



April 6, 1999

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## ENGROSSED HOUSE BILL No. 1309

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DIGEST OF HB 1309 (Updated March 31, 1999 4:00 pm - DI 97)

**Citations Affected:** IC 27-13; IC 34-30; noncode.

**Synopsis:** Health maintenance organization grievances. Requires a health maintenance organization to establish a grievance procedure for appeal to an independent review organization resolution of grievances related to: (1) an adverse utilization review determination; (2) an  
(Continued next page)

**Effective:** July 1, 1999; July 1, 2000.

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**Pelath, Crosby, Cheney, Welch,  
Becker, Goeglein, Budak, Hasler,  
Grubb, Burton, Ulmer, Bailey,  
Adams T, Porter, Bardon**  
(SENATE SPONSORS — GARD, SIMPSON, MILLER)

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January 12, 1999, read first time and referred to Committee on Insurance, Corporations and Small Business.

February 22, 1999, amended, reported — Do Pass.

March 1, 1999, read second time, amended, ordered engrossed.

March 2, 1999, engrossed. Read third time, passed. Yeas 86, nays 12.

SENATE ACTION

March 8, 1999, read first time and referred to Committee on Health and Provider Services.

April 5, 1999, amended, reported favorably — Do Pass.

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adverse medical necessity determination; or (3) a determination that a proposed service is experimental or investigational; made by a health maintenance organization, or an agent of a health maintenance organization, regarding a service proposed by the treating physician. Provides that an external review may be requested within 45 days of the health maintenance organization's resolution. Provides that the costs of the independent review are paid by the health maintenance organization except a maximum \$25 filing fee which may be paid by the enrollee. Requires annual reporting to the department of insurance and notice of the external review process to the enrollee. Provides that the department of insurance may certify a sufficient number of independent review organizations based on certain criteria. Provides that the determination is binding on the health maintenance organization. Provides civil immunity for an independent review organization for good faith actions taken in connection with an external review. Provides civil immunity for a health maintenance organization for good faith actions taken in connection with an independent review organization's reversal of the health maintenance organization's resolution.

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April 6, 1999

First Regular Session 111th General Assembly (1999)

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 1998 General Assembly.

## ENGROSSED HOUSE BILL No. 1309

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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 27-13-8-2 (CURRENT VERSION) IS AMENDED  
2 TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. (a) In  
3 addition to the report required by section 1 of this chapter, a health  
4 maintenance organization shall each year file with the commissioner  
5 the following:  
6 (1) Audited financial statements of the health maintenance  
7 organization for the preceding calendar year.  
8 (2) A list of participating providers who provide health care  
9 services to enrollees or subscribers of the health maintenance  
10 organization.  
11 (3) A description of the grievance procedure of the health  
12 maintenance organization:  
13 (A) **established under IC 27-13-10, including:**  
14 (i) the total number of grievances handled through the  
15 procedure during the preceding calendar year;  
16 (ii) a compilation of the causes underlying those grievances;  
17 and

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1 (iii) a summary of the final disposition of those grievances;  
 2 and  
 3 **(B) established under IC 27-13-10.1, including:**  
 4 (i) the total number of external grievances handled  
 5 through the procedure during the preceding calendar  
 6 year;  
 7 (ii) a compilation of the causes underlying those  
 8 grievances; and  
 9 (iii) a summary of the final disposition of those  
 10 grievances;  
 11 for each independent review organization used by the  
 12 health maintenance organization during the reporting  
 13 year.

14 (b) The information required by subsection (a)(2) and (a)(3) must  
 15 be filed with the commissioner on or before March 1 of each year. The  
 16 audited financial statements required by subsection (a)(1) must be filed  
 17 with the commissioner on or before June 1 of each year. The  
 18 commissioner shall:

19 (1) make the information required to be filed under this section  
 20 available to the public; and  
 21 (2) prepare an annual compilation of the data required under  
 22 subsection (a)(3) that allows for comparative analysis.

23 (c) The commissioner may require any additional reports as are  
 24 necessary and appropriate for the commissioner to carry out the  
 25 commissioner's duties under this article.

26 SECTION 2. IC 27-13-8-2 (DELAYED VERSION) IS AMENDED  
 27 TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. (a) In  
 28 addition to the report required by section 1 of this chapter, a health  
 29 maintenance organization shall each year file with the commissioner  
 30 the following:

31 (1) Audited financial statements of the health maintenance  
 32 organization for the preceding calendar year.  
 33 (2) A list of participating providers who provide health care  
 34 services to enrollees or subscribers of the health maintenance  
 35 organization.  
 36 (3) A description of the grievance procedure of the health  
 37 maintenance organization:

38 **(A) established under IC 27-13-10, including:**  
 39 (i) the total number of grievances handled through the  
 40 procedure during the preceding calendar year;  
 41 (ii) a compilation of the causes underlying those grievances;  
 42 and

