

January 27, 1998

SENATE BILL No. 364

DIGEST OF SB 364 (Updated January 23, 1998 10:38 am - DI 88)

Citations Affected: IC 27-14; noncode.

Synopsis: Managed care consumer protection. Defines a managed care entity as a health maintenance organization or a provider sponsored organization. Requires a managed care entity 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 specialized medical services, including physical therapy, occupational therapy, rehabilitation services, and mental and behavioral care services. (4) Provide enrollees with continuation of care and referrals to out of network specialists as necessary. (5) Provide coverage for emergency services under a prudent layperson standard. (6) Adequate choice among health care providers that are accessible and qualified. (7) Offer a point-of-service option to each purchaser of a managed care plan. (8) Allow open
(Continued next page)

Effective: July 1, 1998.

**Lawson, Simpson, Miller, Gard,
Wolf, Breaux, Landske**

January 8, 1998, read first time and referred to Committee on Health and Environmental Affairs.
January 26, 1998, amended, reported favorably — Do Pass.

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communication between participating providers and enrollees. (9) Develop and implement a procedure to evaluate whether to provide coverage for experimental treatments. (10) Provide coverage for all drugs and devices approved by the United States Food and Drug Administration, with certain limitations. (11) Provide annual reports with certain required information that are available to the public. (12) Provide descriptions of grievance and appeal resolution plans. (13) Provide timely resolution of grievances and appeals. (14) Provide information regarding quality management programs that a managed care entity is required to maintain. (15) Confidentiality regarding enrollees' medical information and medical records. (14) Provide comprehensive descriptions of each managed care plan operated by the managed care entity. Provides that a limited service health maintenance organization and a preferred provider organization must comply with certain statutes governing managed care consumer protection. Requires the department of insurance to oversee all managed care entities.

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January 27, 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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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 27-14 IS ADDED TO THE INDIANA CODE AS
2 A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1,
3 1998]:
4 ARTICLE 14. MANAGED CARE CONSUMER
5 PROTECTION
6 Chapter 1. Applicability
7 Sec. 1. This article applies to all managed care entities operating
8 in Indiana.
9 Sec. 2. The provisions of this article are in addition to the
10 provisions of IC 27-13. If a provision in this article conflicts with
11 a provision in IC 27-13, the provision in this article controls.
12 Chapter 2. Definitions
13 Sec. 1. The definitions in this chapter apply throughout this
14 article.
15 Sec. 2. "Appeal" means a formal process by which an enrollee:

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- 1 (1) whose coverage for a particular service or treatment has
- 2 been reduced, denied, or terminated; or
- 3 (2) who believes that the level of care authorized by the
- 4 enrollee's managed care plan is inappropriate;
- 5 can contest an adverse grievance decision by the managed care
- 6 plan.

7 Sec. 3. "Commissioner" refers to the insurance commissioner
8 appointed under IC 27-1-1-2.

9 Sec. 4. "Copayment" has the meaning set forth in IC 27-13-1-8.

10 Sec. 5. "Coverage" means the health care services to which a
11 person is contractually entitled, either directly or indirectly, under
12 a contract with a managed care plan.

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

16 Sec. 7. "Department" refers to the Indiana department of
17 insurance.

18 Sec. 8. "Emergency" means a medical condition that arises
19 suddenly and unexpectedly and manifests itself by acute symptoms
20 of severity, including severe pain, that the absence of immediate
21 medical attention could reasonably be expected by a prudent lay
22 person who possesses an average knowledge of health and medicine
23 to result in:

- 24 (1) placing an individual's health in serious jeopardy;
- 25 (2) serious impairment to the individual's bodily functions; or
- 26 (3) serious dysfunction of a bodily organ or part of the
- 27 individual.

28 Sec. 9. "Enrollee" means a subscriber or a subscriber's
29 dependent who is covered by a managed care plan.

30 Sec. 10. "Expedited review" means a review process under
31 IC 27-8-17 or IC 27-13-10 that takes not more than seventy-two
32 (72) hours to complete.

33 Sec. 11. "Experimental treatment" means new medical
34 technology or a new application of existing medical technology,
35 including medical procedures, drugs, and devices for treatment of
36 an illness or injury.

37 Sec. 12. "Grievance" means a complaint submitted in
38 accordance with the formal grievance procedure of a managed
39 care plan by or on behalf of the enrollee or subscriber regarding
40 any aspect of the managed care plan relative to the enrollee or
41 subscriber.

