

SENATE BILL No. 363

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-7.5.

Synopsis: Point of service option. Provides that if a health insurance plan restricts the access of enrollees of the health insurance plan to health care providers, each enrollee in the health service plan is entitled to have the opportunity to obtain covered services at any time through a point of service option. Allows a health insurance plan to impose a cost sharing requirement, within specified limits, on an enrollee who exercises a point of service option. Provides that a health insurance plan may not offer a provider incentive plan that has the effect of reducing or limiting medically necessary services provided to enrollees
(Continued next page)

Effective: July 1, 1998.

Gard, Miller

January 8, 1998, read first time and referred to Committee on Health and Environmental Affairs.

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Digest Continued

in the health insurance plan. Requires a health insurance plan to provide a written description of the health insurance plan, including the terms and conditions of the health insurance plan's point of service option and any cost sharing requirements, to all enrollees and prospective enrollees.

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Introduced

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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SENATE BILL No. 363

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 27-8-7.5 IS ADDED TO THE INDIANA CODE
2 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 1998]:

4 **Chapter 7.5. Point of Service Option and Cost Sharing**
5 **Requirements**

6 **Sec. 1. As used in this chapter, "cost sharing requirement"**
7 **means a provision in a health insurance plan contract that**
8 **obligates an enrollee to pay for additional costs resulting from the**
9 **exercise of a point of service option.**

10 **Sec. 2. As used in this chapter, "enrollee" means an individual**
11 **who contracts with or is covered under a health insurance plan**
12 **that provides payment, reimbursement, or indemnification for**
13 **health care services to:**

- 14 (1) the individual;
15 (2) eligible dependents of the individual; or



1 (3) the individual and eligible dependents of the individual.

2 Sec. 3. As used in this chapter, "health care provider" has the
3 meaning set forth in IC 16-18-2-163(a).

4 Sec. 4. As used in this chapter, "health insurance plan" means
5 an individual or group accident or health insurance policy. The
6 term includes a:

7 (1) hospital policy or certificate;

8 (2) medical policy or certificate;

9 (3) service policy or certificate;

10 (4) hospital or medical service plan contract;

11 (5) policy or contract issued by a health maintenance
12 organization (as defined in IC 27-13-1-19); and

13 (6) preferred provider plan (as defined in IC 27-8-11-1).

14 Sec. 5. As used in this chapter, "network health plan" means a
15 health insurance plan that provides coverage and services to
16 enrollees through a provider network.

17 Sec. 6. As used in this chapter, "out of network service" means
18 a service provided by a health care provider that is not a
19 participating provider in a particular provider network.

20 Sec. 7. As used in this chapter, "participating provider" means
21 a health care provider that has entered into a contract or an
22 agreement to provide health care services for enrollees of a
23 specified health insurance plan.

24 Sec. 8. As used in this chapter, "person" means an individual, a
25 corporation, a limited liability company, a partnership, or another
26 business entity or association.

27 Sec. 9. As used in this chapter, "point of service option" means
28 a provision in a health insurance plan contract that allows an
29 enrollee to obtain diagnostic, treatment, surgical, and other
30 covered services from a health care provider without first
31 obtaining a referral.

32 Sec. 10. As used in this chapter, "provider incentive plan"
33 means a compensation arrangement that rewards or penalizes a
34 health care provider for performance under an agreement to
35 provide health care services to enrollees of a health insurance plan.

36 Sec. 11. As used in this chapter, "provider network" means a
37 group of participating providers that have entered into an
38 agreement to provide health care services to enrollees of a specific
39 health insurance plan.

40 Sec. 12. If a health insurance plan restricts the access of
41 enrollees to health care providers, each enrollee in the health
42 insurance plan shall have the opportunity to obtain covered



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1 services at any time through a point of service option.

2 **Sec. 13. (a) A health insurance plan may impose a cost sharing**
 3 **requirement on an enrollee who exercises a point of service option**
 4 **under section 12 of this chapter.**

5 **(b) A cost sharing requirement imposed by a network health**
 6 **plan with respect to out of network services may not:**

7 **(1) be unreasonable; or**

8 **(2) exceed the lesser of:**

9 **(A) twenty percent (20%) of the reasonable or customary**
 10 **fees for the item or service; or**

11 **(B) the actuarial value of the coverage.**

12 **Sec. 14. A health insurance plan may not:**

13 **(1) exclude or threaten to exclude a provider from**
 14 **participation in the health insurance plan based on the**
 15 **number of referrals made by the provider;**

16 **(2) offer a provider incentive plan that has the effect of**
 17 **reducing or limiting medically necessary services provided**
 18 **with respect to enrollees of the health insurance plan; or**

19 **(3) require a participating provider to pay for any patient**
 20 **care that is provided as a result of:**

21 **(A) a referral; or**

22 **(B) the exercise of a point of service option.**

23 **Sec. 15. (a) A health insurance plan must provide to:**

24 **(1) a prospective enrollee before enrollment; and**

25 **(2) all enrollees at least thirty (30) days before annual renewal**
 26 **of the plan;**

27 **written information that describes the terms and conditions of the**
 28 **point of service option and cost sharing requirements.**

29 **(b) If a health insurance plan is described orally to an enrollee**
 30 **or prospective enrollee, the person describing the health insurance**
 31 **plan must use terms that are easily understood, truthful, objective,**
 32 **and consumer tested.**

33 **(c) A written description of a health insurance plan must be**
 34 **readable, easily understood, objective, and in a consumer tested**
 35 **format.**

36 **(d) A written description of a health insurance plan must be**
 37 **provided at the same time an oral description of the health**
 38 **insurance plan is given.**

39 **Sec. 16. The commissioner of insurance shall adopt rules under**
 40 **IC 4-22-2 to implement this chapter.**



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