

SENATE BILL No. 364

DIGEST OF SB 364 (Updated January 30, 1998 12:07 pm - DI 88)

Citations Affected: IC 27-13; 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 enrollees with continuation of care and referrals to out of network specialists as necessary. (4) Provide coverage for emergency services under a prudent layperson standard.
(Continued next page)

Effective: July 1, 1998.

**Lawson, Simpson, Miller, Gard,
Wolf, Breaux, Landske, Dempsey,
Worman, Antich, Randolph**

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

January 26, 1998, amended, reported favorably — Do Pass.

January 30, 1998, read second time, amended, ordered engrossed.

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Digest Continued

(5) Offer adequate choice among health care providers that are accessible and qualified. (6) Offer a point-of-service option to each purchaser of a managed care plan. (7) Develop and implement a procedure to evaluate whether to provide coverage for experimental treatments. (8) Develop and distribute to providers drug formularies, and establish a procedure to allow enrollees to obtain nonformulary drugs if medically necessary. (9) Develop and implement a procedure to evaluate whether to provide coverage for new medical technologies and new applications of existing medical technologies. (10) Provide comprehensive descriptions of each managed care plan operated by the managed care entity. Adds additional reporting requirements for health maintenance organizations. Requires limited service health maintenance organizations to comply with provisions concerning reporting, hold harmless clauses in contracts, referrals to out of network providers, continuation of care, and plan descriptions. Requires managed care entities to comply with current laws that apply to health maintenance organizations concerning quality management programs, annual reports, grievance procedures, hold harmless provisions in contracts, and confidentiality of medical information and limitations of liability. Requires the department of insurance to oversee all managed care entities.

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Reprinted
February 2, 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 27-13-8-1.5 IS ADDED TO THE INDIANA CODE
2 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 1998]: **Sec. 1.5. (a) The report required by section 1 of this
4 chapter must include specific data for each health maintenance
5 organization, including the following:**
6 (1) **Gross outpatient and hospital utilization data.**
7 (2) **Enrollee clinical outcome data.**
8 (3) **The number, amount, and disposition of malpractice
9 claims resolved during the year by:**
10 (A) **the health maintenance organization; and**
11 (B) **any participating provider of the health maintenance
12 organization.**
13 (b) **The information required under subsection (a) shall be made
14 available to the public on a timely basis.**
15 SECTION 2. IC 27-13-8-3 IS ADDED TO THE INDIANA CODE

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1 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
2 1, 1998]: **Sec. 3. Each health maintenance organization shall
3 provide information on the health maintenance organization'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 appeals procedures;**

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

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

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

- 21 (1) **IC 27-13-8, except for IC 27-13-8-1.5(a)(1) and
22 IC 27-13-8-1.5(a)(2) concerning reports.**
23 ~~(2)~~ (2) **IC 27-13-10-1 through IC 27-13-10-3 concerning
24 grievance procedures.**
25 ~~(3)~~ (3) **IC 27-13-11 concerning investments.**
26 (4) **IC 27-13-15 concerning hold harmless clauses in contracts.**
27 ~~(5)~~ (5) **IC 27-13-21 concerning producers.**
28 ~~(6)~~ (6) **IC 27-13-29 concerning statutory construction and
29 relationship to other laws.**
30 ~~(7)~~ (7) **IC 27-13-30 concerning public records.**
31 ~~(8)~~ (8) **IC 27-13-31 concerning confidentiality of medical
32 information and limitation of liability.**
33 (9) **IC 27-14-3-5 and IC 27-14-3-6 concerning referrals to
34 out-of-network providers and continuation of care.**
35 (10) **IC 27-14-7 concerning descriptions of services provided
36 by a limited service health maintenance organization.**

37 SECTION 5. IC 27-14 IS ADDED TO THE INDIANA CODE AS
38 A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1,
39 1998]:

40 **ARTICLE 14. MANAGED CARE CONSUMER
41 PROTECTION**

42 **Chapter 1. Applicability**

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

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

6 **Chapter 2. Definitions**

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

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

10 (1) whose coverage for a particular service or treatment has
 11 been reduced, denied, or terminated; or

12 (2) who believes that the level of care authorized by the
 13 enrollee's managed care plan is inappropriate;

14 **can contest an adverse grievance decision by the managed care**
 15 **plan.**

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

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

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

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

25 **Sec. 7. "Department" refers to the Indiana department of**
 26 **insurance.**

27 **Sec. 8. "Emergency" means a medical condition that arises**
 28 **suddenly and unexpectedly and manifests itself by acute symptoms**
 29 **of severity, including severe pain, that the absence of immediate**
 30 **medical attention could reasonably be expected by a prudent lay**
 31 **person who possesses an average knowledge of health and medicine**
 32 **to result in:**

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

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

35 (3) serious dysfunction of a bodily organ or part of the
 36 individual.

