

# SENATE BILL No. 364

---

## DIGEST OF INTRODUCED BILL

**Citations Affected:** IC 27-13; IC 27-14.

**Synopsis:** Managed care consumer protection. Defines a managed care entity as an entity that establishes, operates, or maintains a network of participating health care providers to provide health care services to individuals enrolled in managed care plans. Requires a managed care entity to provide enrollees of each managed care plan operated by the managed care entity with the following: (1) Full and timely access to clinically appropriate health care personnel. (2) Adequate choice among health care providers that are accessible and qualified. (3) Open communication between participating providers and enrollees. (4)  
(Continued next page)

**Effective:** July 1, 1998.

---

---

Lawson, Simpson, Miller, Gard

---

---

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

---

---

C  
O  
P  
Y



Digest Continued

Access to information regarding limits on coverage for experimental treatments. (5) Coverage for all drugs and devices approved by the United States Food and Drug Administration. (6) Assurance that medical decisions are made by the appropriate medical provider. (7) Appropriate managed care plan data. (8) Full public access to information regarding health care service delivery within managed care plans. (9) Descriptions of grievance and appeal resolution plans. (10) Timely resolution of grievances and appeals. (11) Information regarding quality management programs that a managed care entity is required to maintain. (12) Confidentiality regarding enrollees' medical information and medical records. (13) Comprehensive descriptions of each managed care plan. Requires the department of insurance to oversee all managed care entities. Repeals current provisions governing quality management programs, grievance procedures, and hold harmless contract clauses pertaining to health maintenance organizations. Makes conforming changes.

C  
o  
p  
y



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.

C  
O  
P  
Y

## 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:*

1 SECTION 1. IC 27-13-2-2, AS AMENDED BY P.L.195-1996,  
 2 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 3 JULY 1, 1998]: Sec. 2. (a) A person may not establish or operate a  
 4 health maintenance organization without obtaining a certificate of  
 5 authority under this article.  
 6 (b) If a participating provider contracts with another provider under  
 7 a contract that complies with ~~IC 27-13-15~~ **IC 27-14-5** to provide health  
 8 services on a prepaid basis to enrollees of a health maintenance  
 9 organization that holds a certificate of authority, neither provider, with  
 10 respect to the contract is:  
 11 (1) considered to be engaged in the business of insurance; or  
 12 (2) required to obtain a certificate of authority under this article.  
 13 SECTION 2. IC 27-13-9-4, AS AMENDED BY P.L.191-1997,  
 14 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE



1 JULY 1, 1998]: Sec. 4. A health maintenance organization shall  
 2 provide to each enrollee and subscriber:

3 (1) information on:

4 (A) how services can be obtained;

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

7 (C) how to file a grievance under ~~IC 27-13-10~~; **IC 27-14-8**;  
 8 and

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

12 SECTION 3. IC 27-13-24-1, AS ADDED BY P.L.26-1994,  
 13 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 14 JULY 1, 1998]: Sec. 1. (a) The commissioner may suspend or revoke  
 15 a certificate of authority issued under this article or deny an application  
 16 submitted under this article if the commissioner finds that any of the  
 17 following conditions exists:

18 (1) The health maintenance organization is operating:

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

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

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

27 (2) The health maintenance organization:

28 (A) issues an evidence of coverage;

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

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

31 that does not comply with the requirements of IC 27-13-7,  
 32 ~~IC 27-13-15~~; **IC 27-14-5**, and IC 27-13-20.

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

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

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

41 (6) The health maintenance organization has failed to correct,  
 42 within the time prescribed by section 2 of this chapter, any

C  
O  
P  
Y



1 deficiency occurring due to the impairment of the prescribed  
2 minimum net worth of the health maintenance organization.

3 (7) The health maintenance organization has failed to implement  
4 the grievance procedures required by ~~IC 27-13-10~~ **IC 27-14-8** in  
5 a reasonable manner to resolve valid complaints.

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

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

13 (10) The health maintenance organization has otherwise failed  
14 substantially to comply with this article.

15 (b) The commissioner, in a proceeding under IC 4-21.5-3-8, may  
16 impose a civil penalty of not more than twenty-five thousand dollars  
17 (\$25,000) against a health maintenance organization for each cause  
18 listed in subsection (a). The civil penalties may not exceed one hundred  
19 thousand dollars (\$100,000) for any one (1) health maintenance  
20 organization in one (1) calendar year. The penalty may be imposed in  
21 addition to or instead of a suspension or revocation of the certificate of  
22 authority of the health maintenance organization.

23 SECTION 4. IC 27-13-31-4, AS ADDED BY P.L.26-1994,  
24 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
25 JULY 1, 1998]: Sec. 4. To fulfill its obligations under ~~IC 27-13-6~~  
26 **IC 27-14-9** concerning the quality management program of the  
27 organization, a health maintenance organization is entitled to access to  
28 treatment records and other information pertaining to the diagnosis,  
29 treatment, and health status of any enrollee during the period of time  
30 the enrollee is covered by the health maintenance organization.

31 SECTION 5. IC 27-13-34-8, AS ADDED BY P.L.26-1994,  
32 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
33 JULY 1, 1998]: Sec. 8. (a) An application for a certificate of authority  
34 to operate a limited service health maintenance organization must be  
35 filed with the commissioner on a form prescribed by the commissioner.  
36 An application must be verified by an officer or authorized  
37 representative of the applicant and must set forth, or be accompanied  
38 by, the following:

39 (1) A copy of the applicant's basic organizational document, such  
40 as the articles of incorporation, articles of association, partnership  
41 agreement, trust agreement, articles of organization, or other  
42 applicable documents, and all amendments to those documents.



