



Reprinted
April 9, 1999

**ENGROSSED
HOUSE BILL No. 1309**

DIGEST OF HB 1309 (Updated April 8, 1999 3:58 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.

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

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.

April 8, 1999, read second time, amended, ordered engrossed.

EH 1309—LS 6866/DI 97+



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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 shall 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 that the work product and determination, or both, of an independent review organization are admissible in a judicial or administrative proceeding, but do not, without other supporting evidence, satisfy any party's burden of proof or persuasion. Requires a health maintenance organization or limited service health maintenance organization to notify an enrollee of the termination of a participating provider seen by the enrollee during the previous year.

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April 9, 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

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 27-13-9-3 IS AMENDED TO READ AS
 36 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) A health
 37 maintenance organization shall notify an enrollee in writing of the
 38 termination of:
 39 (1) the provider who currently provides primary health care
 40 services to that enrollee; **and**
 41 (2) **any other participating provider seen by the enrollee**
 42 **during the previous year.**

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1 (b) After the termination of the provider who provided primary
 2 health care services to an enrollee, the health maintenance organization
 3 shall assist the enrollee in transferring to another participating primary
 4 care provider.

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

8 (1) information on:

9 (A) how services can be obtained;

10 (B) where additional information on access to services can be
 11 obtained;

12 (C) how to file a grievance under IC 27-13-10 **and**
 13 **IC 27-13-10.1;**

14 (D) the health maintenance organization's:

15 (i) structure;

16 (ii) health care benefits and exclusions; and

17 (iii) criteria for denying coverage; and

18 (E) costs for which the enrollee or subscriber is responsible;
 19 and

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

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

25 SECTION 5. IC 27-13-10-4 IS AMENDED TO READ AS
 26 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4. (a) A health
 27 maintenance organization shall provide timely, adequate, and
 28 appropriate notice to each enrollee or subscriber of the grievance
 29 procedure under this chapter **and IC 27-13-10.1.**

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

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

37 SECTION 6. IC 27-13-10-8 IS AMENDED TO READ AS
 38 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 8. (a) A health
 39 maintenance organization shall establish written policies and
 40 procedures for the timely resolution of appeals of grievance decisions.
 41 The procedures for registering and responding to oral and written
 42 appeals of grievance decisions must include the following:



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- 1 (1) Acknowledgment of the appeal, orally or in writing, within
 2 three (3) business days after receipt of the appeal being filed.
 3 (2) Documentation of the substance of the appeal and the actions
 4 taken.
 5 (3) Investigation of the substance of the appeal, including any
 6 aspects of clinical care involved.
 7 (4) Notification to enrollees or subscribers of the disposition of
 8 the appeal and that the enrollee or subscriber may have the right
 9 to further remedies allowed by law.
 10 (5) Standards for timeliness in responding to appeals and
 11 providing notice to enrollees or subscribers of the disposition of
 12 the appeal and the right to initiate an external appeals process that
 13 accommodate the clinical urgency of the situation.
- 14 (b) The health maintenance organization shall appoint a panel of
 15 qualified individuals to resolve an appeal. An individual may not be
 16 appointed to the panel who has been involved in the matter giving rise
 17 to the complaint or in the initial investigation of the complaint. Except
 18 for grievances that have previously been appealed under IC 27-8-17, in
 19 the case of an appeal from the proposal, refusal, or delivery of a health
 20 care procedure, treatment, or service, the health maintenance
 21 organization shall appoint one (1) or more individuals to the panel to
 22 resolve the appeal. The panel must include one (1) or more individuals
 23 who:
 24 (1) have knowledge in the medical condition, procedure, or
 25 treatment at issue;
 26 (2) are in the same licensed profession as the provider who
 27 proposed, refused, or delivered the health care procedure,
 28 treatment, or service;
 29 (3) are not involved in the matter giving rise to the appeal or the
 30 previous grievance process; and
 31 (4) do not have a direct business relationship with the enrollee or
 32 the health care provider who previously recommended the health
 33 care procedure, treatment, or service giving rise to the grievance.
- 34 (c) An appeal of a grievance decision must be resolved as
 35 expeditiously as possible and with regard to the clinical urgency of the
 36 appeal. However, an appeal must be resolved not later than forty-five
 37 (45) days after the appeal is filed.
- 38 (d) A health maintenance organization shall allow enrollees and
 39 subscribers the opportunity to appear in person at the panel or to
 40 communicate with the panel through appropriate other means if the
 41 enrollee or subscriber is unable to appear in person.
- 42 (e) A health maintenance organization shall notify the enrollee or

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1 subscriber in writing of the resolution of the appeal of a grievance
 2 within five (5) business days after completing the investigation. The
 3 grievance resolution notice must contain the following:

- 4 (1) The decision reached by the health maintenance organization.
 5 (2) The reasons, policies, or procedures that are the basis of the
 6 decision.
 7 (3) Notice of the enrollee's or subscriber's right to further
 8 remedies allowed by law, **including the right to review by an**
 9 **independent review organization under IC 27-13-10.1.**
 10 (4) The department, address, and telephone number through
 11 which an enrollee may contact a qualified representative to obtain
 12 more information about the decision or the right to an appeal.

13 SECTION 7. IC 27-13-10.1 IS ADDED TO THE INDIANA CODE
 14 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 15 JULY 1, 1999]:

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

17 **Sec. 1. A health maintenance organization shall establish and**
 18 **maintain an external grievance procedure for the resolution of**
 19 **grievances regarding:**

- 20 (1) **an adverse utilization review determination (as defined in**
 21 **IC 27-8-17-8);**
 22 (2) **an adverse determination of medical necessity; or**
 23 (3) **a determination that a proposed service is experimental or**
 24 **investigational;**

25 **made by a health maintenance organization or an agent of a health**
 26 **maintenance organization regarding a service proposed by the**
 27 **treating physician.**

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

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



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1 clause (A).
 2 An enrollee may file not more than one (1) appeal of a health
 3 maintenance organization's grievance resolution under this
 4 chapter.