42 Sec. 13. "Health care services" has the meaning set forth in

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1 IC 27-13-1-18.

2 Sec. 14. "Health maintenance organization" has the meaning set
3 forth in IC 27-13-1-19.

4 Sec. 15. "In-plan covered services" means the following:

5 (1) Covered health care services that are obtained from a
6 provider who:

7 (A) is employed by;

8 (B) is under contract with;

9 (C) provides health care services to an enrollee referred
10 by; or

11 (D) is otherwise affiliated with;

12 the managed care plan.

13 (2) Emergency services.

14 Sec. 16. "Limited service health maintenance organization" has
15 the meaning set forth in IC 27-13-34-4.

16 Sec. 17. "Managed care entity" means:

17 (1) a provider sponsored organization (as defined in 42 U.S.C.
18 1395w-25d); or

19 (2) a health maintenance organization (as defined in
20 IC 27-13-1-19);

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

24 Sec. 18. "Managed care plan" means a plan operated by a
25 managed care entity that does the following:

26 (1) Provides for the financing and delivery of health care
27 services to individuals enrolled in the plan.

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

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

31 Sec. 19. (a) "Out-of-plan covered services" means
32 nonemergency, self-referred covered health care services that:

33 (1) are obtained from a provider who is:

34 (A) not otherwise employed by;

35 (B) not under contract with; and

36 (C) not otherwise affiliated with;

37 the managed care plan; or

38 (2) are obtained from a participating provider without a
39 referral.

40 (b) The term does not include uncovered services.

41 Sec. 20. "Participating provider" means a provider that, under
42 an express or implied contract with:

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- 1 (1) a managed care plan; or
- 2 (2) a contractor of the managed care plan or a subcontractor
- 3 of a contractor of the managed care plan;
- 4 agrees to provide health care services to enrollees with an
- 5 expectation of directly or indirectly receiving payment, other than
- 6 copayment or deductible, from the managed care plan.
- 7 Sec. 21. "Person" has the meaning set forth in IC 27-13-1-25.
- 8 Sec. 22. "Point of service product" has the meaning set forth in
- 9 IC 27-13-1-26.
- 10 Sec. 23. "Primary care provider" means a provider under
- 11 contract with a managed care plan who is designated by the
- 12 managed care plan to coordinate, supervise, or provide ongoing
- 13 care to an enrollee.
- 14 Sec. 24. "Provider" has the meaning set forth in IC 27-13-1-28.
- 15 Sec. 25. "Quality assurance" means the ongoing evaluation of
- 16 the quality of health care services provided to enrollees.
- 17 Sec. 26. "Subscriber" means:
- 18 (1) an individual whose employment status or other status,
- 19 except family dependency, is the basis for eligibility for
- 20 enrollment in a managed care plan; or
- 21 (2) in the case of an individual contract, the person in whose
- 22 name the contract is issued.
- 23 Chapter 3. Clinical Decision Making; Access to Personnel and
- 24 Facilities
- 25 Sec. 1. (a) Each managed care plan shall appoint a medical
- 26 director who has an unlimited license to practice medicine under
- 27 IC 25-22.5 or an equivalent license issued by another state.
- 28 (b) The medical director is responsible for oversight of
- 29 treatment policies, protocols, quality assurance activities, and
- 30 utilization management decisions of the managed care plan.
- 31 (c) A managed care entity shall employ at least one (1)
- 32 individual who holds an unlimited license to practice medicine
- 33 under IC 25-22.5 to:
- 34 (1) develop treatment policies, protocols, and quality
- 35 assurance activities; and
- 36 (2) make utilization management decisions;
- 37 of a managed care plan operated by the managed care entity.
- 38 Sec. 2. Each managed care plan shall include a sufficient
- 39 number and type of primary care providers and specialists
- 40 throughout the managed care plan's service area to:
- 41 (1) meet the needs of; and
- 42 (2) provide a choice of primary care providers and specialists

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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;**
 - (C) specialists and subspecialists; and**
 - (D) pharmacy services, if the managed care entity offers pharmacy services;**

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

- (2) The availability of specialty medical services, including physical therapy, occupational therapy, rehabilitation services, and mental and behavioral care services.**

Sec. 4. 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) When an enrollee's primary care provider determines that the type of medical specialist needed to treat a specific condition is not represented in a managed care plan's network of participating providers, the primary care provider shall refer the enrollee to an appropriate provider that does not participate in the managed care plan's network for treatment that is not available within the managed care plan's network.