C  
O  
P  
Y

- 1 (2) A copy of all bylaws, rules and regulations, or similar  
 2 documents, if any, regulating the conduct of the internal affairs of  
 3 the applicant.
- 4 (3) A list of the names, addresses, official positions, and  
 5 biographical information of the individuals who are to be  
 6 responsible for conducting the affairs and daily operations of the  
 7 applicant, including the following:
- 8 (A) All members of the board of directors, board of trustees,  
 9 executive committee, or other governing board or committee.
- 10 (B) The principal officers.
- 11 (C) Any person or entity owning or having the right to acquire  
 12 at least ten percent (10%) of the voting securities of the  
 13 applicant.
- 14 (D) In the case of a partnership or an association, the partners  
 15 or members of the partnership or association.
- 16 (E) In the case of a limited liability company, the managers or  
 17 members of the limited liability company.
- 18 (4) A statement generally describing the applicant, the facilities  
 19 and personnel of the applicant, and the limited health service or  
 20 services that the applicant will offer.
- 21 (5) A copy of the form of any contract that has been made or is to  
 22 be made between the applicant and any providers regarding the  
 23 provision of limited health services to enrollees.
- 24 (6) A copy of the form of any contract that has been made or is to  
 25 be made between the applicant and any person referred to in  
 26 subdivision (3).
- 27 (7) A copy of the form of any contract that has been made or is to  
 28 be made between the applicant and any person, corporation,  
 29 partnership, or other entity for the performance of any functions  
 30 on behalf of the applicant, including the following:
- 31 (A) Marketing.
- 32 (B) Administration.
- 33 (C) Enrollment.
- 34 (D) Investment management.
- 35 (E) Subcontracting for the provision of limited health services  
 36 to enrollees.
- 37 (8) A copy of the form of any contract that is to be issued to  
 38 employers, unions, trustees, or other organizations or individuals,  
 39 and a copy of any form of evidence of coverage to be issued to  
 40 subscribers.
- 41 (9) Subject to subsection (b), a copy of the most recent financial  
 42 statements of the applicant, audited by an independent certified

C  
O  
P  
Y

1 public accountant.

2 (10) A copy of the financial plan of the applicant, including:

3 (A) a projection of anticipated operating results for at least  
4 three (3) years; and

5 (B) a statement of the sources of working capital and any other  
6 sources of funding and provisions for contingencies.

7 (11) A description of the proposed method of marketing.

8 (12) A statement acknowledging that all lawful process in any  
9 legal action or proceeding against the applicant on a cause of  
10 action arising in Indiana is valid if served in accordance with the  
11 Indiana Rules of Trial Procedure.

12 (13) A description of the ~~complaint~~ **grievance** procedures to be  
13 established and maintained under ~~IC 27-13-10~~ **IC 27-14-8**.

14 (14) A description of the quality assessment and utilization review  
15 procedures to be used by the applicant.

16 (15) A description of how the applicant will comply with sections  
17 16 and 17 of this chapter.

18 (16) The fee for the issuance of a certificate of authority required  
19 by section 23 of this chapter.

20 (17) A written waiver of the applicant's rights under federal  
21 bankruptcy laws.

22 (18) Other information that the commissioner reasonably requires  
23 to make the determinations required by this chapter.

24 (19) If the applicant is not domiciled in Indiana, an executed  
25 power of attorney appointing the commissioner, the  
26 commissioner's successors in office, and authorized deputies of  
27 the commissioner as the true and lawful attorney of the applicant  
28 in and for Indiana upon whom all lawful process in any legal  
29 action or proceeding against the limited service health  
30 maintenance organization on a cause of action arising in Indiana  
31 may be served.

32 (b) If the financial affairs of the parent company of the applicant are  
33 audited by independent certified public accountants but those of the  
34 applicant are not, an applicant may satisfy the requirement set forth in  
35 subsection (a)(9) by including with the application the most recent  
36 audited financial statement of the applicant's parent company, certified  
37 by an independent certified public accountant, attached to which shall  
38 be consolidating financial statements of the applicant, unless the  
39 commissioner determines that additional or more recent financial  
40 information is required for the proper administration of this chapter.

41 SECTION 6. IC 27-13-34-12, AS AMENDED BY P.L.191-1997,  
42 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

C  
O  
P  
Y



1 JULY 1, 1998]: Sec. 12. A limited service health maintenance  
2 organization operated under this chapter is subject to the following:

3 (1) ~~IC 27-13-10-1 through IC 27-13-10-3 concerning grievance~~  
4 ~~procedures:~~

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

6 ~~(3)~~ (2) IC 27-13-21 concerning producers.

7 ~~(4)~~ (3) IC 27-13-29 concerning statutory construction and  
8 relationship to other laws.

9 ~~(5)~~ (4) IC 27-13-30 concerning public records.

10 ~~(6)~~ (5) IC 27-13-31 concerning confidentiality of medical  
11 information and limitation of liability.

12 SECTION 7. IC 27-13-34-20, AS ADDED BY P.L.26-1994,  
13 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
14 JULY 1, 1998]: Sec. 20. (a) The commissioner may suspend or revoke  
15 the certificate of authority issued to a limited service health  
16 maintenance organization under this chapter or deny an application  
17 submitted under this chapter upon determining that any of the  
18 following conditions exist:

19 (1) The limited service health maintenance organization is  
20 operating:

21 (A) significantly in contravention of the basic organizational  
22 document of the organization; or

23 (B) in a manner contrary to that described in and reasonably  
24 inferred from any other information submitted under section  
25 8 of this chapter;

26 unless amendments to the organization's submissions have been  
27 filed and authorized under section 11 of this chapter.

28 (2) The limited service health maintenance organization issues an  
29 evidence of coverage that does not comply with the requirements  
30 of section 13 of this chapter.

31 (3) The limited service health maintenance organization is unable  
32 to fulfill its obligations to furnish limited health services.

33 (4) The limited service health maintenance organization is not  
34 financially responsible and may reasonably be expected to be  
35 unable to meet its obligations to enrollees or prospective  
36 enrollees.

37 (5) The net worth of the limited service health maintenance  
38 organization is less than that required by section 16 of this  
39 chapter, or the limited service health maintenance organization  
40 has failed to correct any deficiency in its net worth as required by  
41 the commissioner.

42 (6) The limited service health maintenance organization has failed

C  
O  
P  
Y



1 to implement in a reasonable manner the grievance system  
2 required by ~~IC 27-13-10~~ **IC 27-14-8**.

3 (7) The continued operation of the limited service health  
4 maintenance organization would be hazardous to the enrollees of  
5 the organization.

6 (8) The limited service health maintenance organization has  
7 otherwise failed to comply with this chapter.

8 (b) The commissioner may suspend or revoke a certificate of  
9 authority or deny an application for a certificate of authority by written  
10 order sent to the limited service health maintenance organization by  
11 certified mail or registered mail. The written order shall state the  
12 grounds for the suspension, revocation, or denial. A limited service  
13 health maintenance organization may request in writing a hearing  
14 within thirty (30) days after mailing of the order. If the limited service  
15 health maintenance organization requests a hearing within the time  
16 specified, the commissioner shall hold a hearing, which may not be less  
17 than twenty (20) days or more than sixty (60) days after the date of the  
18 notice for a hearing on the matter under IC 4-21.5.