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- 1 (iii) a summary of the final disposition of those grievances;  
 2 **and**  
 3 **(B) established under IC 27-13-10.1, including:**  
 4 (i) the total number of external grievances handled  
 5 through the procedure during the preceding calendar  
 6 year;  
 7 (ii) a compilation of the causes underlying those  
 8 grievances; and  
 9 (iii) a summary of the final disposition of those  
 10 grievances;  
 11 **for each independent review organization used by the**  
 12 **health maintenance organization during the reporting**  
 13 **year.**  
 14 (4) The percentage of providers credentialed by the health  
 15 maintenance organization according to the most current standards  
 16 or guidelines, if any, developed by the National Committee on  
 17 Quality Assurance or a successor organization.  
 18 (5) The health maintenance organization's Health Plan Employer  
 19 Data and Information Set (HEDIS) data.  
 20 (b) The information required by subsection (a)(2) through (a)(4)  
 21 must be filed with the commissioner on or before March 1 of each year.  
 22 The audited financial statements required by subsection (a)(1) must be  
 23 filed with the commissioner on or before June 1 of each year. The  
 24 health maintenance organization's HEDIS data required by subsection  
 25 (a)(5) must be filed with the commissioner on or before July 1 of each  
 26 year. The commissioner shall:  
 27 (1) make the information required to be filed under this section  
 28 available to the public; and  
 29 (2) prepare an annual compilation of the data required under  
 30 subsection (a)(3) through (a)(5) that allows for comparative  
 31 analysis.  
 32 (c) The commissioner may require any additional reports as are  
 33 necessary and appropriate for the commissioner to carry out the  
 34 commissioner's duties under this article.  
 35 SECTION 3. IC 27-13-9-4 IS AMENDED TO READ AS  
 36 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4. A health  
 37 maintenance organization shall provide to each enrollee and subscriber:  
 38 (1) information on:  
 39 (A) how services can be obtained;  
 40 (B) where additional information on access to services can be  
 41 obtained;  
 42 (C) how to file a grievance under IC 27-13-10 **and**



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- 1           **IC 27-13-10.1;**  
 2           (D) the health maintenance organization's:  
 3           (I) structure;  
 4           (ii) health care benefits and exclusions; and  
 5           (iii) criteria for denying coverage; and  
 6           (E) costs for which the enrollee or subscriber is responsible;  
 7           and  
 8           (2) a toll free telephone number through which the enrollee can  
 9           contact the health maintenance organization at no cost to the  
 10          enrollee to obtain information and to file grievances.  
 11          The information under this section must be provided to a potential  
 12          enrollee of the health maintenance organization upon request.  
 13          SECTION 4. IC 27-13-10-4 IS AMENDED TO READ AS  
 14          FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4. (a) A health  
 15          maintenance organization shall provide timely, adequate, and  
 16          appropriate notice to each enrollee or subscriber of the grievance  
 17          procedure under this chapter **and IC 27-13-10.1.**  
 18          (b) A health maintenance organization shall prominently display on  
 19          all notices to enrollees and subscribers the telephone number and  
 20          address at which a grievance may be filed.  
 21          (c) A written description of the enrollee's or subscriber's right to file  
 22          a grievance must be posted by the provider in a conspicuous public  
 23          location in each facility that offers services on behalf of a health  
 24          maintenance organization.  
 25          SECTION 5. IC 27-13-10-8 IS AMENDED TO READ AS  
 26          FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 8. (a) A health  
 27          maintenance organization shall establish written policies and  
 28          procedures for the timely resolution of appeals of grievance decisions.  
 29          The procedures for registering and responding to oral and written  
 30          appeals of grievance decisions must include the following:  
 31                  (1) Acknowledgment of the appeal, orally or in writing, within  
 32                  three (3) business days after receipt of the appeal being filed.  
 33                  (2) Documentation of the substance of the appeal and the actions  
 34                  taken.  
 35                  (3) Investigation of the substance of the appeal, including any  
 36                  aspects of clinical care involved.  
 37                  (4) Notification to enrollees or subscribers of the disposition of  
 38                  the appeal and that the enrollee or subscriber may have the right  
 39                  to further remedies allowed by law.  
 40                  (5) Standards for timeliness in responding to appeals and  
 41                  providing notice to enrollees or subscribers of the disposition of  
 42                  the appeal and the right to initiate an external appeals process that

