 27-13-1-11.7**".

Page 9, line 14, delete "managed care plan" and insert "**health maintenance organization**".

Page 9, line 15, delete "the rate the enrollee's in-plan covered" and insert "**a rate equal to the lesser of the following:**

(1) The usual, customary, and reasonable charge in the health maintenance organization's service area for health care services provided during the emergency.

(2) An amount agreed to between the health maintenance organization and the out of network provider.".

Page 9, line 16, delete "emergency services would be paid.".

Page 9, line 16, before "A" begin a new line blocked left.

Page 9, line 19, after "deductible." insert "**Care and treatment provided to an enrollee once the enrollee is stabilized is not care obtained in an emergency.**".

Page 9, line 20, delete "managed care plan" and insert "**health maintenance organization**".

Page 9, line 21, delete "managed care plan" and insert "**health maintenance organization**".

Page 9, line 22, after "of" insert "**the health maintenance organization's enrollees, including**".

Page 9, line 22, delete "populations," and insert "**enrollees and**".

Page 9, line 23, delete "including".

Page 9, line 24, delete ", as defined by rules adopted" and insert "**.**".

Page 9, delete line 25.

Page 9, line 26, delete "managed care plan" and insert "**health maintenance organization**".

Page 9, line 28, delete "managed care plan" and insert "**health maintenance organization**".

Page 9, delete lines 29 through 34, begin a new paragraph and insert:

"SECTION 15. IC 27-13-37 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:".

Page 9, line 35, delete "4." and insert "**37. Patient Protection;**".

Page 9, delete lines 36 through 38.

Page 9, line 39, delete "2" and insert "**1**".

Page 9, line 39, delete "managed care plan shall permit" and insert "**health maintenance organization shall allow**".

Page 9, line 40, delete "managed care plan" and insert "**health maintenance organization**".

Page 9, line 42, delete "plan" and insert "**health maintenance**

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organization".

Page 10, line 1, delete "as" and insert "**semiannually**".

Page 10, line 2, delete "participating providers are added or removed".

Page 10, line 2, delete "the" and insert "**a sufficient number of primary care providers that accept new enrollees. The list must be:**

(1) provided to each enrollee annually; and

(2) sent to an enrollee at the enrollee's request.".

Page 10, delete lines 3 through 11.

Page 10, line 12, delete "3" and insert "**2**".

Page 10, line 12, delete "managed care plan" and insert "**health maintenance organization**".

Page 10, line 13, delete "permit" and insert "**allow**".

Page 10, line 13, after "appropriate" insert "**participating**".

Page 10, line 13, delete "treat" and insert "**manage**".

Page 10, line 15, delete "a medical specialist" and insert "**another appropriate participating provider**".

Page 10, line 18, after "to a" insert "**participating**".

Page 10, line 19, delete "that" and insert "**whom**".

Page 10, line 20, delete "managed care plan" and insert "**health maintenance organization**".

Page 10, line 21, after "appropriate" insert "**participating**".

Page 10, line 22, after "to the" insert "**participating**".

Page 10, line 24, after "condition" insert "**, subject to the terms and conditions of the enrollee's contract with the health maintenance organization**".

Page 10, between lines 24 and 25, begin a new paragraph and insert:

"**(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a referral allowed under this section.**".

Page 10, line 25, delete "4" and insert "**3**".

Page 10, line 25, delete "Each managed care plan" and insert "**Beginning July 1, 1999, each health maintenance organization**".

Page 10, line 26, after "and" delete "appropriate".

Page 10, line 26, after "to appropriate" insert "**participating**".

Page 10, line 26, delete "within the".

Page 10, line 27, delete "managed care plan".

Page 10, line 29, delete "shall".

Page 10, line 29, after "appropriate" insert "**participating**".

Page 10, line 31, delete "are provided with" and insert "**have**".

Page 10, line 31, after "appropriate" insert "**participating**".