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

Sec. 6. (a) A managed care plan shall include provisions in the managed care plan's contracts with providers to provide for

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1 continuation of care in the event that a provider's contract with the
 2 managed care plan is terminated, provided that the termination is
 3 not due to a quality of care issue.

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

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

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

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

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

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

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

23 (1) Telephone access to the managed care plan during
 24 business hours to ensure enrollee access for routine care.

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

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

27 (B) a participating provider;

28 for emergency care or authorization for care.

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

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

37 (1) Prenatal care appointments.

38 (2) Well-child visits and immunizations.

39 (3) Routine physicals.

40 (4) Follow-up appointments for chronic conditions.

41 (5) Urgent care.

42 **Sec. 9.** (a) As used in this section "care obtained in an

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1 emergency" means, with respect to an enrollee in a managed care
2 plan, covered inpatient and outpatient services that are:

- 3 (1) furnished by a provider within the scope of the provider's
4 license and as otherwise authorized under law; and
5 (2) needed to evaluate or stabilize an individual in an
6 emergency.

7 (b) As used in this section, "stabilize" means to provide medical
8 treatment to an individual in an emergency as may be necessary to
9 assure, within reasonable medical probability, that material
10 deterioration of the individual's condition is not likely to result
11 from or during any of the following:

- 12 (1) The discharge of the individual from an emergency
13 department or other care setting where emergency services
14 are provided to the individual.
15 (2) The transfer of the individual from an emergency
16 department or other care setting where emergency services
17 are provided to the individual to another health care facility.
18 (3) The transfer of the individual from a hospital emergency
19 department or other hospital care setting where emergency
20 services are provided to the individual to the hospital's
21 inpatient setting.

22 (c) Each managed care plan shall cover and reimburse expenses
23 for care obtained in an emergency by an enrollee without:

- 24 (1) prior authorization; or
25 (2) regard to the contractual relationship between the:
26 (A) provider who provided health care services to an
27 enrollee in an emergency; and
28 (B) managed care plan;

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

33 Sec. 10. Each managed care plan shall demonstrate to the
34 commissioner that the managed care plan has developed an access
35 plan to meet the needs of vulnerable and underserved populations,
36 including enrollees from major population groups who speak a
37 primary language other than English, as defined by rules adopted
38 by the commissioner.

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

42 Sec. 12. Each managed care plan shall require that a

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1 participating provider hold enrollees harmless for covered health
 2 services, except for applicable deductibles and copayments, as
 3 provided in IC 27-13-15-1(4).

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

6 **Chapter 4. Choice of Health Care Professional**

7 **Sec. 1.** Each enrollee of a managed care plan shall be given
 8 adequate choice among accessible and qualified participating
 9 providers.

10 **Sec. 2. (a)** A managed care plan shall permit each enrollee of the
 11 managed care plan to choose the enrollee's own primary care
 12 provider from a list of participating primary care providers within
 13 the plan.

14 **(b)** The list described in subsection (a) shall be updated as
 15 participating providers are added or removed and must include the
 16 following:

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

20 (2) To the greatest extent possible, a sufficient combination of
 21 primary care providers that reflect a diversity to meet the
 22 needs of the enrolled population's varied characteristics,
 23 including age, gender, race, and health status, as provided
 24 under rules adopted by the commissioner.

25 **Sec. 3. (a)** Each managed care plan shall develop a system to
 26 permit an enrollee to use a medical specialist to treat the enrollee's
 27 medical condition when the enrollee's primary care provider
 28 determines that the use of a medical specialist is warranted by the
 29 enrollee's medical condition.

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

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

39 **Sec. 4.** Each managed care plan shall provide continuity of care
 40 and appropriate referral to specialists within the managed care
 41 plan when specialty care is warranted, including the following:

42 (1) Enrollees shall have access to medical specialists on a

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timely basis.

(2) Enrollees are provided with a choice of specialists when a referral is made.

Sec. 5. (a) Each managed care entity shall offer to each purchaser of a managed care plan a point-of-service product.

(b) 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.

(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 under subsection (b).

Sec. 6. Each managed care plan shall provide enrollees in the managed care plan with a second medical 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. A contract between a managed care plan and a participating provider of health care services must meet the following conditions:

- (1) The contract must be in writing.
- (2) The contract may not prohibit the participating provider from disclosing:
 - (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 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 policy or 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

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1 service under a policy or contract unless that health care service is
2 included in the enrollee's policy or contract.

