

January 29, 1998

HOUSE BILL No. 1275

DIGEST OF HB 1275 (Updated January 27, 1998 9:47 pm - DI 77)

Citations Affected: IC 27-4; IC 27-13.

Synopsis: Medical complaint review. Establishes that an adverse utilization review or medical necessity determination made by a health maintenance organization, or an agent of a health maintenance organization, which disagrees with the patient's attending physician's plan of treatment is an unfair claim settlement practice. Provides for the commissioner of the department of insurance to appoint or contract with a medical complaint professional for review of adverse utilization review and medical necessity determinations. Requires that health
(Continued next page)

Effective: July 1, 1998.

Goeglein, Crosby

January 13, 1998, read first time and referred to Committee on Public Health.
January 28, 1998, amended, reported — Do Pass.

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Digest Continued

maintenance organizations provide notice to enrollees or subscribers of the right to file a complaint with the department of insurance for review of adverse utilization review or medical necessity determinations that disagree with the patient's attending physician's plan of treatment.

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January 29, 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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HOUSE BILL No. 1275

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

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

- 1 SECTION 1. IC 27-4-1-4.5 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 4.5. The following are
3 unfair claim settlement practices:
4 (1) Misrepresenting pertinent facts or insurance policy provisions
5 relating to coverages at issue.
6 (2) Failing to acknowledge and act reasonably promptly upon
7 communications with respect to claims arising under insurance
8 policies.
9 (3) Failing to adopt and implement reasonable standards for the
10 prompt investigation of claims arising under insurance policies.
11 (4) Refusing to pay claims without conducting a reasonable
12 investigation based upon all available information.
13 (5) Failing to affirm or deny coverage of claims within a
14 reasonable time after proof of loss statements have been
15 completed.

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- 1 (6) Not attempting in good faith to effectuate prompt, fair, and
2 equitable settlements of claims in which liability has become
3 reasonably clear.
- 4 (7) Compelling insureds to institute litigation to recover amounts
5 due under an insurance policy by offering substantially less than
6 the amounts ultimately recovered in actions brought by such
7 insureds.
- 8 (8) Attempting to settle a claim for less than the amount to which
9 a reasonable man would have believed he was entitled by
10 reference to written or printed advertising material accompanying
11 or made part of an application.
- 12 (9) Attempting to settle claims on the basis of an application
13 which was altered without notice to or knowledge or consent of
14 the insured.
- 15 (10) Making claims payments to insureds or beneficiaries not
16 accompanied by a statement setting forth the coverage under
17 which the payments are being made.
- 18 (11) Making known to insureds or claimants a policy of appealing
19 from arbitration awards in favor of insureds or claimants for the
20 purpose of compelling them to accept settlements or compromises
21 less than the amount awarded in arbitration.
- 22 (12) Delaying the investigation or payment of claims by requiring
23 an insured, claimant, or the physician of either to submit a
24 preliminary claim report and then requiring the subsequent
25 submission of formal proof of loss forms, both of which
26 submissions contain substantially the same information.
- 27 (13) Failing to promptly settle claims, where liability has become
28 reasonably clear, under one (1) portion of the insurance policy
29 coverage in order to influence settlements under other portions of
30 the insurance policy coverage.
- 31 (14) Failing to promptly provide a reasonable explanation of the
32 basis in the insurance policy in relation to the facts or applicable
33 law for denial of a claim or for the offer of a compromise
34 settlement.
- 35 (15) In negotiations concerning liability insurance claims,
36 ascribing a percentage of fault to a person seeking to recover from
37 an insured party, in spite of an obvious absence of fault on the
38 part of that person.
- 39 (16) The unfair claims settlement practices defined in
40 IC 27-4-1.5.
- 41 **(17) An adverse:**
42 **(A) utilization review determination (as defined in**

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1 **IC 27-8-17-8); or**
 2 **(B) determination of medical necessity;**
 3 **made by a health maintenance organization or an agent of a**
 4 **health maintenance organization that disagrees with the**
 5 **patient's attending physician's plan of treatment.**

6 SECTION 2. IC 27-4-1-5.7 IS ADDED TO THE INDIANA CODE
 7 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 8 1, 1998]: **Sec. 5.7. (a) A complaint filed under section 5.6 of this**
 9 **chapter involving an alleged unfair claims settlement practice**
 10 **under section 4.5(17) of this chapter shall be forwarded to the**
 11 **medical complaint professional employed under section 15(b) of**
 12 **this chapter.**

13 **(b) The medical complaint professional shall, within five (5)**
 14 **business days after the complaint is filed:**

15 **(1) make a determination of appropriateness of the utilization**
 16 **review determination or determination of medical necessity**
 17 **based on information gathered from the complaining party,**
 18 **the health maintenance organization, the attending physician,**
 19 **and any additional information that the medical complaint**
 20 **professional considers necessary and appropriate; and**

21 **(2) submit the medical complaint professional's findings to the**
 22 **commissioner.**

23 **If the medical complaint professional needs additional time to**
 24 **investigate before submitting findings to the commissioner, the**
 25 **medical complaint professional shall advise the commissioner of**
 26 **the need for additional time.**

27 **(c) The commissioner shall consider the medical complaint**
 28 **professional's findings in any action taken by the commissioner on**
 29 **a complaint filed under section 5.6 of this chapter involving an**
 30 **alleged unfair claims settlement practice under section 4.5(17) of**
 31 **this chapter.**