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Page 10, line 33, delete "Sec. 5. (a) Each managed care entity" and insert "**Sec. 4. Beginning July 1, 1999, each health maintenance organization**".

Page 10, line 34, delete "managed care plan" and insert "**group contract or individual contract**".

Page 10, line 34, after "product" insert "**to the extent permitted by IC 27-13-13-8**".

Page 10, delete lines 35 through 42.

Page 11, delete lines 1 through 3.

Page 11, line 4, delete "6" and insert "**5**".

Page 11, line 4, delete "managed care plan" and insert "**health maintenance organization**".

Page 11, line 4, delete "provide enrollees in the" and insert "**allow an enrollee who has received a medical opinion from a participating provider to obtain a second medical opinion from an appropriate participating provider concerning the enrollee's medical condition at the enrollee's request.**".

Page 11, delete lines 5 through 8, begin a new paragraph and insert:

"SECTION 16. IC 27-13-38 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]:".

Page 11, line 9, delete "5." and insert "**38. Patient Protection;**".

Page 11, line 11, delete "managed care plan that provides" and insert "**health maintenance organization may apply a formulary to the**".

Page 11, line 11, after "drug" insert "**and devices**".

Page 11, delete lines 12 through 13 and insert "**benefits provided by the health maintenance organization if the formulary is developed, reviewed, and updated:**".

Page 11, line 14, delete "(A)", begin a new line block indented and insert:

"**(1)**".

Page 11, line 15, delete "(B)", begin a new line block indented and insert:

"**(2)**".

Page 11, line 16, before "a pharmacy" begin a new line blocked left.

Page 11, line 18, delete "(2) If the managed care plan", begin a new paragraph and insert:

"**(b) If a health maintenance organization**".

Page 11, line 18, after "drug" insert "**and devices**".

Page 11, line 19, after "," insert "**the health maintenance organization shall do the following:**".

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Page 11, line 19, delete "disseminate", begin a new line block indented and insert:

"**(1) Disseminate**".

Page 11, line 20, after "drug" insert "**and devices**".

Page 11, line 21, delete "managed care plan" and insert "**health maintenance organization**".

Page 11, line 21, after "of the" insert "**devices and**".

Page 11, line 23, after "drug" insert "**or device**".

Page 11, line 24, after "drugs" insert "**or devices**".

Page 11, line 25, delete "(3)" and insert "**(2)**".

Page 11, line 27, delete "formulary" and insert "**in the enrollee's covered benefits with the health maintenance organization, coverage for a specific, medically necessary and appropriate nonformulary drug or device if the participating provider documents and certifies in the enrollee's medical records that:**

(A) the formulary drug or device is ineffective in treating the enrollee's disease or condition; or

(B) the participating provider believes that the formulary drug or device causes or is reasonably expected to cause a harmful outcome or a less than reasonably optimal outcome to the enrollee.".

Page 11, delete lines 28 through 32.

Page 11, line 33, delete "(b) A managed care plan" and insert "**(c) A health maintenance organization**".

Page 11, line 36, delete "managed care plan" and insert "**health maintenance organization**".

Page 11, line 37, delete "determines that a drug or" and insert "**has prescribed a medically necessary and appropriate nonformulary drug or device as provided in subsection (b)(2).**".

Page 11, delete lines 38 through 39, begin a new paragraph and insert:

"**Sec. 2. Subject to section 1(b)(2) of this chapter, a prescribing provider who prescribes drugs or devices shall determine the appropriate drug therapy or device for an enrollee. A generic substitution for a prescribed drug or device may be made only in compliance with IC 16-42-22.**".

Page 11, line 40, delete "2" and insert "**3**".

Page 11, line 40, delete "managed care service plan" and insert "**health maintenance organization that has a prescription drug benefit**".

Page 12, line 18, delete "3" and insert "**4**".

Page 12, line 19, delete "2" and insert "**3**".

C o p y

Page 12, line 21, delete "4" and insert "**5**".

Page 12, line 23, delete "5" and insert "**6**".

Page 12, lines 24, delete "shall" and insert "**may**".