19 (c) Immediately after the certificate of authority of a limited service  
20 health maintenance organization is revoked, the organization shall  
21 proceed to wind up its affairs. An organization whose certificate is  
22 revoked:

23 (1) shall not conduct further business except as may be essential  
24 to the orderly conclusion of the affairs of the organization; and

25 (2) shall not engage in further advertising or solicitation.

26 However, the commissioner may, by written order, permit the further  
27 operation of the organization as the commissioner may find to be in the  
28 best interest of enrollees, to the end that enrollees will be afforded the  
29 greatest practical opportunity to obtain continuing limited health  
30 services.

31 SECTION 8. IC 27-14 IS ADDED TO THE INDIANA CODE AS  
32 A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1,  
33 1998]:

34 **ARTICLE 14. MANAGED CARE CONSUMER**  
35 **PROTECTION**

36 **Chapter 1. Applicability**

37 **Sec. 1. This article applies to all managed care entities operating**  
38 **in Indiana.**

39 **Sec. 2. The provisions of this article are in addition to the**  
40 **provisions of IC 27-13. If a provision in this article conflicts with**  
41 **a provision in IC 27-13, the provision in this article controls.**

42 **Chapter 2. Definitions**



C  
O  
P  
Y

1       **Sec. 1.** The definitions in this chapter apply throughout this  
2 article.

3       **Sec. 2.** "Appeal" means a formal process by which an enrollee:

4           (1) whose care is reduced, denied, or terminated; or

5           (2) who believes that the care received by the enrollee is  
6 inappropriate;

7 can contest an adverse grievance decision by the managed care  
8 plan.

9       **Sec. 3.** "Commissioner" refers to the insurance commissioner  
10 appointed under IC 27-1-1-2.

11       **Sec. 4.** "Copayment" means an amount, or a percentage of the  
12 charge, that an enrollee must pay to receive a specific service that  
13 is not fully prepaid.

14       **Sec. 5.** "Coverage" means the health care services to which a  
15 person is contractually entitled, either directly or indirectly, under  
16 a contract with a managed care plan.

17       **Sec. 6.** "Deductible" means the amount that an enrollee is  
18 responsible to pay out-of-pocket before the managed care plan  
19 begins to pay the costs associated with the health care services.

20       **Sec. 7.** "Department" refers to the Indiana department of  
21 insurance.

22       **Sec. 8.** "Emergency" means the sudden onset of symptoms of  
23 sufficient severity, including severe pain, that the absence of  
24 immediate medical attention could reasonably be expected by a  
25 prudent lay person who possesses an average knowledge of health  
26 and medicine to result in:

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

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

29           (3) serious dysfunction of a bodily organ or part of the  
30 individual.

31       **Sec. 9.** "Enrollee" means a subscriber or a subscriber's  
32 dependent who is covered by a managed care plan.

33       **Sec. 10.** "Expedited review" means a review process that takes  
34 less than seventy-two (72) hours to complete.

35       **Sec. 11.** "Experimental treatment" means treatment that, while  
36 not routinely used in the medical community to treat a particular  
37 condition or illness, is recognized for treatment of a particular  
38 condition or illness, while a clearly superior, nonexperimental  
39 treatment alternative is not available to the enrollee.

40       **Sec. 12.** "Grievance" means a written complaint submitted in  
41 accordance with the formal grievance procedure of a managed  
42 care plan by or on behalf of the enrollee or subscriber regarding



C  
O  
P  
Y

1 any aspect of the managed care plan relative to the enrollee or  
2 subscriber.

3 **Sec. 13. (a) "Health care provider" means a physician, a**  
4 **hospital, or another person licensed or authorized to furnish health**  
5 **care services.**

6 **(b) The term includes an entity that:**

7 **(1) is owned in whole or in part by one (1) or more physicians,**  
8 **hospitals, or other persons licensed or authorized to furnish**  
9 **health care services; and**

10 **(2) was established for purposes of furnishing health care**  
11 **services through:**

12 **(A) contracts; or**

13 **(B) employment agreements;**

14 **with one (1) or more physicians, hospitals, or other persons**  
15 **licensed or authorized to furnish health care services.**

16 **Sec. 14. (a) "Health care services" means:**

17 **(1) services provided by individuals licensed under IC 25-10,**  
18 **IC 25-13, IC 25-14, IC 25-22.5, IC 25-23, IC 25-24, IC 25-26,**  
19 **IC 25-27, IC 25-29, IC 25-33, or IC 25-35.6;**

20 **(2) services provided as a result of hospitalization;**

21 **(3) services incidental to the furnishing of services described**  
22 **in subdivision (1) or (2); or**

23 **(4) any other services or goods furnished for the purpose of**  
24 **preventing, alleviating, curing, or healing human illness,**  
25 **physical disability, or injury.**

26 **(b) The term does not include any service provided by, from, or**  
27 **through a licensed health care facility in connection with a life**  
28 **care, founder's fee, or other type of prepaid fee contract for**  
29 **residency and health care in a retirement home, community, or**  
30 **facility for elderly persons.**

31 **Sec. 15. "Health maintenance organization" means a person**  
32 **that undertakes to provide or arrange for the delivery of health**  
33 **care services to enrollees on a prepaid basis, except for enrollee**  
34 **responsibility for copayments or deductibles.**

35 **Sec. 16. "In-plan covered services" means the following:**

36 **(1) Covered health care services that are obtained from a**  
37 **provider who:**

38 **(A) is employed by;**

39 **(B) is under contract with;**

40 **(C) provides health care services to an enrollee referred**  
41 **by; or**

42 **(D) is otherwise affiliated with;**



C  
O  
P  
Y

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

the managed care plan.

(2) Emergency services.

Sec. 17. "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

Sec. 18. "Managed care entity" means:

- (1) a licensed insurance company;
- (2) a hospital or medical service plan;
- (3) a health maintenance organization or limited service health maintenance organization;
- (4) a preferred provider plan;
- (5) a third party administrator; or
- (6) any other person or entity;

that establishes, operates, or maintains a network of participating health care providers that provide health care services under a managed care plan.

Sec. 19. "Managed care plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to individuals enrolled in the plan. The term includes a plan that provides financial incentives for individuals enrolled in the plan to use the participating health care providers and procedures covered by the plan.