32 SECTION 3. IC 27-4-1-15 IS AMENDED TO READ AS
 33 FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 15. (a) For the purpose**
 34 **of maintaining the affirmative, active, and definite administration of the**
 35 **provisions of this chapter, the commissioner, with the approval of the**
 36 **governor, may appoint such additional actuaries, agents, deputies,**
 37 **examiners, assistants, stenographers, reporters, and other employees in**
 38 **the department as may be found necessary to carry out the provisions**
 39 **of this chapter. Except as otherwise provided in this chapter, such**
 40 **additional deputies, examiners, assistants, reporters, and employees so**
 41 **appointed shall be chosen for their fitness, either professional or**
 42 **practical, as the nature of the position may require, irrespective of their**



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1 political beliefs or affiliations. The technical or professional
 2 qualifications of any applicant shall be determined by examination,
 3 professional rating, or otherwise, as the commissioner with the
 4 approval of the governor may determine. Subject to the approval of the
 5 governor and the state budget director, the salaries of such additional
 6 actuaries, agents, deputies, examiners, assistants, stenographers,
 7 reporters, and other employees shall be fixed by the commissioner. Any
 8 actuary agent, deputy, examiner, assistant, stenographer, or employee
 9 so employed may be removed at any time by the commissioner.

10 **(b) The commissioner shall appoint or enter into a contract for**
 11 **services with a physician licensed under IC 25-22.5 for all**
 12 **complaints filed under section 5.6 of this chapter regarding alleged**
 13 **unfair claims settlement practices under section 4.5(17) of this**
 14 **chapter.**

15 ~~(b)~~ (c) In the absence of the commissioner, he may, by written order,
 16 designate a deputy to conduct any hearing, and, in such case, such
 17 deputy commissioner shall possess and may exercise all powers of the
 18 commissioner with respect to the matter in hearing.

19 ~~(c)~~ (d) Neither the commissioner nor any actuary, deputy, examiner,
 20 assistant, or employee in the department shall be liable in their
 21 individual capacity, except to the state of Indiana, for any act done or
 22 omitted in connection with the performance of their respective duties
 23 under the provisions of this chapter.

24 SECTION 4. IC 27-13-10-8, AS ADDED BY P.L.191-1997,
 25 SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 26 JULY 1, 1998]: Sec. 8. (a) A health maintenance organization shall
 27 establish written policies and procedures for the timely resolution of
 28 appeals of grievance decisions. The procedures for registering and
 29 responding to oral and written appeals of grievance decisions must
 30 include the following:

- 31 (1) Acknowledgment of the appeal, orally or in writing, within
 32 three (3) business days after receipt of the appeal being filed.
- 33 (2) Documentation of the substance of the appeal and the actions
 34 taken.
- 35 (3) Investigation of the substance of the appeal, including any
 36 aspects of clinical care involved.
- 37 (4) Notification to enrollees or subscribers of the disposition of
 38 the appeal and that the enrollee or subscriber may have the right
 39 to further remedies allowed by law.
- 40 (5) Standards for timeliness in responding to appeals and
 41 providing notice to enrollees or subscribers of the disposition of
 42 the appeal and the right to initiate an external appeals process that



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- 1 accommodate the clinical urgency of the situation.
- 2 (b) The health maintenance organization shall appoint a panel of
3 qualified individuals to resolve an appeal. An individual may not be
4 appointed to the panel who has been involved in the matter giving rise
5 to the complaint or in the initial investigation of the complaint. Except
6 for grievances that have previously been appealed under IC 27-8-17, in
7 the case of an appeal from the proposal, refusal, or delivery of a health
8 care procedure, treatment, or service, the health maintenance
9 organization shall appoint one (1) or more individuals to the panel to
10 resolve the appeal. The panel must include one (1) or more individuals
11 who:
- 12 (1) have knowledge in the medical condition, procedure, or
13 treatment at issue;
 - 14 (2) are in the same licensed profession as the provider who
15 proposed, refused, or delivered the health care procedure,
16 treatment, or service;
 - 17 (3) are not involved in the matter giving rise to the appeal or the
18 previous grievance process; and
 - 19 (4) do not have a direct business relationship with the enrollee or
20 the health care provider who previously recommended the health
21 care procedure, treatment, or service giving rise to the grievance.
- 22 (c) An appeal of a grievance decision must be resolved as
23 expeditiously as possible and with regard to the clinical urgency of the
24 appeal. However, an appeal must be resolved not later than forty-five
25 (45) days after the appeal is filed.
- 26 (d) A health maintenance organization shall allow enrollees and
27 subscribers the opportunity to appear in person at the panel or to
28 communicate with the panel through appropriate other means if the
29 enrollee or subscriber is unable to appear in person.
- 30 (e) A health maintenance organization shall notify the enrollee or
31 subscriber in writing of the resolution of the appeal of a grievance
32 within five (5) business days after completing the investigation. The
33 grievance resolution notice must contain the following:
- 34 (1) The decision reached by the health maintenance organization.
 - 35 (2) The reasons, policies, or procedures that are the basis of the
36 decision.
 - 37 (3) Notice of the enrollee's or subscriber's right to further
38 remedies allowed by law.
 - 39 (4) The department, address, and telephone number through
40 which an enrollee may contact a qualified representative to obtain
41 more information about the decision or the right to an appeal.
- 42 (f) **The notice required under subsection (e)(3) for a grievance**

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1 **that involves an adverse utilization review determination or**
2 **adverse determination of medical necessity must include notice of**
3 **the enrollee's or subscriber's right to file a complaint with the**
4 **department of insurance under IC 27-4-1-4.5(17).**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1275, 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 4, line 11, delete "a medical complaint professional who is:".

Page 4, delete line 12.

Page 4, line 13, delete "(2)".

Page 4, line 13, delete ";".

Page 4, run in lines 11 through 14.

and when so amended that said bill do pass.

(Reference is to House Bill 1275 as introduced.)

C. BROWN, Chair

Committee Vote: yeas 11, nays 4.

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