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- 1 accommodate the clinical urgency of the situation.
- 2 (b) The health maintenance organization shall appoint a panel of  
 3 qualified individuals to resolve an appeal. An individual may not be  
 4 appointed to the panel who has been involved in the matter giving rise  
 5 to the complaint or in the initial investigation of the complaint. Except  
 6 for grievances that have previously been appealed under IC 27-8-17, in  
 7 the case of an appeal from the proposal, refusal, or delivery of a health  
 8 care procedure, treatment, or service, the health maintenance  
 9 organization shall appoint one (1) or more individuals to the panel to  
 10 resolve the appeal. The panel must include one (1) or more individuals  
 11 who:
- 12 (1) have knowledge in the medical condition, procedure, or  
 13 treatment at issue;
  - 14 (2) are in the same licensed profession as the provider who  
 15 proposed, refused, or delivered the health care procedure,  
 16 treatment, or service;
  - 17 (3) are not involved in the matter giving rise to the appeal or the  
 18 previous grievance process; and
  - 19 (4) do not have a direct business relationship with the enrollee or  
 20 the health care provider who previously recommended the health  
 21 care procedure, treatment, or service giving rise to the grievance.
- 22 (c) An appeal of a grievance decision must be resolved as  
 23 expeditiously as possible and with regard to the clinical urgency of the  
 24 appeal. However, an appeal must be resolved not later than forty-five  
 25 (45) days after the appeal is filed.
- 26 (d) A health maintenance organization shall allow enrollees and  
 27 subscribers the opportunity to appear in person at the panel or to  
 28 communicate with the panel through appropriate other means if the  
 29 enrollee or subscriber is unable to appear in person.
- 30 (e) A health maintenance organization shall notify the enrollee or  
 31 subscriber in writing of the resolution of the appeal of a grievance  
 32 within five (5) business days after completing the investigation. The  
 33 grievance resolution notice must contain the following:
- 34 (1) The decision reached by the health maintenance organization.
  - 35 (2) The reasons, policies, or procedures that are the basis of the  
 36 decision.
  - 37 (3) Notice of the enrollee's or subscriber's right to further  
 38 remedies allowed by law, **including the right to review by an**  
 39 **independent review organization under IC 27-13-10.1.**
  - 40 (4) The department, address, and telephone number through  
 41 which an enrollee may contact a qualified representative to obtain  
 42 more information about the decision or the right to an appeal.

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1 SECTION 6. IC 27-13-10.1 IS ADDED TO THE INDIANA CODE  
 2 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
 3 JULY 1, 1999]:

4 **Chapter 10.1. External Review of Grievances**

5 **Sec. 1. A health maintenance organization shall establish and**  
 6 **maintain an external grievance procedure for the resolution of**  
 7 **grievances regarding:**

- 8 (1) an adverse utilization review determination (as defined in  
 9 IC 27-8-17-8);  
 10 (2) an adverse determination of medical necessity; or  
 11 (3) a determination that a proposed service is experimental or  
 12 investigational;

13 **made by a health maintenance organization or an agent of a health**  
 14 **maintenance organization regarding a service proposed by the**  
 15 **treating physician.**

16 **Sec. 2. (a) An external grievance procedure established under**  
 17 **section 1 of this chapter must:**

- 18 (1) allow an enrollee or the enrollee's representative to file a  
 19 written request with the health maintenance organization for  
 20 an appeal of the health maintenance organization's grievance  
 21 resolution under IC 27-13-10-8 not later than forty-five (45)  
 22 days after the enrollee is notified of the resolution under  
 23 IC 27-13-10-8; and  
 24 (2) provide for:  
 25 (A) an expedited appeal for a grievance related to an  
 26 illness, a disease, a condition, an injury, or a disability that  
 27 would seriously jeopardize the enrollee's:  
 28 (i) life or health; or  
 29 (ii) ability to reach and maintain maximum function; or  
 30 (B) a standard appeal for a grievance not described in  
 31 clause (A).

32 **An enrollee may file not more than one (1) appeal of a health**  
 33 **maintenance organization's grievance resolution.**

34 **(b) When a request is filed under subsection (a), the health**  
 35 **maintenance organization shall select:**

- 36 (1) an independent review organization from the list of  
 37 independent review organizations that are certified by the  
 38 department under section 8 of this chapter; and  
 39 (2) a different independent review organization for each  
 40 appeal filed under this chapter on a rotational basis;

41 **in compliance with the requirements of subsection (d).**

42 **(c) The independent review organization shall assign a medical**

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1 review professional who is board certified in the applicable  
2 specialty for resolution of an appeal.

3 (d) The independent review organization and the medical review  
4 professional conducting the external review under this chapter  
5 may not have a material professional, familial, or financial conflict  
6 of interest with any of the following:

- 7 (1) The health maintenance organization.  
8 (2) Any officer, director, or management employee of the  
9 health maintenance organization.  
10 (3) The physician or the physician's medical group that is  
11 proposing the service.  
12 (4) The facility at which the service would be provided.  
13 (5) The development or manufacture of the principal drug,  
14 device, procedure, or other therapy that is proposed by the  
15 treating physician.

16 However, the medical review professional may have a contractual  
17 relationship under which the medical review professional provides  
18 health care services to enrollees of the health maintenance  
19 organization and may have an affiliation that is limited to staff  
20 privileges at the health facility if the relationship or affiliation is  
21 disclosed to the enrollee and the health maintenance organization.

22 (e) The enrollee may be required to pay not more than  
23 twenty-five dollars (\$25) of the costs associated with the services of  
24 an independent review organization under this chapter. All  
25 additional costs must be paid by the health maintenance  
26 organization.