Sec. 20. (a) "Out-of-plan covered services" means nonemergency, self-referred covered health care services that:

- (1) are obtained from a health care provider who is:
  - (A) not otherwise employed by;
  - (B) not under contract with; and
  - (C) not otherwise affiliated with;
- the managed care plan; or
- (2) are obtained from a participating provider without a referral.

(b) The term does not include uncovered services.

Sec. 21. "Participating provider" means a health care provider that, under an express or implied contract with:

- (1) a managed care plan; or
- (2) a contractor of the managed care plan or a subcontractor of a contractor of the managed care plan;

agrees to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the managed care plan.

Sec. 22. "Person" includes the following:

- (1) An individual.
- (2) A partnership.

C  
O  
P  
Y



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

- (3) An association.
- (4) A trust.
- (5) A limited liability company.
- (6) A corporation.

**Sec. 23. "Point of service product" means a product that covers both:**

- (1) in-plan covered services; and
- (2) out-of-plan covered services.

**Sec. 24. "Primary care provider" means a health care provider under contract with a managed care plan who is designated by the managed care plan to coordinate, supervise, or provide ongoing care to an enrollee.**

**Sec. 25. "Quality assurance" means the ongoing evaluation of the quality of health care services provided to enrollees.**

**Sec. 26. "Subscriber" means:**

- (1) an individual whose employment status or other status, except family dependency, is the basis for eligibility for enrollment in a managed care plan; or
- (2) in the case of an individual contract, the person in whose name the contract is issued.

**Chapter 3. Clinical Decision Making; Access to Personnel and Facilities**

**Sec. 1. (a) Each managed care plan shall appoint a medical director who has an unlimited license to practice medicine under IC 25-22.5.**

**(b) The medical director is responsible for treatment policies, protocols, quality assurance activities, and utilization management decisions of the managed care plan.**

**Sec. 2. Each managed care plan shall include a sufficient number and type of primary care providers and specialists throughout the managed care plan's service area to:**

- (1) meet the needs of; and
- (2) provide a meaningful choice of primary care providers and specialists to;

**enrollees of the managed care plan.**

**Sec. 3. A managed care entity shall demonstrate to the department that each managed care plan operated by the managed care entity offers the following:**

- (1) An adequate number of accessible:
  - (A) acute care hospital services;
  - (B) primary care providers; and
  - (C) specialists and subspecialists;

C  
O  
P  
Y



1 that are located within a reasonable distance or travel time of  
2 enrollees of the managed care plan.

3 (2) The availability of:

4 (A) specialty medical services, including physical therapy,  
5 occupational therapy, and rehabilitation services; and

6 (B) out-of-network specialists, when warranted by an  
7 enrollee's unique medical circumstances.

8 **Sec. 4. Primary care providers shall include licensed physicians**  
9 **who practice in one (1) or more of the following areas:**

10 (1) Family practice.

11 (2) General practice.

12 (3) Internal medicine.

13 (4) Obstetrics or gynecology.

14 (5) Pediatrics.

15 **Sec. 5. When the type of medical specialist needed to treat a**  
16 **specific condition is not represented in a managed care plan's**  
17 **network of participating providers, an enrollee is entitled to access**  
18 **to a health care provider who does not participate in the managed**  
19 **care plan's network.**

20 **Sec. 6. A managed care plan shall allow an enrollee, at no**  
21 **additional cost, to continue receiving services from a primary care**  
22 **provider whose contract with the managed care plan is terminated**  
23 **without cause. This continuation is effective for sixty (60) days**  
24 **when the enrollee requests continued care.**

25 **Sec. 7. Each managed care plan shall provide the following:**

26 (1) Telephone access to the managed care plan during  
27 business and evening hours to ensure enrollee access for  
28 routine care.

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

30 (A) a representative of the managed care plan; or

31 (B) a participating provider;

32 for emergency care or authorization for care.

33 **Sec. 8. (a) Each managed care plan shall establish standards for**  
34 **establishing reasonable periods of time within which an enrollee**  
35 **must be given an appointment with a participating provider, except**  
36 **as provided in section 9 of this chapter regarding emergency**  
37 **services.**

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

41 (1) Prenatal care appointments.

42 (2) Well-child visits and immunizations.



C  
O  
P  
Y

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

(3) Routine physicals.

(4) Follow-up appointments for chronic conditions.

(5) Urgent care.

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

(1) furnished by a health care provider within the scope of the health care 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 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) Each managed care plan 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 the:

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

(B) managed care plan;

in a situation where a prudent lay person could reasonably believe that the enrollee's condition required immediate medical attention at the nearest facility. The care obtained by an enrollee under this section includes care for the management of severe pain.

(d) Inpatient and outpatient services are not uncovered services on the grounds that the inpatient and outpatient services were rendered in the course of evaluating or stabilizing an enrollee in an emergency.

Sec. 10. (a) Each managed care plan shall demonstrate to the

C  
O  
P  
Y



1 commissioner that the managed care plan has developed an access  
2 plan to meet the needs of vulnerable and underserved populations,  
3 as defined by rules adopted by the commissioner.

4 (b) When a significant number of enrollees in a managed care  
5 plan speak a primary language other than English, the managed  
6 care plan shall provide access to personnel fluent in those other  
7 languages to the greatest extent possible.

8 Sec. 11. The managed care plan shall develop standards for  
9 continuity of care following enrollment, including sufficient  
10 information on how to access care within the managed care plan.

11 Sec. 12. Each managed care plan shall hold harmless enrollees  
12 against claims from participating providers in the managed care  
13 plan for payment of the cost of covered health services.

14 Sec. 13. The commissioner shall adopt rules under IC 4-22-2 to  
15 implement this chapter.

16 Chapter 4. Choice of Health Care Professional

17 Sec. 1. Each enrollee of a managed care plan shall be given  
18 adequate choice among accessible and qualified participating  
19 providers.

20 Sec. 2. (a) A managed care plan shall permit each enrollee of the  
21 managed care plan to choose the enrollee's own primary care  
22 provider from a list of participating providers within the plan.

23 (b) The list described in subsection (a) shall be updated as  
24 participating providers are added or removed and must include the  
25 following:

26 (1) A sufficient number of primary care providers that accept  
27 new enrollees, as provided under rules adopted by the  
28 commissioner.

29 (2) A sufficient combination of primary care providers that  
30 reflect a diversity that is adequate to meet the needs of the  
31 enrolled population's varied characteristics, including age,  
32 gender, race, and health status, as provided under rules  
33 adopted by the commissioner.