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

6 Sec. 4. If a contract:

7 (1) between a managed care entity and a participating
8 provider has not been reduced to writing as required by
9 section 1 of this chapter; or

10 (2) fails to contain the provision required by section 1(2) of
11 this chapter;

12 the participating provider may not collect or attempt to collect
13 from the subscriber or an enrollee any sums that are owed by the
14 managed care entity.

15 Sec. 5. A:

16 (1) participating provider; or

17 (2) trustee, an agent, a representative, or an assignee of a
18 participating provider;

19 may not maintain any legal action against a subscriber or an
20 enrollee of a managed care plan to collect sums owed by the
21 managed care plan.

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

24 Chapter 6. Drugs and Devices; Drug Utilization Review
25 Program

26 Sec. 1. (a) Each managed care plan shall provide coverage for
27 all drugs and devices approved by the United States Food and Drug
28 Administration, whether or not a particular drug or device has
29 been approved for a specific treatment or condition, so long as the
30 primary care provider or other medical specialist treating an
31 enrollee determines that the drug or device is medically necessary
32 and appropriate for the enrollee's condition.

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

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

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

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

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(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).

Sec. 2. Each managed care service plan shall establish and operate 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.

Sec. 3. The primary emphasis of the drug utilization review program established under section 2 of this chapter is to enhance quality of care for enrollees by assuring appropriate drug therapy.

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

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

Sec. 6. A participating provider who prescribes drugs shall determine the appropriate drug therapy for an enrollee. A substitution shall not be made without the direct approval of the participating provider who prescribed the drugs (as provided in IC 16-42-22).

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

Chapter 7. Experimental Treatments

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

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technologies, including medical procedures, drugs, and devices.

(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.

Sec. 2. (a) A managed care plan that limits coverage for 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) Who is authorized to make a determination regarding a limitation under subsection (a).
- (2) The criteria the managed care plan uses to determine whether a service is experimental, as provided in section 1 of this chapter.

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.

Chapter 8. Grievance Procedures, Reviews and Appeals

Sec. 1. Each managed care plan shall establish and maintain a procedure for the resolution of grievances initiated by enrollees and subscribers of the managed care plan. The grievance procedure of a managed care plan must be approved by the commissioner.

Sec. 2. The commissioner may examine the grievance

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1 procedures of a managed care plan.

2 **Sec. 3.** A managed care plan shall maintain records regarding
3 all grievances of enrollees that the managed care plan has received
4 since an examination by the commissioner of the grievance
5 procedure of the managed care plan that immediately preceded the
6 receipt of the grievances.

7 **Sec. 4. (a)** A managed care plan shall provide timely, adequate,
8 and appropriate notice to each enrollee or subscriber of the
9 grievance procedure required under this chapter.

10 (b) A managed care plan shall prominently display on all notices
11 to enrollees and subscribers the telephone number and address at
12 which a grievance may be filed.

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

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

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

- 22 (1) be staffed by a qualified representative of the managed
- 23 care plan;
- 24 (2) be available for at least forty (40) normal business hours
- 25 per week; and
- 26 (3) accept grievances in the languages of the major population
- 27 groups served.

28 (c) A grievance is considered to be filed on the first date the
29 grievance is received, either by telephone or in writing.

30 **Sec. 6. (a)** A managed care plan shall establish procedures to
31 assist enrollees and subscribers in filing grievances.

32 (b) An enrollee or a subscriber may designate a representative
33 to file a grievance for the enrollee or subscriber and to represent
34 the enrollee or subscriber in a grievance under this chapter.

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

- 39 (1) An acknowledgment of the grievance, orally or in writing,
- 40 to the enrollee or subscriber within three (3) business days.
- 41 (2) Documentation of the substance of the grievance and any
- 42 actions taken.



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- (3) An investigation of the substance of the grievance, including any aspects involving clinical care.
 - (4) Notification to the enrollee or subscriber of the disposition of the grievance and the right to appeal.
 - (5) Standards for timeliness in responding to grievances and providing notice to enrollees and subscribers of the disposition of the complaint 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 complaint.
- (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 or subscriber 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 or subscriber 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.
 - (2) The reasons, policies, and procedures that are the basis of the decision.
 - (3) Notice of the enrollee's or subscriber's right to appeal the decision.
 - (4) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to appeal.
- Sec. 9. (a) A managed care plan shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:
- (1) Acknowledgment of the appeal, orally or in writing, within three (3) business days after receipt of the appeal being filed.
 - (2) Documentation of the substance of the appeal and the actions taken.