27 Sec. 3. (a) An enrollee who files an appeal under this chapter  
28 shall:

- 29 (1) not be subject to retaliation for exercising the enrollee's  
30 right to an appeal under this chapter;  
31 (2) be permitted to utilize the assistance of other individuals,  
32 including physicians, attorneys, friends, and family members  
33 throughout the review process;  
34 (3) be permitted to submit additional information relating to  
35 the proposed service throughout the review process; and  
36 (4) cooperate with the independent review organization by:  
37 (A) providing any requested medical information; or  
38 (B) authorizing the release of necessary medical  
39 information.

40 (b) A health maintenance organization shall cooperate with an  
41 independent review organization selected under section 2 of this  
42 chapter by promptly providing any information requested by the

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1 independent review organization.

2 **Sec. 4. (a) An independent review organization shall:**

3 (1) for an expedited appeal filed under section 2(a)(2)(A) of  
4 this chapter, within seventy-two (72) hours after the appeal is  
5 filed; or

6 (2) for a standard appeal filed under section 2(a)(2)(B) of this  
7 chapter, within fifteen (15) business days after the appeal is  
8 filed;

9 make a determination to uphold or reverse the health maintenance  
10 organization's grievance resolution under IC 27-13-10-8 based on  
11 information gathered from the enrollee or the enrollee's designee,  
12 the health maintenance organization, and the treating physician,  
13 and any additional information that the independent review  
14 organization considers necessary and appropriate.

15 (b) When making the determination under this section, the  
16 independent review organization shall apply:

17 (1) standards of decision making that are based on objective  
18 clinical evidence; and

19 (2) the terms of the enrollee's benefit contract.

20 (c) The independent review organization shall notify the health  
21 maintenance organization, the enrollee, and the department of the  
22 determination made under this section:

23 (1) for an expedited appeal filed under section 2(a)(2)(A) of  
24 this chapter, within twenty-four (24) hours after making the  
25 determination; or

26 (2) for a standard appeal filed under section 2(a)(2)(B) of this  
27 chapter, within seventy-two (72) hours after making the  
28 determination.

29 **Sec. 5. A determination made under section 4 of this chapter is**  
30 **binding on the health maintenance organization. However, the**  
31 **enrollee may pursue any additional remedies in an appropriate**  
32 **court of law.**

33 **Sec. 6. (a) If at any time during an external review performed**  
34 **under this chapter, the enrollee obtains new information not**  
35 **considered by the health maintenance organization under**  
36 **IC 27-13-10:**

37 (1) the enrollee shall submit the information to the health  
38 maintenance organization for reconsideration of the health  
39 maintenance organization's resolution under IC 27-13-10-8;  
40 and

41 (2) the independent review organization shall cease the  
42 external review process until the reconsideration under



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1 subsection (b) is completed.

2 (b) A health maintenance organization to which information is  
3 submitted under subsection (a) shall reconsider the resolution  
4 under IC 27-13-10-8 based on the information and notify the  
5 enrollee of the health maintenance organization's decision:

6 (1) within seventy-two (72) hours after the information is  
7 submitted for a reconsideration related to an illness, a disease,  
8 a condition, an injury, or a disability that would seriously  
9 jeopardize the enrollee's:

10 (A) life or health; or

11 (B) ability to reach and maintain maximum function; or

12 (2) within fifteen (15) days after the information is submitted  
13 for a reconsideration not described in subdivision (1).

14 (c) If the decision reached under subsection (b) is adverse to the  
15 enrollee, the enrollee may request that the independent review  
16 organization resume the external review under this chapter.

17 Sec. 7. This chapter does not add to or otherwise change the  
18 terms of coverage included in a contract under which an enrollee  
19 receives health care benefits under IC 27-13.

20 Sec. 8. (a) The department shall establish and maintain a  
21 process for annual certification of independent review  
22 organizations.

23 (b) The department may have a sufficient number of  
24 independent review organizations certified at any one (1) time as  
25 determined by the department.

26 (c) An independent review organization shall meet the following  
27 minimum requirements for certification by the department:

28 (1) Medical review professionals assigned by the independent  
29 review organization to perform external grievance reviews  
30 under this chapter:

31 (A) must be board certified in the specialty in which an  
32 enrollee's proposed service would be provided;

33 (B) must be knowledgeable about a proposed service  
34 through actual clinical experience;

35 (C) must hold an unlimited license to practice in a state of  
36 the United States; and

37 (D) must have no history of disciplinary actions or  
38 sanctions including:

39 (i) loss of staff privileges; or

40 (ii) restriction on participation;

41 taken or pending by any hospital, government, or  
42 regulatory body.