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

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

42 **Sec. 11. "Experimental treatment" means new medical**

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1 technology or a new application of existing medical technology,
 2 including medical procedures, drugs, and devices for treatment of
 3 an illness or injury.

4 **Sec. 12. "Grievance"** means a complaint submitted in
 5 accordance with the formal grievance procedure of a managed
 6 care plan by or on behalf of the enrollee or subscriber regarding
 7 any aspect of the managed care plan relative to the enrollee or
 8 subscriber.

9 **Sec. 13. "Health care services"** has the meaning set forth in
 10 IC 27-13-1-18.

11 **Sec. 14. "Health maintenance organization"** has the meaning set
 12 forth in IC 27-13-1-19.

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

14 (1) Covered health care services that are obtained from a
 15 provider who:

16 (A) is employed by;

17 (B) is under contract with;

18 (C) provides health care services to an enrollee referred
 19 by; or

20 (D) is otherwise affiliated with;

21 the managed care plan.

22 (2) Emergency services.

23 **Sec. 16. "Managed care entity"** means:

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

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

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

31 **Sec. 17. "Managed care plan"** means a plan operated by a
 32 managed care entity that does the following:

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

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

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

38 **Sec. 18. (a) "Out-of-plan covered services"** means
 39 nonemergency, self-referred covered health care services that:

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

41 (A) not otherwise employed by;

42 (B) not under contract with; and



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1 (C) not otherwise affiliated with;
 2 the managed care plan; or
 3 (2) are obtained from a participating provider without a
 4 referral.
 5 (b) The term does not include uncovered services.
 6 Sec. 19. "Participating provider" means a provider that, under
 7 an express or implied contract with:
 8 (1) a managed care plan; or
 9 (2) a contractor of the managed care plan or a subcontractor
 10 of a contractor of the managed care plan;
 11 agrees to provide health care services to enrollees with an
 12 expectation of directly or indirectly receiving payment, other than
 13 payment or deductible, from the managed care plan.
 14 Sec. 20. "Person" has the meaning set forth in IC 27-13-1-25.
 15 Sec. 21. "Point of service product" has the meaning set forth in
 16 IC 27-13-1-26.
 17 Sec. 22. "Primary care provider" means a provider under
 18 contract with a managed care plan who is designated by the
 19 managed care plan to coordinate, supervise, or provide ongoing
 20 care to an enrollee.
 21 Sec. 23. "Provider" has the meaning set forth in IC 27-13-1-28.
 22 Sec. 24. "Quality assurance" means the ongoing evaluation of
 23 the quality of health care services provided to enrollees.
 24 Sec. 25. "Subscriber" means:
 25 (1) an individual whose employment status or other status,
 26 except family dependency, is the basis for eligibility for
 27 enrollment in a managed care plan; or
 28 (2) in the case of an individual contract, the person in whose
 29 name the contract is issued.
 30 Chapter 3. Clinical Decision Making; Access to Personnel and
 31 Facilities
 32 Sec. 1. (a) Each managed care plan shall appoint a medical
 33 director who has an unlimited license to practice medicine under
 34 IC 25-22.5 or an equivalent license issued by another state.
 35 (b) The medical director is responsible for oversight of
 36 treatment policies, protocols, quality assurance activities, and
 37 utilization management decisions of the managed care plan.
 38 (c) A managed care entity shall employ at least one (1)
 39 individual who holds an unlimited license to practice medicine
 40 under IC 25-22.5 to:
 41 (1) develop treatment policies, protocols, and quality
 42 assurance activities; and

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1 (2) make utilization management decisions;
2 of a managed care plan operated by the managed care entity.

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

6 (1) meet the needs of; and

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

9 enrollees of the managed care plan.