34 Sec. 3. (a) Each managed care plan shall develop a system to  
35 permit enrollees to use a medical specialist as the enrollee's  
36 primary care provider when use of a medical specialist is  
37 warranted by the enrollee's medical conditions.

38 (b) The system required under subsection (a) may provide for  
39 enrollees suffering from chronic diseases as well as for enrollees  
40 with other special needs.

41 Sec. 4. Each managed care plan shall provide continuity of care  
42 and appropriate referral to specialists within the managed care

C  
O  
P  
Y



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

plan when specialty care is warranted, including the following:

- (1) Enrollees shall have access to medical specialists on a timely basis.
- (2) Enrollees are provided with a choice of specialists when a referral is made.

Sec. 5. (a) Each managed care plan shall offer a point-of-service plan.

(b) The point-of-service plan may require that an enrollee in the managed care plan pay for a reasonable portion of the costs for out-of-plan care.

Sec. 6. Each managed care plan shall provide enrollees in the managed care plan with a second opinion at the enrollee's request.

Sec. 7. The commissioner shall adopt rules under IC 4-22-2 to implement this chapter.

**Chapter 5. Prohibition Against Particular Contract Clauses**

Sec. 1. An employment contract or a contract for services between a managed care plan and a participating provider of the managed care plan must meet the following conditions:

- (1) The contract must be in writing.
- (2) The contract may not prohibit the participating provider from disclosing to an enrollee of the managed care plan:
  - (A) the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider; or
  - (B) all treatment options available to an enrollee, including those treatment options not covered by the enrollee's policy or contract.
- (3) The contract may not provide for a financial or other penalty to a participating provider for making a disclosure permitted under subdivision (2).
- (4) The contract must provide that in the event the managed care entity fails to pay for health care services as specified by the contract, the enrollee is not liable to the participating provider for any sums owed by the managed care entity.

Sec. 2. An enrollee is not entitled to coverage of a health care service under a policy or contract unless that health care service is included in the enrollee's policy or contract.

Sec. 3. A health care provider is not entitled to payment under a contract for health care services provided to an enrollee unless the health care provider has a contract or an agreement with the managed care entity.

Sec. 4. If a contract:

C  
O  
P  
Y



1 (1) between a managed care entity and a participating  
 2 provider has not been reduced to writing as required by  
 3 section 1 of this chapter; or  
 4 (2) fails to contain the provision required by section 1(2) of  
 5 this chapter;  
 6 a participating provider may not collect or attempt to collect from  
 7 an enrollee any sums that are owed by the managed care entity.

8 **Sec. 5. A:**

9 (1) participating provider; or  
 10 (2) trustee, an agent, a representative, or an assignee of a  
 11 participating provider;  
 12 may not maintain any legal action against an enrollee of a managed  
 13 care plan to collect sums owed by the managed care entity.

14 **Sec. 6.** This chapter applies to a contract that is entered,  
15 renewed, or modified after June 30, 1998.

16 **Chapter 6. Drugs and Devices; Drug Utilization Review**  
17 **Program**

18 **Sec. 1.** Each managed care plan shall provide coverage for all  
19 drugs and devices approved by the United States Food and Drug  
20 Administration, whether or not a particular drug or device has  
21 been approved for a specific treatment or condition, so long as the  
22 primary care provider or other medical specialist treating an  
23 enrollee determines that the drug or device is medically necessary  
24 and appropriate for the enrollee's condition.

25 **Sec. 2.** Each managed care service plan shall establish and  
26 operate a drug utilization review program that includes the  
27 following:

- 28 (1) Retrospective review of prescription drugs furnished to  
29 enrollees.
- 30 (2) Education of physicians, enrollees, and pharmacists  
31 regarding the appropriate use of prescription drugs.
- 32 (3) Ongoing periodic examination of data on outpatient  
33 prescription drugs to ensure quality therapeutic outcomes for  
34 enrollees.
- 35 (4) Clinically relevant criteria and standards for drug  
36 therapy.
- 37 (5) Nonproprietary criteria and standards, developed and  
38 revised through an open, professional consensus process.
- 39 (6) Interventions that focus on improving therapeutic  
40 outcomes.

41 **Sec. 3.** The primary emphasis of the drug utilization review  
42 program established under section 2 of this chapter is to enhance

C  
O  
P  
Y



1 quality of care for enrollees by assuring appropriate drug therapy.

2 Sec. 4. The name of an enrollee that is discovered in the course  
3 of the drug utilization review program shall remain confidential.

4 Sec. 5. Prospective review of drug therapy may only deny  
5 services in cases of enrollee ineligibility, coverage limitations, or  
6 fraud.

7 Sec. 6. A participating provider who prescribes drugs shall  
8 determine the appropriate drug therapy for an enrollee. A  
9 substitution shall not be made without the direct approval of the  
10 participating provider who prescribed the drugs.

11 Sec. 7. The commissioner shall adopt rules under IC 4-22-2 to  
12 implement this chapter.

13 Chapter 7. Experimental Treatments

14 Sec. 1. (a) A managed care plan that limits coverage for services  
15 must:

- 16 (1) define each limitation; and
- 17 (2) disclose the limits in any contract, policy, agreement, or  
18 certificate of coverage.

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

- 21 (1) Who is authorized to make a determination regarding a  
22 limitation under subsection (a).
- 23 (2) The criteria the managed care plan uses to determine  
24 whether a service is experimental.

25 Sec. 2. A managed care plan that denies coverage for an  
26 experimental treatment, procedure, drug, or device for an enrollee  
27 who has a terminal condition or illness shall provide the enrollee  
28 with a denial letter within twenty (20) working days of a request  
29 submitted by the enrollee or the enrollee's primary care provider  
30 for the treatment, procedure, drug, or device. The letter must  
31 include the following:

- 32 (1) The name and title of the individual making the decision.
- 33 (2) A statement setting forth the specific medical and scientific  
34 reasons for denying coverage.
- 35 (3) A description of alternative treatment, services, or supplies  
36 covered by the managed care plan, if any.
- 37 (4) A copy of the managed care plan's grievance and appeal  
38 procedure.

39 Chapter 8. Grievance Procedures, Reviews and Appeals

40 Sec. 1. Each managed care plan shall establish and maintain a  
41 procedure for the resolution of grievances initiated by enrollees of  
42 the managed care plan. The grievance procedure of a managed

C  
O  
P  
Y



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

care plan must be approved by the commissioner.