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**(2) The independent review organization must have a quality assurance mechanism to ensure the:**

- (A) timeliness and quality of reviews;**
- (B) qualifications and independence of medical review professionals;**
- (C) confidentiality of medical records and other review materials; and**
- (D) satisfaction of enrollees with the procedures utilized by the independent review organization, including the use of enrollee satisfaction surveys.**

**(3) The independent review organization must file with the department the following information before March 1 of each year:**

- (A) The number and percentage of determinations made in favor of enrollees.**
- (B) The number and percentage of determinations made in favor of health maintenance organizations.**
- (C) The average time to process a determination.**
- (D) Any other information required by the department.**

**The information required under this subdivision must be specified for each health maintenance organization for which the independent review organization performed reviews during the reporting year.**

**(4) Any additional requirements established by the department.**

**(d) The department may not certify an independent review organization that is one (1) of the following:**

- (1) A professional or trade association of health care providers, or a subsidiary of a professional or trade association of health care providers.**
- (2) A health insurer or health plan association, or a subsidiary of a health insurer or health plan association.**

**(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.**

**(f) The department shall make available to health maintenance organizations a list of all certified independent review organizations.**

**(g) The department shall make the information provided to the department under subdivision (c)(3) available to the public in a format that does not identify individual enrollees.**

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1        **Sec. 9. Except as provided in section 8(g) of this chapter,**  
 2 **documents and other information created or received by the**  
 3 **independent review organization, the medical review professional,**  
 4 **or the department in connection with an external review under this**  
 5 **chapter:**

6            (1) **are not public records;**

7            (2) **may not be disclosed under IC 5-14-3; and**

8            (3) **must be treated in accordance with confidentiality**  
 9 **requirements of state and federal law.**

10        **Sec. 10. (a) An independent review organization is immune from**  
 11 **civil liability for actions taken in good faith in connection with an**  
 12 **external review under this chapter.**

13        (b) **A health maintenance organization is immune from civil**  
 14 **liability for actions taken in good faith in connection with a**  
 15 **determination under this chapter that reverses the health**  
 16 **maintenance organization's resolution under IC 27-13-10.**

17        **Sec. 11. If an enrollee has the right to an external review under**  
 18 **Medicare (42 U.S.C. 1395 et seq.) the enrollee may not request an**  
 19 **external review under this chapter.**

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

22        SECTION 7. IC 34-30-2-119.5 IS ADDED TO THE INDIANA  
 23 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 24 [EFFECTIVE JULY 1, 1999]: **Sec. 119.5. IC 27-13-10.1 (Concerning**  
 25 **health maintenance organizations and independent review**  
 26 **organizations.)**

27        SECTION 8. [EFFECTIVE JULY 1, 1999] (a) **IC 27-13-8-2, as**  
 28 **amended by this act, applies to external grievances filed by**  
 29 **enrollees after January 1, 2000.**

30        (b) **IC 27-13-10.1, as added by this act, applies to grievances**  
 31 **filed under IC 27-13-10-5 after January 1, 2000.**

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1309, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, delete lines 1 through 18.

Delete pages 2 through 4.

Page 5, delete lines 1 through 5.

Page 5, line 15, delete "that conflicts with the prescribing" and insert "**regarding a service proposed by the treating physician.**".

Page 5, delete line 16.

Page 5, line 24, delete "a life" and insert "**an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:**

**(i) life or health; or**

**(ii) ability to reach and maintain maximum function; or".**

Page 5, delete lines 25 through 27

Page 5, line 28, after "condition" insert ":".

Page 5, line 29, before "not" begin a new line triple block indented and insert "**(i)**".

Page 5, line 29, delete "." and insert "; and

**(ii) for which the cost of the proposed service exceeds five hundred dollars (\$500).**".

Page 5, between lines 29 and 30, begin a new paragraph and insert: "**(c) When filing an appeal of an adverse determination under this section, an enrollee shall submit a twenty-five dollar (\$25) filing fee.**".

Page 5, line 30, delete (c) and insert "**(d)**".

Page 5, line 31, before "a medical" insert "**an independent review organization that shall assign**".

Page 5, line 31, delete "a physician licensed under" and insert "**board certified in the applicable specialty**".

Page 5, line 32, delete "IC 25-22.5".

Page 5, between lines 32 and 33, begin a new paragraph and insert: "**(e) The independent review organization and the medical review professional may not have a material professional, familial, or financial conflict of interest with any of the following:**

**(1) The health maintenance organization.**

**(2) Any officer, director, or management employee of the health maintenance organization.**

**(3) The physician or the physician's medical group that is proposing the service.**

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- (4) The facility at which the service would be provided.
- (5) The development or manufacture of the principal drug, device, procedure, or other therapy that would be provided to the enrollee whose appeal is under review.

However, the medical review professional may have a contractual relationship under which the medical review professional provides health services to enrollees of the health maintenance organization and may have an affiliation that is limited to staff privileges at the health facility.

(f) The independent review organization must have a quality assurance mechanism to ensure the:

- (1) timeliness and quality of reviews performed under this section;
- (2) qualifications and independence of medical review professionals; and
- (3) confidentiality of medical records and other review materials."

Page 5, line 33, delete "(d)" and insert "(g)".

Page 5, line 35, delete "twenty four (24)" and insert "seventy-two (72)".