Page 12, between lines 25 and 26, begin a new paragraph and insert:

"SECTION 17. IC 27-13-39 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]:".

Page 12, line 26, delete "6." and insert "**39. Patient Protection;**".

Page 12, line 27, delete "managed care plan" and insert "**health maintenance organization**".

Page 12, line 31, delete "managed care plan" and insert "**health maintenance organization**".

Page 12, line 33, delete "managed care" and insert "**health maintenance organization**".

Page 12, line 34, delete "plan".

Page 12, line 40, delete "managed care plan" and insert "**health maintenance organization**".

Page 13, line 2, delete "managed care plan" and insert "**health maintenance organization**".

Page 13, line 2, after "for" insert "**experimental**".

Page 13, line 7, delete "Who is authorized to make a" and insert "**A description of the process used to make the**".

Page 13, line 9, delete "The criteria the managed care plan" and insert "**A description of the criteria the health maintenance organization**".

Page 13, line 12, delete "(a) If a managed care plan" and insert "**(a) If a health maintenance organization**".

Page 13, line 14, delete "managed" and insert "**health maintenance organization**".

Page 13, line 15, delete "care plan".

Page 13, line 15, delete "letter in writing that" and insert "**written explanation that includes the following:**".

Page 13, delete line 16.

Page 13, line 17, after "(1)" delete "the" and insert "**The**".

Page 13, line 17, delete "; and" and insert "**.**".

Page 13, line 18, after "(2)" delete "the" and insert "**The**".

Page 13, line 18, delete "managed care plan's" and insert "**health maintenance organization's**".

Page 13, between lines 20 and 21, begin a new line block indented and insert:

"**(3) The telephone number of:**

(A) an individual employed by the health maintenance

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organization whom; or

(B) a department of the health maintenance organization that;

the enrollee may contact for assistance in initiating an appeal of the health maintenance organization's decision.".

Page 13, line 21, delete "an expedited review" and insert "**a review that takes not more than seventy-two (72) hours**".

Page 13, between lines 22 and 23, begin a new paragraph and insert:

"SECTION 18. IC 27-13-40 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:".

Page 13, line 23, delete "7." and insert "**40. Patient Protection; Health Maintenance Organization Comparison Sheets**".

Page 13, line 24, delete "managed care entity" and insert "**health maintenance organization**".

Page 13, line 25, delete "offering a managed care plan".

Page 13, line 25, delete "managed care" and insert "**health maintenance organization comparison sheet**".

Page 13, line 26, delete "plan description form".

Page 13, line 28, delete "form" and insert "**comparison sheet**".

Page 13, line 30, delete "managed care plan policies or" and insert "**group contracts and individual**".

Page 13, line 32, delete "managed care plan policy or" and insert "**group contract or individual**".

Page 13, line 34, delete "form" and insert "**comparison sheet**".

Page 13, line 35, delete "managed care plans" and insert "**health maintenance organizations**".

Page 13, line 36, delete "managed care entity" and insert "**health maintenance organization**".

Page 13, line 36, after "completed" insert "**health maintenance organization comparison sheet**".

Page 13, delete line 37.

Page 13, line 38, delete "operated by the managed care entity".

Page 13, line 39, delete "managed" and insert "**health maintenance organization**".

Page 13, line 40, delete "care plan".

Page 13, line 41, delete "managed care entity's" and insert "**health maintenance organization's**".

Page 13, line 42, after "or" insert "**an**".

Page 14, line 1, delete "managed care plan offered by" and insert "**group contract or individual contract offered by the health maintenance organization.**".

C o p y

Page 14, delete lines 2 through 30.

Page 14, line 34, delete "managed care plan description form" and insert "**health maintenance organization comparison sheet**".

Page 14, line 35, delete "IC 27-14-7-1" and insert "**IC 27-13-40-1**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 364 as reprinted February 2, 1998.)

C. BROWN, Chair

Committee Vote: yeas 10, nays 2.

C o p y