**Sec. 2.** A managed care plan shall maintain records regarding all grievances of enrollees that the managed care plan has received since an examination by the commissioner of the grievance procedure of the managed care plan that immediately preceded the receipt of the grievances.

**Sec. 3. (a)** A managed care plan shall provide timely, adequate, and appropriate notice in writing to each enrollee of the grievance procedure required under this chapter.

**(b)** The notice required under subsection (a) shall be provided to:

- (1)** a prospective enrollee before the prospective enrollee enrolls in the managed care plan; and
- (2)** an enrollee at the time that health care services are denied or limited under the managed care plan.

**(c)** A managed care plan shall prominently display on all notices to enrollees the telephone number and address where a grievance may be filed.

**(d)** A written description of the enrollee's right to file a grievance must be posted by each participating provider in a conspicuous public location in each facility that offers health care services on behalf of a managed care plan.

**Sec. 4.** Whenever health care services are denied or limited to an enrollee, the managed care plan shall notify the enrollee of the right to file a grievance. The notification must:

- (1)** be in writing; and
- (2)** include the following:
  - (A)** The reason for denying or limiting care.
  - (B)** The name of the individual responsible for making the decision regarding the grievance.
  - (C)** The criteria for making the determination under clause **(B)**.
  - (D)** The right to file a grievance.

**Sec. 5. (a)** An enrollee may file a grievance orally or in writing.

**(b)** A managed care plan shall make available to enrollees a toll free telephone number through which grievances may be filed. The toll free number must:

- (1)** be staffed by a qualified representative of the managed care plan;
- (2)** be available for at least forty (40) normal business hours per week; and
- (3)** accept grievances in all languages spoken by the major

C  
O  
P  
Y



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

population groups served.  
(c) A grievance is considered to be filed on the first date the grievance is received by the managed care plan, either by telephone or in writing.

Sec. 6. (a) A managed care plan shall establish procedures to assist enrollees in filing grievances.

(b) An enrollee may designate a representative to file a grievance for the enrollee and to represent the enrollee in a grievance procedure under this chapter.

Sec. 7. (a) A managed care plan shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:

- (1) An acknowledgment of the grievance, in writing, to the enrollee within three (3) business days.
- (2) Documentation of the substance of the grievance and any actions taken.
- (3) An investigation of the substance of the grievance, including any aspects involving clinical care.
- (4) Notification to the enrollee of the disposition of the grievance and the right to appeal.
- (5) Standards for timeliness in responding to grievances and providing notice to enrollees of the disposition of the grievance and the right to appeal that accommodate the clinical urgency of the situation.

(b) The managed care plan shall appoint at least one (1) individual to resolve the grievance.

(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the grievance is filed. If a managed care plan is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the managed care plan's control, the managed care plan shall do the following:

- (1) Notify the enrollee in writing of the reason for the delay before the twentieth business day.
- (2) Issue a written decision regarding the complaint within an additional ten (10) business days.

(d) A managed care plan shall notify the enrollee in writing of the resolution of the grievance within five (5) business days after completing the investigation. The grievance resolution notice must contain the following:

- (1) The decision reached by the managed care plan.

C  
O  
P  
Y



1 (2) The reasons, policies, and procedures that are the basis of  
2 the decision.

3 (3) Notice of the enrollee's right to appeal the decision.

4 (4) The department, address, and telephone number through  
5 which an enrollee may contact a qualified representative of  
6 the managed care plan to obtain more information about the  
7 decision or the right to appeal.

8 **Sec. 8. (a) The managed care plan shall provide for expedited  
9 review for cases that involve an imminent, emergent, or serious  
10 threat to the health of an enrollee.**

11 (b) The managed care plan shall immediately inform an enrollee  
12 of the right to an expedited review in each case that the enrollee's  
13 primary care provider:

14 (1) determines that an imminent, emergent, or serious threat  
15 to the enrollee's health is involved; and

16 (2) notifies the managed care plan of the information under  
17 subdivision (1).

18 (c) The managed care plan must provide an enrollee with a  
19 written statement of the disposition or pending status of the  
20 grievance within seventy-two (72) hours after beginning the review  
21 process.

22 **Sec. 9. (a) A managed care plan shall establish written policies  
23 and procedures for the timely resolution of appeals of grievance  
24 decisions. The procedures for registering and responding to oral  
25 and written appeals of grievance decisions must include the  
26 following:**

27 (1) Acknowledgment of the appeal, orally or in writing, within  
28 three (3) business days after receipt of the appeal being filed.

29 (2) Documentation of the substance of the appeal and the  
30 actions taken.

31 (3) Investigation of the substance of the appeal, including any  
32 aspects of clinical care involved.

33 (4) Notification to enrollees of the disposition of the appeal  
34 and that the enrollee may have the right to further remedies  
35 allowed by law.

36 (5) Standards for timeliness in responding to appeals and  
37 providing notice to enrollees of the disposition of the appeal  
38 and the right to initiate an external appeals process that  
39 accommodates the clinical urgency of the situation.

40 (b) The managed care plan shall appoint a panel of qualified  
41 individuals to resolve an appeal. An individual may not be  
42 appointed to the panel who has been involved in the matter giving

C  
O  
P  
Y



1 rise to the complaint or in the initial investigation of the complaint.  
 2 Except for grievances that have previously been appealed under  
 3 IC 27-8-17, in the case of an appeal from the proposal, refusal, or  
 4 delivery of a health care procedure, treatment, or service, the  
 5 managed care entity shall appoint one (1) or more individuals to  
 6 the panel to resolve the appeal. The panel must include one (1) or  
 7 more individuals who:

8 (1) have knowledge in the medical condition, procedure, or  
 9 treatment at issue;

10 (2) are in the same licensed profession as the participating  
 11 provider who proposed, refused, or delivered the health care  
 12 procedure, treatment, or service;

13 (3) are not involved in the matter giving rise to the appeal or  
 14 the previous grievance process; and

15 (4) do not have a direct business relationship with the enrollee  
 16 or the participating provider who previously recommended  
 17 the health care procedure, treatment, or service giving rise to  
 18 the grievance.

19 (c) An appeal of a grievance decision must be resolved:

20 (1) as expeditiously as possible; and

21 (2) with regard to the clinical urgency of the appeal.

22 However, an appeal must be resolved not later than thirty (30)  
 23 days after the appeal is filed.

24 (d) A managed care plan shall allow an enrollee the opportunity  
 25 to appear in person before the panel or to communicate with the  
 26 panel through other appropriate means if the enrollee is unable to  
 27 appear in person.