Page 5, line 41, delete "complaining party," and insert "enrollee or the enrollee's designee,".

Page 5, line 42, delete "prescribing" and insert "treating".

Page 6, between lines 4 and 5, begin a new paragraph and insert:

**"(h) When making the determination of appropriateness under subsection (g), the medical review professional shall apply:**

- (1) standards of decision making that are based on objective clinical evidence; and
- (2) the terms of the enrollee's benefit contract."

Page 6, line 5, delete "(e)" and insert "(i)".

Page 6, line 5, delete "consider" and insert "receive".

Page 6, line 6, delete "may:" and insert "shall provide them to the enrollee and the health maintenance organization:".

Page 6, line 8, delete "issue an".

Page 6, line 9, delete "emergency order under IC 4-21.5-4".

Page 6, line 9, delete "twenty four" and insert "twenty-four".

Page 6, line 12, after "and" insert "under rules adopted under this section, within seventy-two (72) hours of receiving the medical review professional's findings.

(j) The medical review professional's determination under subsection (g) is binding on the health maintenance organization."

Page 6, delete lines 13 through 21.

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Page 6, line 22, delete "(h)" and insert "**(k)**".

Page 6, between lines 24 and 25, begin a new paragraph and insert:

**"(l) All costs associated with the services of an independent review organization under this section, other than the filing fee paid by an enrollee under subsection (c), must be paid by the health maintenance organization.**

**(m) This chapter does not add to or otherwise change the terms of coverage included in a contract under which an enrollee receives health care benefits under IC 27-13.**

**(n) Documents and other information created or received by the department in connection with an external review under this chapter are not public records and may not be disclosed under IC 5-14-3."**

Page 6, line 25, delete "(i)" and insert "**(o)**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1309 as introduced.)

FRY, Chair

Committee Vote: yeas 13, nays 0.

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1309 be amended to read as follows:

Page 3, line 40, delete "chapter" and insert "**section**".

Page 4, line 3, delete "chapter" and insert "**section**".

(Reference is to HB 1309 as printed February 23, 1999.)

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## COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1309, 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, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-13-8-2 (CURRENT VERSION) IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:

- (1) Audited financial statements of the health maintenance organization for the preceding calendar year.
- (2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.
- (3) A description of the grievance procedure of the health maintenance organization:

**(A) established under IC 27-13-10, including:**

- (i) the total number of grievances handled through the procedure during the preceding calendar year;
- (ii) a compilation of the causes underlying those grievances; and
- (iii) a summary of the final disposition of those grievances; and

**(B) established under IC 27-13-10.1, including:**

- (i) the total number of external grievances handled through the procedure during the preceding calendar year;
- (ii) a compilation of the causes underlying those grievances; and
- (iii) a summary of the final disposition of those grievances;

**for each independent review organization used by the health maintenance organization during the reporting year.**

(b) The information required by subsection (a)(2) and (a)(3) must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be filed with the commissioner on or before June 1 of each year. The

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commissioner shall:

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

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

SECTION 2. IC 27-13-8-2 (DELAYED VERSION) IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:

- (1) Audited financial statements of the health maintenance organization for the preceding calendar year.
- (2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.
- (3) A description of the grievance procedure of the health maintenance organization:

**(A) established under IC 27-13-10, including:**

- (i) the total number of grievances handled through the procedure during the preceding calendar year;
  - (ii) a compilation of the causes underlying those grievances; and
  - (iii) a summary of the final disposition of those grievances;
- and**

**(B) established under IC 27-13-10.1, including:**

- (i) the total number of external grievances handled through the procedure during the preceding calendar year;
- (ii) a compilation of the causes underlying those grievances; and
- (iii) a summary of the final disposition of those grievances;

**for each independent review organization used by the health maintenance organization during the reporting year.**

- (4) The percentage of providers credentialed by the health maintenance organization according to the most current standards or guidelines, if any, developed by the National Committee on Quality Assurance or a successor organization.



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(5) The health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data.

(b) The information required by subsection (a)(2) through (a)(4) must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be filed with the commissioner on or before June 1 of each year. The health maintenance organization's HEDIS data required by subsection (a)(5) must be filed with the commissioner on or before July 1 of each year. The commissioner shall:

- (1) make the information required to be filed under this section available to the public; and
- (2) prepare an annual compilation of the data required under subsection (a)(3) through (a)(5) that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

SECTION 3. IC 27-13-9-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4. A health maintenance organization shall provide to each enrollee and subscriber:

- (1) information on:
  - (A) how services can be obtained;
  - (B) where additional information on access to services can be obtained;
  - (C) how to file a grievance under IC 27-13-10 **and IC 27-13-10.1;**
  - (D) the health maintenance organization's:
    - (i) structure;
    - (ii) health care benefits and exclusions; and
    - (iii) criteria for denying coverage; and
  - (E) costs for which the enrollee or subscriber is responsible; and
- (2) a toll free telephone number through which the enrollee can contact the health maintenance organization at no cost to the enrollee to obtain information and to file grievances.