10 **Sec. 3. (a) A managed care entity shall demonstrate to the**
11 **department that each managed care plan operated by the managed**
12 **care entity offers an adequate number of:**

13 (1) acute care hospital services;

14 (2) primary care providers; and

15 (3) other appropriate providers;

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

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

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

22 (2) mental and behavioral care services; or

23 (3) pharmacy services;

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

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

29 (1) Family practice.

30 (2) General practice.

31 (3) Internal medicine.

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

34 (5) Pediatrics.

35 **Sec. 5. (a) When an enrollee's primary care provider determines**
36 **that the type of health care service needed by an enrollee to treat**
37 **a specific condition is not available from a managed care plan's**
38 **network of participating providers, the primary care provider**
39 **shall refer the enrollee to an appropriate provider that is not a**
40 **participating provider for treatment.**

41 (b) When an enrollee receives health care services from a
42 provider to which the enrollee was referred as described in

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1 subsection (a), the managed care entity shall indemnify the enrollee
2 for the lesser of the following:

3 (1) The usual, customary, and reasonable charge in the
4 managed care plan's service area for the health care services
5 provided by the medical specialist for the treatment.

6 (2) The payment that the provider agrees to accept for the
7 health care services provided by the provider for the
8 treatment.

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

13 (c) A contract between a managed care entity and a primary
14 care provider may not provide for a financial or other penalty to
15 the primary care provider for making a referral permitted under
16 subsection (a), but may provide for reasonable sharing between the
17 primary care provider and the managed care entity for the
18 additional costs incurred as a result of services provided by an out
19 of network provider.

20 Sec. 6. (a) A managed care plan shall include provisions in the
21 managed care plan's contracts with providers to provide for
22 continuation of care in the event that a provider's contract with the
23 managed care plan is terminated, provided that the termination is
24 not due to a quality of care issue.

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

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

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

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

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

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



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

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

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

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

6 (B) a participating provider;

7 for emergency care or authorization for care.

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

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

16 (1) Prenatal care appointments.

17 (2) Well-child visits and immunizations.

18 (3) Routine physicals.

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

20 (5) Urgent care.

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

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

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

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

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

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

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



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1 (c) As described in subsection (d), each managed care plan shall
 2 cover and reimburse expenses for care obtained in an emergency
 3 by an enrollee without:

4 (1) prior authorization; or

5 (2) regard to the contractual relationship between the:

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

8 (B) managed care plan;

9 in a situation where a prudent lay person could reasonably believe
 10 that the enrollee's condition required immediate medical attention
 11 at the nearest facility. The emergency care obtained by an enrollee
 12 under this section includes care for the alleviation of severe pain,
 13 which is a symptom of an emergency as provided in IC 27-14-1-8.

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

20 Sec. 10. Each managed care plan shall demonstrate to the
 21 commissioner that the managed care plan has developed an access
 22 plan to meet the needs of vulnerable and underserved populations,
 23 including enrollees from major population groups who speak a
 24 primary language other than English, as defined by rules adopted
 25 by the commissioner.

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

29 Sec. 12. Each managed care plan shall require that a
 30 participating provider hold enrollees harmless for covered health
 31 services, except for applicable deductibles and copayments, as
 32 provided in IC 27-13-15-1(4).

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

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

36 Sec. 1. Each enrollee of a managed care plan shall be given
 37 adequate choice among accessible and qualified participating
 38 providers.

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



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

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

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

12 Sec. 3. (a) Each managed care plan shall develop a system to
13 permit an enrollee to use an appropriate provider to treat the
14 enrollee's medical condition when the enrollee's primary care
15 provider determines that the use of a medical specialist is
16 warranted by the enrollee's medical condition.

17 (b) A primary care provider who makes the required
18 determination under subsection (a) shall refer the enrollee to a
19 provider that the primary care provider determines is appropriate.

20 (c) A managed care plan shall provide coverage under this
21 section for treatment received by an enrollee from an appropriate
22 provider when the enrollee is referred to the provider as provided
23 in this section for as long as the treatment is appropriate for the
24 medical condition.

25 Sec. 4. Each managed care plan shall provide continuity of care
26 and appropriate referral to appropriate providers within the
27 managed care plan when specialty care is warranted, including the
28 following:

29 (1) Enrollees shall have access to appropriate providers on a
30 timely basis.