28 (e) A managed care plan shall notify the enrollee in writing of  
 29 the resolution of the appeal of a grievance within five (5) business  
 30 days after completing the investigation. The grievance resolution  
 31 notice must contain the following:

32 (1) The decision reached by the managed care plan.

33 (2) The reasons, policies, or procedures that are the basis of  
 34 the decision.

35 (3) Notice of the enrollee's right to further remedies allowed  
 36 by law.

37 (4) The department, address, and telephone number through  
 38 which an enrollee may contact a qualified representative of  
 39 the managed care plan to obtain more information about the  
 40 decision or the right to further appeal.

41 Sec. 10. A managed care plan may not take action against a  
 42 participating provider solely on the basis that the participating

C  
O  
P  
Y



1 provider represents an enrollee in a grievance filed under this  
2 chapter.

3 **Sec. 11. (a) Notwithstanding this article, the commissioner shall**  
4 **approve the grievance and appeals procedures of a managed care**  
5 **plan if:**

- 6 (1) the managed care plan certifies in writing to the  
7 department the managed care plan's compliance with  
8 grievance and appeals procedures established by the Health  
9 Care Financing Administration of the United States  
10 Department of Health and Human Services; and  
11 (2) the department certifies that the grievance and appeals  
12 procedures established by the Health Care Financing  
13 Administration of the United States Department of Health  
14 and Human Services are substantially similar to the grievance  
15 and appeals process in this chapter.

16 (b) Subsection (a) does not:

- 17 (1) limit the authority of the department;  
18 (2) limit the responsibility of a managed care plan;  
19 (3) release a managed care plan from the prohibitions  
20 established under section 10 of this chapter; or  
21 (4) require a managed care plan to use a grievance and  
22 appeals procedure established by the Health Care Financing  
23 Administration of the United States Department of Health  
24 and Human Services.

25 **Sec. 12. The commissioner shall adopt rules under IC 4-22-2 to**  
26 **implement this chapter.**

27 **Chapter 9. Quality Management Programs**

28 **Sec. 1. (a) A managed care entity shall establish procedures**  
29 **based on professionally recognized standards to assess and monitor**  
30 **the health care services provided to enrollees of each managed care**  
31 **plan operated by the managed care entity.**

32 (b) The procedures established under this section must include  
33 mechanisms to implement corrective action when necessary and to  
34 assess the availability, accessibility, and continuity of care.

35 **Sec. 2. Each managed care plan shall have an ongoing internal**  
36 **quality management program to monitor and evaluate the health**  
37 **care services provided by the managed care plan, including:**

- 38 (1) primary and specialist physician services; and  
39 (2) ancillary and preventive health care services;

40 across all institutional and noninstitutional settings.

41 **Sec. 3. The quality management program required by section 2**  
42 **of this chapter must include at least the following:**

C  
O  
P  
Y



- 1 (1) A written statement of the scope and purpose of the  
 2 managed care plan's quality management program, including  
 3 a written statement of goals and objectives that emphasizes  
 4 improved health status in evaluating the quality of care  
 5 rendered to enrollees.  
 6 (2) The organizational structure responsible for quality  
 7 management activities.  
 8 (3) Any contractual arrangements, when appropriate, for  
 9 delegation of quality management activities.  
 10 (4) Confidentiality of policies and procedures.  
 11 (5) A system of ongoing evaluation activities.  
 12 (6) A system of focused evaluation activities.  
 13 (7) A system for credentialing providers and performing peer  
 14 review activities.  
 15 (8) Duties and responsibilities of the designated physician  
 16 responsible for the quality management activities.

17 **Sec. 4. The quality management program required by section 2**  
 18 **of this chapter must contain a written statement describing the**  
 19 **system of ongoing quality management activities, including the**  
 20 **following:**

- 21 (1) Problem assessment, identification, selection, and study.  
 22 (2) Corrective action, monitoring, evaluation, and  
 23 reassessment.  
 24 (3) Interpretation and analysis of patterns of care rendered to  
 25 individual patients by individual participating providers.  
 26 (4) Comparison between patterns of care, including outcomes,  
 27 rendered to patients by participating providers and the cost  
 28 to the managed care plan of that care.  
 29 (5) A written statement describing the system of focused  
 30 quality assurance activities based on representative samples  
 31 of the enrolled population that identifies method of topic  
 32 selection, study, data collection, analysis, interpretation, and  
 33 report format.

34 **Sec. 5. The quality management program required by section 2**  
 35 **of this chapter must contain written plans for taking appropriate**  
 36 **corrective action whenever the quality management program**  
 37 **determines that:**

- 38 (1) inappropriate or substandard services have been  
 39 provided; or  
 40 (2) services that should have been provided were not  
 41 provided.

42 **Sec. 6. Each managed care plan shall ensure the use and**

C  
O  
P  
Y



1 maintenance of an adequate patient record system that will  
2 facilitate:

- 3 (1) documentation and retrieval of clinical information to  
4 enable the managed care plan to evaluate continuity and  
5 coordination of patient care; and  
6 (2) the assessment of the quality of health and medical care  
7 provided to enrollees.

8 **Sec. 7.** A managed care plan shall establish a mechanism for  
9 periodic reporting of quality management program activities to the  
10 governing body, providers, and appropriate staff of the managed  
11 care plan.

12 **Sec. 8.** A managed care plan shall:

- 13 (1) record the proceedings of formal quality management  
14 program activities; and  
15 (2) maintain documentation of the managed care plan's  
16 quality management program in a confidential manner.

17 **Sec. 9.** The commissioner may inspect the records of a managed  
18 care plan's quality management program. The managed care plan  
19 shall cooperate with the inspections by making available to the  
20 commissioner the records requested by the commissioner while  
21 protecting the confidentiality of individual enrollee medical  
22 records.

23 **Sec. 10. (a)** A managed care plan may not refuse to enter into an  
24 agreement with a hospital solely because the hospital has not  
25 obtained accreditation from an accreditation organization that:

- 26 (1) establishes standards for the organization and operation  
27 of hospitals;  
28 (2) requires the hospital to undergo a survey process for a fee  
29 paid by the hospital; and  
30 (3) was organized and formed in 1951.

31 **(b)** This section does not prohibit a managed care plan from  
32 using performance indicators or quality standards that:

- 33 (1) are developed by private organizations; and  
34 (2) do not rely upon a survey process for a fee charged to the  
35 hospital to evaluate performance.