The information under this section must be provided to a potential enrollee of the health maintenance organization upon request.

SECTION 4. IC 27-13-10-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4. (a) A health maintenance organization shall provide timely, adequate, and appropriate notice to each enrollee or subscriber of the grievance procedure under this chapter **and IC 27-13-10.1.**



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(b) A health maintenance organization shall prominently display on all notices to enrollees and subscribers the telephone number and address at which a grievance may be filed.

(c) A written description of the enrollee's or subscriber's right to file a grievance must be posted by the provider in a conspicuous public location in each facility that offers services on behalf of a health maintenance organization.

SECTION 5. IC 27-13-10-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 8. (a) A health maintenance organization 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.
- (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 accommodate the clinical urgency of the situation.

(b) The health maintenance organization 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 health maintenance organization 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 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

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previous grievance process; and

(4) do not have a direct business relationship with the enrollee or the health care 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 as expeditiously as possible and 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 health maintenance organization shall allow enrollees and subscribers the opportunity to appear in person at the panel or to communicate with the panel through appropriate other means if the enrollee or subscriber is unable to appear in person.

(e) A health maintenance organization 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 resolution notice must contain the following:

(1) The decision reached by the health maintenance organization.

(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, **including the right to review by an independent review organization under IC 27-13-10.1.**

(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 an appeal."

Page 1, line 1, delete "IC 27-13-10-11.1" and insert "IC 27-13-10.1".

Page 1, line 2, delete "SECTION" and insert "CHAPTER".

Page 1, line 3, delete "Sec. 11.1. (a) The department", begin a new paragraph and insert:

**"Chapter 10.1. External Review of Grievances**

**Sec. 1. A health maintenance organization".**

Page 1, line 5, delete "an adverse"

Page 1, line 6, after "(1)" insert "**an adverse**".

Page 1, line 7, delete "or".

Page 1, line 8, after "(2)" insert "**an adverse**".

Page 1, line 8, after ";" insert "**or**".

Page 1, between lines 8 and 9, begin a new line block indented and insert:

**"(3) a determination that a proposed service is experimental or investigational;"**.

Page 1, delete lines 12 through 18, begin a new paragraph and insert:

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**"Sec. 2. (a) An external grievance procedure established under section 1 of this chapter must:**

- (1) allow an enrollee or the enrollee's representative to file a written request with the health maintenance organization for an appeal of the health maintenance organization's grievance resolution under IC 27-13-10-8 not later than forty-five (45) days after the enrollee is notified of the resolution under IC 27-13-10-8; and**
- (2) provide for:**
  - (A) an expedited appeal for a grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:**
    - (i) life or health; or**
    - (ii) ability to reach and maintain maximum function; or**
  - (B) a standard appeal for a grievance not described in clause (A).**

**An enrollee may file not more than one (1) appeal of a health maintenance organization's grievance resolution.**

**(b) When a request is filed under subsection (a), the health maintenance organization shall select:**

- (1) an independent review organization from the list of independent review organizations that are certified by the department under section 8 of this chapter; and**
- (2) a different independent review organization for each appeal filed under this chapter on a rotational basis;**

**in compliance with the requirements of subsection (d).**

**(c) The independent review organization shall assign a medical review professional who is board certified in the applicable specialty for resolution of an appeal.**

**(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, or financial conflict of interest with any of the following:**

- (1) The health maintenance organization.**
- (2) Any officer, director, or management employee of the health maintenance organization.**
- (3) The physician or the physician's medical group that is proposing the service.**
- (4) The facility at which the service would be provided.**
- (5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.**



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However, the medical review professional may have a contractual relationship under which the medical review professional provides health care services to enrollees of the health maintenance organization and may have an affiliation that is limited to staff privileges at the health facility if the relationship or affiliation is disclosed to the enrollee and the health maintenance organization.

(e) The enrollee may be required to pay not more than twenty-five dollars (\$25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the health maintenance organization.

**Sec. 3. (a) An enrollee who files an appeal under this chapter shall:**

- (1) not be subject to retaliation for exercising the enrollee's right to an appeal under this chapter;
- (2) be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the review process;
- (3) be permitted to submit additional information relating to the proposed service throughout the review process; and
- (4) cooperate with the independent review organization by:
  - (A) providing any requested medical information; or
  - (B) authorizing the release of necessary medical information.

(b) A health maintenance organization shall cooperate with an independent review organization selected under section 2 of this chapter by promptly providing any information requested by the independent review organization.