31 (2) Enrollees are provided with a choice of appropriate
32 providers when a referral is made.

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

35 (b) A managed care entity is liable to pay a provider that
36 provides health care services to an enrollee of the managed care
37 entity under a point-of-service product the same amount that the
38 managed care entity would pay to a participating provider that
39 provides the same health care services.

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

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(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. Drugs and Devices; Drug Utilization Review
Program**

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

- (1) Develop a formulary:
 - (A) in consultation with; and
 - (B) with the approval of;
 - a pharmacy and therapeutics committee, a majority of whose
members are licensed physicians.
- (2) If the managed care plan maintains one (1) or more drug
formularies, disseminate to participating providers and
pharmacists the complete drug formulary or formularies
maintained by the managed care plan, including a list of the
prescription drugs on the formulary by major therapeutic
category that specifies whether a particular drug is preferred
over other drugs.
- (3) Establish and maintain an expeditious process or
procedure that allows an enrollee to obtain, without penalty
or additional cost sharing beyond that provided for formulary
drugs in the enrollee's contract with the managed care plan,
coverage of a specific nonformulary prescription drug if the
prescribing provider determines that the nonformulary
alternative is medically necessary or appropriate to treat a
covered condition or disease.

(b) 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 or appropriate for an enrollee's
condition, as provided in subsection (a).

Sec. 2. Each managed care service plan shall establish and
operate, or cause to be established and operated, a drug utilization
review program that includes the following:

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- 1 **(1) Retrospective review of prescription drugs furnished to**
- 2 **enrollees.**
- 3 **(2) Education of physicians, enrollees, and pharmacists**
- 4 **regarding the appropriate use of prescription drugs.**
- 5 **(3) Ongoing periodic examination of data on outpatient**
- 6 **prescription drugs to ensure quality therapeutic outcomes for**
- 7 **enrollees.**
- 8 **(4) Clinically relevant criteria and standards for drug**
- 9 **therapy.**
- 10 **(5) Nonproprietary criteria and standards, developed and**
- 11 **revised through an open, professional consensus process.**
- 12 **(6) Interventions that focus on improving therapeutic**
- 13 **outcomes, including prospective drug utilization review**
- 14 **programs that monitor for possible prescription drug**
- 15 **problems or complications, including drug to disease**
- 16 **interactions, drug to drug interactions, or therapeutic**
- 17 **duplication.**

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

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

23 **Sec. 5. The commissioner, with input and assistance from the**
 24 **state health commissioner, shall adopt rules under IC 4-22-2 to**
 25 **implement this chapter.**

26 **Chapter 6. Experimental Treatments**

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

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

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

40 **(d) A managed care plan shall include appropriate professionals**
 41 **in the decision making process to determine whether new medical**
 42 **technologies and new uses of existing medical technologies qualify**

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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 7. Managed Care Plan Descriptions

Sec. 1. Beginning January 1, 2000, each managed care entity offering a managed care plan shall make available a managed care plan description form for each policy or contract that either covers or is marketed to an Indiana resident or the resident's employer.

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

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

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

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

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

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

(2) As part of the managed care entity's marketing materials, to a person or employer that may be interested in purchasing

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1 or obtaining coverage under a managed care plan offered by
2 the managed care entity.
3 **Chapter 8. Miscellaneous Provisions**
4 **Sec. 1. A managed care entity operated under this article is**
5 **subject to the following:**
6 (1) IC 27-13-6 concerning quality management programs.
7 (2) IC 27-13-8 concerning annual reports.
8 (3) IC 27-13-10 concerning grievance procedures.
9 (4) IC 27-13-15 concerning hold harmless provisions in
10 contracts.
11 (5) IC 27-13-31 concerning confidentiality of medical
12 information and limitations of liability.
13 **Chapter 9. Oversight of Managed Care Entities**
14 **Sec. 1. The department shall oversee managed care entities**
15 **operating within Indiana.**
16 **Sec. 2. Each managed care entity operating in Indiana must be**
17 **legally authorized by the department to operate in Indiana under**
18 **rules adopted by the department.**
19 **Sec. 3. The department shall perform audits on an annual basis**
20 **to review enrollee clinical outcome data, enrollee service data, and**
21 **operational and other financial data.**
22 **Sec. 4. This article does not preclude the department from**
23 **investigating complaints, grievances, or appeals on behalf of**
24 **enrollees or health care providers.**
25 **Sec. 5. The commissioner shall adopt rules under IC 4-22-2 to**
26 **develop:**
27 (1) standards for the compliance of a managed care entity's
28 managed care plans regarding mandated requirements; and
29 (2) penalties for violations of the standards developed under
30 subdivision (1).
31 **SECTION 6. [EFFECTIVE JULY 1, 1998] (a) Not later than**
32 **January 1, 1999, the commissioner of the department of insurance**
33 **shall adopt rules under IC 4-22-2 regarding the format for and**
34 **elements of the managed care plan description form required**
35 **under IC 27-14-7-1, as added by this act.**
36 (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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SENATE MOTION