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

(4) Notification to enrollees or subscribers of the disposition of the appeal and that the enrollee or subscriber may have the right to further remedies allowed by law.

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

(b) The managed care plan shall appoint a panel of qualified individuals to resolve an appeal. An individual may not be appointed to the panel who has been involved in the matter giving rise to the complaint or in the initial investigation of the complaint. Except for grievances that have previously been appealed under IC 27-8-17, in the case of an appeal from the proposal, refusal, or delivery of a health care procedure, treatment, or service, the managed care plan shall appoint one (1) or more individuals to the panel to resolve the appeal. The panel must include one (1) or more individuals who:

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

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

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

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

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

(1) as expeditiously as possible; and

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

However, an appeal must be resolved not later than forty-five (45) days after the appeal is filed.

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

(e) A managed care plan shall notify the enrollee or subscriber in writing of the resolution of the appeal of a grievance within five (5) business days after completing the investigation. The grievance

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resolution notice must contain the following:

- (1) The decision reached by the managed care plan.
- (2) The reasons, policies, or procedures that are the basis of the decision.
- (3) Notice of the enrollee's or subscriber's right to further remedies allowed by law.
- (4) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to further appeal.

Sec. 10. A managed care plan may not take action against a participating provider solely on the basis that the participating provider represents an enrollee or a subscriber in a grievance filed under this chapter.

Sec. 11. (a) Notwithstanding this article, the department shall approve the grievance and appeals procedures of a managed care plan if:

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

(b) Subsection (a) does not:

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

Sec. 12. The department may adopt rules under IC 4-22-2 to implement this chapter.

Chapter 9. Quality Management Programs

Sec. 1. (a) A managed care entity shall establish procedures based on professionally recognized standards to assess and monitor the health care services provided to enrollees of each managed care

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plan operated by the managed care entity.

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

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

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

across all institutional and noninstitutional settings.

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

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

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

- (1) Problem assessment, identification, selection, and study.
- (2) Corrective action, monitoring, evaluation, and reassessment.
- (3) Interpretation and analysis of patterns of care rendered to individual patients by individual participating providers.
- (4) Comparison between patterns of care, including outcomes, rendered to patients by participating providers and the cost to the managed care plan of that care.
- (5) A written statement describing the system of focused quality assurance activities based on representative samples

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1 of the enrolled population that identifies method of topic
2 selection, study, data collection, analysis, interpretation, and
3 report format.

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

- 8 (1) inappropriate or substandard services have been
9 provided; or
- 10 (2) services that should have been provided were not
11 provided.

12 **Sec. 6. A managed care plan shall ensure the use and**
13 **maintenance of an adequate patient record system that will**
14 **facilitate:**

- 15 (1) documentation and retrieval of clinical information to
16 enable the managed care plan to evaluate continuity and
17 coordination of patient care; and
- 18 (2) the assessment of the quality of health and medical care
19 provided to enrollees.

20 **Sec. 7. A managed care plan shall establish a mechanism for**
21 **periodic reporting of quality management program activities to the**
22 **governing body, participating providers, and appropriate staff of**
23 **the managed care plan.**

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

- 25 (1) record the proceedings of formal quality management
26 program activities; and
- 27 (2) maintain documentation of the managed care plan's
28 quality management program in a confidential manner.

29 **Sec. 9. The commissioner may inspect the records of a managed**
30 **care plan's quality management program. The managed care plan**
31 **shall cooperate with the inspections by making available to the**
32 **commissioner the records requested by the commissioner while**
33 **protecting the confidentiality of enrollee medical records.**

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

- 37 (1) establishes standards for the organization and operation
38 of hospitals;
- 39 (2) requires the hospital to undergo a survey process for a fee
40 paid by the hospital; and
- 41 (3) was organized and formed in 1951.

42 **(b) This section does not prohibit a managed care plan from**

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1 using performance indicators or quality standards that:

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

5 **Chapter 10. Reporting Requirements**

6 **Sec. 1. Not later than March 1 of each year, a managed care**
7 **entity must file with the commissioner a report that covers the**
8 **preceding calendar year. The report must be:**

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

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

- 15 (1) Gross outpatient and hospital utilization data.
- 16 (2) Enrollee clinical outcome data.
- 17 (3) The number, amount, and disposition of malpractice
- 18 claims resolved during the year by the managed care plan and
- 19 any participating provider of the managed care plan.