**Sec. 4. (a) An independent review organization shall:**

- (1) for an expedited appeal filed under section 2(a)(2)(A) of this chapter, within seventy-two (72) hours after the appeal is filed; or
- (2) for a standard appeal filed under section 2(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the health maintenance organization's grievance resolution under IC 27-13-10-8 based on information gathered from the enrollee or the enrollee's designee, the health maintenance organization, and the treating physician, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the



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**independent review organization shall apply:**

- (1) standards of decision making that are based on objective clinical evidence; and**
- (2) the terms of the enrollee's benefit contract.**

**(c) The independent review organization shall notify the health maintenance organization, the enrollee, and the department of the determination made under this section:**

- (1) for an expedited appeal filed under section 2(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; or**
- (2) for a standard appeal filed under section 2(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.**

**Sec. 5. A determination made under section 4 of this chapter is binding on the health maintenance organization. However, the enrollee may pursue any additional remedies in an appropriate court of law.**

**Sec. 6. (a) If at any time during an external review performed under this chapter, the enrollee obtains new information not considered by the health maintenance organization under IC 27-13-10:**

- (1) the enrollee shall submit the information to the health maintenance organization for reconsideration of the health maintenance organization's resolution under IC 27-13-10-8; and**
- (2) the independent review organization shall cease the external review process until the reconsideration under subsection (b) is completed.**

**(b) A health maintenance organization to which information is submitted under subsection (a) shall reconsider the resolution under IC 27-13-10-8 based on the information and notify the enrollee of the health maintenance organization's decision:**

- (1) within seventy-two (72) hours after the information is submitted for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:**
  - (A) life or health; or**
  - (B) ability to reach and maintain maximum function; or**
- (2) within fifteen (15) days after the information is submitted for a reconsideration not described in subdivision (1).**

**(c) If the decision reached under subsection (b) is adverse to the enrollee, the enrollee may request that the independent review**

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organization resume the external review under this chapter.

**Sec. 7.** This chapter does not add to or otherwise change the terms of coverage included in a contract under which an enrollee receives health care benefits under IC 27-13.

**Sec. 8. (a)** The department shall establish and maintain a process for annual certification of independent review organizations.

(b) The department may have a sufficient number of independent review organizations certified at any one (1) time as determined by the department.

(c) An independent review organization shall meet the following minimum requirements for certification by the department:

(1) Medical review professionals assigned by the independent review organization to perform external grievance reviews under this chapter:

(A) must be board certified in the specialty in which an enrollee's proposed service would be provided;

(B) must be knowledgeable about a proposed service through actual clinical experience;

(C) must hold an unlimited license to practice in a state of the United States; and

(D) must have no history of disciplinary actions or sanctions including:

(i) loss of staff privileges; or

(ii) restriction on participation;

taken or pending by any hospital, government, or regulatory body.

(2) The independent review organization must have a quality assurance mechanism to ensure the:

(A) timeliness and quality of reviews;

(B) qualifications and independence of medical review professionals;

(C) confidentiality of medical records and other review materials; and

(D) satisfaction of enrollees with the procedures utilized by the independent review organization, including the use of enrollee satisfaction surveys.

(3) The independent review organization must file with the department the following information before March 1 of each year:

(A) The number and percentage of determinations made in favor of enrollees.

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**(B) The number and percentage of determinations made in favor of health maintenance organizations.**

**(C) The average time to process a determination.**

**(D) Any other information required by the department.**

The information required under this subdivision must be specified for each health maintenance organization for which the independent review organization performed reviews during the reporting year.

**(4) Any additional requirements established by the department.**

**(d) The department may not certify an independent review organization that is one (1) of the following:**

**(1) A professional or trade association of health care providers, or a subsidiary of a professional or trade association of health care providers.**

**(2) A health insurer or health plan association, or a subsidiary of a health insurer or health plan association.**

**(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.**

**(f) The department shall make available to health maintenance organizations a list of all certified independent review organizations.**

**(g) The department shall make the information provided to the department under subdivision (c)(3) available to the public in a format that does not identify individual enrollees.**

**Sec. 9. Except as provided in section 8(g) of this chapter, documents and other information created or received by the independent review organization, the medical review professional, or the department in connection with an external review under this chapter:**

**(1) are not public records;**

**(2) may not be disclosed under IC 5-14-3; and**

**(3) must be treated in accordance with confidentiality requirements of state and federal law.**

**Sec. 10. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.**

**(b) A health maintenance organization is immune from civil liability for actions taken in good faith in connection with a determination under this chapter that reverses the health**

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**maintenance organization's resolution under IC 27-13-10.**

**Sec. 11. If an enrollee has the right to an external review under Medicare (42 U.S.C. 1395 et seq.) the enrollee may not request an external review under this chapter.**

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

SECTION 6. IC 34-30-2-119.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 119.5. IC 27-13-10.1 (Concerning health maintenance organizations and independent review organizations.)**

SECTION 7. [EFFECTIVE JULY 1, 1999] (a) **IC 27-13-8-2, as amended by this act, applies to external grievances filed by enrollees after January 1, 2000.**

(b) **IC 27-13-10.1, as added by this act, applies to grievances filed under IC 27-13-10-5 after January 1, 2000."**

Delete pages 2 through 4.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1309 as reprinted March 2, 1999.)

MILLER, Chairperson

Committee Vote: Yeas 10, Nays 0.

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