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

LAWSON

SENATE MOTION

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

LAWSON

SENATE MOTION

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

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

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

- (1) Gross outpatient and hospital utilization data.**
- (2) Enrollee clinical outcome data.**
- (3) The number, amount, and disposition of malpractice claims resolved during the year by:**
 - (A) the health maintenance organization; and**
 - (B) any participating provider of the health maintenance organization.**

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

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

- (1) structure;**
- (2) decision making process;**



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

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

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

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

- (1) IC 27-13-8, except for IC 27-13-8-1.5(a)(1) and IC 27-13-8-1.5(a)(2) concerning reports.**
- ~~(2)~~ (2) IC 27-13-10-1 through IC 27-13-10-3 concerning grievance procedures.
- ~~(3)~~ (3) IC 27-13-11 concerning investments.
- (4) IC 27-13-15 concerning hold harmless clauses in contracts.**
- ~~(5)~~ (5) IC 27-13-21 concerning producers.
- ~~(6)~~ (6) IC 27-13-29 concerning statutory construction and relationship to other laws.
- ~~(7)~~ (7) IC 27-13-30 concerning public records.
- ~~(8)~~ (8) IC 27-13-31 concerning confidentiality of medical information and limitation of liability.
- (9) IC 27-14-3-5 and IC 27-14-3-6 concerning referrals to out-of-network providers and continuation of care.**
- (10) IC 27-14-7 concerning descriptions of services provided by a limited service health maintenance organization."**

Page 3, delete lines 14 through 15.

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

Page 3, line 24, delete "18" and insert "**17**".

Page 3, line 31, delete "19" and insert "**18**".

Page 3, line 41, delete "20" and insert "**19**".

Page 4, line 7, delete "21" and insert "**20**".

Page 4, line 8, delete "22" and insert "**21**".

Page 4, line 10, delete "23" and insert "**22**".

Page 4, line 14, delete "24" and insert "**23**".

Page 4, line 15, delete "25" and insert "**24**".

Page 4, line 17, delete "26" and insert "**25**".



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

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

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

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

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

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

(2) **primary care providers; and**

(3) **other appropriate providers;**

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

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

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

(2) **mental and behavioral care services; or**

(3) **pharmacy services;**

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

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

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

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

Page 5, delete lines 30 through 31.

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

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

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

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

"(1) **The**".

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

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

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treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Page 9, delete lines 22 through 42.

Page 10, delete lines 1 through 23.

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

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

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Page 12, delete lines 36 through 42.

Delete pages 13 through 21.

Page 22, delete lines 1 through 19.

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

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

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

"Chapter 8. Miscellaneous Provisions

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

- (1) **IC 27-13-6 concerning quality management programs.**
- (2) **IC 27-13-8 concerning annual reports.**
- (3) **IC 27-13-10 concerning grievance procedures.**
- (4) **IC 27-13-15 concerning hold harmless provisions in contracts.**
- (5) **IC 27-13-31 concerning confidentiality of medical information and limitations of liability."**

Page 23, delete lines 1 through 18.

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

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

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

Renumber all SECTIONS consecutively.

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

LAWSON

SENATE MOTION

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

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

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

- (1) **Develop a formulary:**
 - (A) **in consultation with; and**
 - (B) **with the approval of;****a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.**
- (2) **If the managed care plan maintains one (1) or more drug**



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

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

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

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

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

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

Page 11, delete lines 29 through 36.

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

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

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

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