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

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

- 25 (1) Audited financial statements of the managed care entity
- 26 for the preceding calendar year.
- 27 (2) A list of participating providers who provide health care
- 28 services to enrollees or subscribers of each managed care plan
- 29 operated by the managed care entity.
- 30 (3) A description of the grievance procedure of the managed
- 31 care entity, the total number of grievances handled through
- 32 the procedure during the preceding calendar year, a
- 33 compilation of the causes underlying those grievances, and a
- 34 summary of the final disposition of those grievances.

35 **(b) The information required by subsection (a)(2) and (a)(3)**
36 **must be filed with the commissioner not later than March 1 of each**
37 **year. The audited financial statements required by subsection**
38 **(a)(1) must be filed with the commissioner not later than June 1 of**
39 **each year. The commissioner shall:**

- 40 (1) make the information required to be filed under this
- 41 section available to the public; and
- 42 (2) prepare an annual compilation of the data required under

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1 subsection (a)(3) that allows for comparative analysis.
 2 **Sec. 4. Each managed care plan shall provide information on the**
 3 **managed care plan's:**
 4 (1) structure;
 5 (2) decision making process;
 6 (3) health care benefits and exclusions;
 7 (4) cost and cost sharing requirements;
 8 (5) list of participating providers; and
 9 (6) grievance and appeal procedures;
 10 **to all potential enrollees, to all enrollees covered by the managed**
 11 **care plan, and to the department.**
 12 **Sec. 5. The commissioner may require additional reports as are**
 13 **necessary and appropriate for the commissioner to carry out the**
 14 **commissioner's duties under this article.**
 15 **Chapter 11. Confidentiality**
 16 **Sec. 1. (a) Notwithstanding IC 27-13-30, any information:**
 17 (1) that pertains to the diagnosis, treatment, or health of any
 18 enrollee of a managed care entity; and
 19 (2) that is obtained from:
 20 (A) the enrollee; or
 21 (B) a provider;
 22 by a managed care entity;
 23 is confidential and may not be disclosed to any person, except
 24 under the circumstances set forth in subsection (b).
 25 (b) Information described in subsection (a) may be disclosed:
 26 (1) to the extent necessary to carry out this article;
 27 (2) upon the express written consent of the enrollee;
 28 (3) under a statute or court order for the production of
 29 evidence or the discovery of evidence; or
 30 (4) in the event of a claim or litigation between:
 31 (A) the enrollee; and
 32 (B) the managed care entity;
 33 in which the data or information is pertinent.
 34 **Sec. 2. A managed care entity is entitled to claim any statutory**
 35 **privilege against the disclosure of information described in section**
 36 **1(a) of this chapter that the provider who furnished the**
 37 **information to the managed care entity is entitled to claim.**
 38 **Sec. 3. (a) As used in this section, "in good faith and without**
 39 **malice", when used to describe an action taken or a decision or**
 40 **recommendation made, means that:**
 41 (1) a reasonable effort has been taken to obtain the facts of the
 42 matter;

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

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

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

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

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

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

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

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

18 (e) Neither:

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

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

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

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

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

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



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- 1 (1) in proceedings before the appropriate state licensing or
- 2 certifying agency; and
- 3 (2) in an appeal, if permitted, from the finding or
- 4 recommendation of the health care review committee.

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

- 9 (1) shall be kept confidential; and
- 10 (2) are subject to the same provisions concerning discovery
- 11 and use in legal actions as are the original information and
- 12 records in the possession and control of a health care review
- 13 committee.

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

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

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

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

- 27 (1) purchasers of managed care plan policies or contracts;
- 28 and
- 29 (2) individuals covered by each managed care plan policy or
- 30 contract.

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

33 **Sec. 3.** A managed care entity shall provide a completed
 34 managed care plan description form for each managed care plan
 35 operated by the managed care entity to the following:

- 36 (1) Upon request, to an individual covered by the managed
- 37 care plan or to the individual's employer.
- 38 (2) As part of the managed care entity's marketing materials,
- 39 to a person or employer that may be interested in purchasing
- 40 or obtaining coverage under a managed care plan offered by
- 41 the managed care entity.

42 **Chapter 13. Limited Service Health Maintenance Organizations**

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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.

Chapter 14. Oversight of Managed Care Entities

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

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

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

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

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

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

SECTION 2. [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 managed care plan description form required under IC 27-14-12-1, 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**".

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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:

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"(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:



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"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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