36 **Chapter 10. Reporting Requirements**

37 **Sec. 1.** Before March 2 each year, a managed care entity must  
38 file with the commissioner a report that covers the preceding  
39 calendar year. The report must be:

- 40 (1) made on forms prescribed by the commissioner; and  
41 (2) verified by at least two (2) principal officers of the  
42 managed care entity.

C  
O  
P  
Y



1           **Sec. 2. (a) The report required by section 1 of this chapter must**  
 2 **include specific data for each managed care plan operated by the**  
 3 **managed care entity, including the following:**

- 4           (1) **Gross outpatient and hospital utilization data.**  
 5           (2) **Enrollee clinical outcome data.**  
 6           (3) **The number, amount, and disposition of malpractice**  
 7 **claims resolved during the year by the managed care plan and**  
 8 **any participating provider of the managed care plan.**

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

11           **Sec. 3. (a) In addition to the report required by section 1 of this**  
 12 **chapter, a managed care entity shall each year file with the**  
 13 **commissioner the following:**

- 14           (1) **Audited financial statements of the managed care entity**  
 15 **for the preceding calendar year.**  
 16           (2) **A list of participating providers who provide health care**  
 17 **services to enrollees of each managed care plan operated by**  
 18 **the managed care entity.**  
 19           (3) **A description of the grievance procedure of the managed**  
 20 **care entity, the total number of grievances handled through**  
 21 **the procedure during the preceding calendar year, a**  
 22 **compilation of the causes underlying those grievances, and a**  
 23 **summary of the final disposition of those grievances.**

24           **(b) The information required by subsection (a)(2) and (a)(3)**  
 25 **must be filed with the commissioner before March 2 of each year.**  
 26 **The audited financial statements required by subsection (a)(1)**  
 27 **must be filed with the commissioner on or before June 1 of each**  
 28 **year. The commissioner shall:**

- 29           (1) **make the information required to be filed under this**  
 30 **section available to the public; and**  
 31           (2) **prepare an annual compilation of the data required under**  
 32 **subsection (a)(3) that allows for comparative analysis.**

33           **Sec. 4. Each managed care plan shall provide information on the**  
 34 **managed care plan's:**

- 35           (1) **structure;**  
 36           (2) **decision making process;**  
 37           (3) **health care benefits and exclusions;**  
 38           (4) **cost and cost sharing requirements;**  
 39           (5) **list of participating providers; and**  
 40           (6) **grievance and appeal procedures;**

41 **to all potential enrollees, to all enrollees covered by the managed**  
 42 **care plan, and to the department.**



C  
O  
P  
Y

1           **Sec. 5.** The commissioner may require additional reports as are  
 2 necessary and appropriate for the commissioner to carry out the  
 3 commissioner's duties under this article.

4           **Chapter 11. Confidentiality**

5           **Sec. 1. (a) Any information:**

6               (1) that pertains to the diagnosis, treatment, or health of any  
 7 enrollee of a managed care plan; and

8               (2) that is obtained from:

9                   (A) the enrollee; or

10                  (B) a provider;

11               by a managed care plan;

12 is confidential and may not be disclosed to any person, except  
 13 under the circumstances set forth in subsection (b).

14           (b) Information described in subsection (a) may be disclosed:

15               (1) to the extent necessary to carry out this article;

16               (2) upon the express written consent of the enrollee;

17               (3) under a statute or court order for the production of  
 18 evidence or the discovery of evidence; or

19               (4) in the event of a claim or litigation between:

20                   (A) the enrollee; and

21                   (B) the managed care plan;

22               in which the data or information is pertinent.

23           **Sec. 2.** A managed care plan is entitled to claim any statutory  
 24 privilege against the disclosure of information described in section  
 25 1(a) of this chapter that the provider who furnished the  
 26 information to the managed care plan is entitled to claim.

27           **Chapter 12. Managed Care Plan Descriptions**

28           **Sec. 1.** Each managed care entity offering a managed care plan  
 29 shall make available a managed care plan description form for  
 30 each policy or contract that either covers or is marketed to an  
 31 Indiana resident or the resident's employer.

32           **Sec. 2. (a)** The form required under section 1 of this chapter  
 33 must include information of general interest to:

34               (1) purchasers of managed care plan policies or contracts;  
 35               and

36               (2) individuals covered by each managed care plan policy or  
 37 contract.

38           (b) The form must be designed to facilitate comparison of  
 39 different managed care plans.

40           **Sec. 3.** A managed care entity shall provide a completed  
 41 managed care plan description form for each managed care plan  
 42 operated by the managed care entity to the following:

C  
O  
P  
Y



1 (1) Upon request, to an individual covered by the managed  
2 care plan or to the individual's employer.

3 (2) As part of the managed care entity's marketing materials,  
4 to a person or employer that may be interested in purchasing  
5 or obtaining coverage under a managed care plan offered by  
6 the managed care entity.

7 **Chapter 13. Oversight of Managed Care Entities**

8 **Sec. 1. The department shall oversee managed care entities**  
9 **operating within Indiana.**

10 **Sec. 2. Each managed care entity operating in Indiana must be**  
11 **legally authorized by the department to operate in Indiana under**  
12 **rules adopted by the department.**

13 **Sec. 3. The department shall perform audits on an annual basis**  
14 **to review enrollee clinical outcome data, enrollee service data, and**  
15 **operational and other financial data.**

16 **Sec. 4. This article does not preclude the department from**  
17 **investigating complaints, grievances, or appeals on behalf of**  
18 **enrollees or health care providers.**

19 **Sec. 5. The commissioner shall adopt rules under IC 4-22-2 to**  
20 **develop:**

- 21 (1) standards for the compliance of a managed care entity's  
22 managed care plans regarding mandated requirements; and  
23 (2) penalties for violations of the standards developed under  
24 subdivision (1).

25 SECTION 9. THE FOLLOWING ARE REPEALED [EFFECTIVE  
26 JULY 1, 1998]: IC 27-13-6; IC 27-13-10; IC 27-13-15.

27 SECTION 10. [EFFECTIVE JULY 1, 1998] (a) Not later than  
28 January 1, 1999, the commissioner of the department of insurance,  
29 after consulting with representatives of consumers, health care  
30 providers, and managed care entities, shall adopt rules under  
31 IC 4-22-2 regarding the format for and elements of the managed  
32 care plan description form required under IC 27-14-12-1, as added  
33 by this act.

34 (b) This SECTION expires January 1, 2000.

C  
O  
P  
Y