5 (b) Subject to the requirements of subsection (d), when a request
 6 is filed under subsection (a), the health maintenance organization
 7 shall:

8 (1) select a different independent review organization for each
 9 appeal filed under this chapter from the list of independent
 10 review organizations that are certified by the department
 11 under section 8 of this chapter; and

12 (2) rotate the choice of an independent review organization
 13 among all certified independent review organizations before
 14 repeating a selection.

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

18 (d) The independent review organization and the medical review
 19 professional conducting the external review under this chapter
 20 may not have a material professional, familial, financial, or other
 21 affiliation with any of the following:

22 (1) The health maintenance organization.

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

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

27 (4) The facility at which the service would be provided.

28 (5) The development or manufacture of the principal drug,
 29 device, procedure, or other therapy that is proposed by the
 30 treating physician.

31 However, the medical review professional may have an affiliation
 32 under which the medical review professional provides health care
 33 services to enrollees of the health maintenance organization and
 34 may have an affiliation that is limited to staff privileges at the
 35 health facility if the affiliation is disclosed to the enrollee and the
 36 health maintenance organization before commencing the review
 37 and neither the enrollee nor the health maintenance organization
 38 objects.

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



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1 organization.

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

4 (1) not be subject to retaliation for exercising the enrollee's
5 right to an appeal under this chapter;

6 (2) be permitted to utilize the assistance of other individuals,
7 including physicians, attorneys, friends, and family members
8 throughout the review process;

9 (3) be permitted to submit additional information relating to
10 the proposed service throughout the review process; and

11 (4) cooperate with the independent review organization by:

12 (A) providing any requested medical information; or

13 (B) authorizing the release of necessary medical
14 information.

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

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

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

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

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

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

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

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

37 (c) The independent review organization shall notify the health
38 maintenance organization and the enrollee of the determination
39 made under this section:

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



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

4 Sec. 5. A determination made under section 4 of this chapter is
 5 binding on the health maintenance organization.

6 Sec. 6. (a) If at any time during an external review performed
 7 under this chapter, the enrollee submits information to the health
 8 maintenance organization that is relevant to the health
 9 maintenance organization's resolution under IC 27-13-10-8 and
 10 was not considered by the health maintenance organization under
 11 IC 27-13-10:

12 (1) the health maintenance organization shall reconsider the
 13 health maintenance organization's resolution under
 14 IC 27-13-10-8; and

15 (2) the independent review organization shall cease the
 16 external review process until the reconsideration under
 17 subsection (b) is completed.

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

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

26 (A) life or health; or

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

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

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

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

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

39 (b) The department shall certify a number of independent
 40 review organizations determined by the department to be sufficient
 41 to fulfill the purposes of this chapter.

42 (c) An independent review organization shall meet the following



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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.

(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

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1 organization that is one (1) of the following:

2 (1) A professional or trade association of health care
3 providers, or a subsidiary or an affiliate of a professional or
4 trade association of health care providers.

5 (2) A health insurer, health maintenance organization, or
6 health plan association, or a subsidiary or an affiliate of a
7 health insurer, health maintenance organization, or health
8 plan association.

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

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

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

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

24 (1) are not public records;

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

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

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

31 (b) The work product or determination, or both, of an
32 independent review organization under this chapter are admissible
33 in a judicial or administrative proceeding. However, the work
34 product or determination, or both, do not, without other
35 supporting evidence, satisfy any party's burden of proof or
36 persuasion concerning any material issue of fact or law.

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

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

42 SECTION 8. IC 27-13-34-12 IS AMENDED TO READ AS



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1 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 12. A limited service
 2 health maintenance organization operated under this chapter is subject
 3 to the following:

4 (1) IC 27-13-8, except for IC 27-13-8-2(a)(5) concerning reports.

5 (2) **IC 27-13-9-3 concerning termination of providers.**

6 (3) IC 27-13-10-1 through IC 27-13-10-3 concerning grievance
 7 procedures.

8 ~~(3)~~ (4) IC 27-13-11 concerning investments.

9 ~~(4)~~ (5) IC 27-13-15-1(a)(2) through IC 27-13-15-1(a)(3)
 10 concerning gag clauses in contracts.

11 ~~(5)~~ (6) IC 27-13-21 concerning producers.

12 ~~(6)~~ (7) IC 27-13-29 concerning statutory construction and
 13 relationship to other laws.

14 ~~(7)~~ (8) IC 27-13-30 concerning public records.

15 ~~(8)~~ (9) IC 27-13-31 concerning confidentiality of medical
 16 information and limitation of liability.

17 ~~(9)~~ (10) IC 27-13-36-5 and IC 27-13-36-6 concerning referrals to
 18 out of network providers and continuation of care.

19 ~~(10)~~ (11) IC 27-13-40 concerning comparison sheets of services
 20 provided by the limited service health maintenance organization.

21 SECTION 9. IC 34-30-2-119.5 IS ADDED TO THE INDIANA
 22 CODE AS A NEW SECTION TO READ AS FOLLOWS
 23 [EFFECTIVE JULY 1, 1999]: **Sec. 119.5. IC 27-13-10.1 (Concerning
 24 independent review organizations.)**

25 SECTION 10. [EFFECTIVE JULY 1, 1999] (a) **IC 27-13-8-2, as
 26 amended by this act, applies to external grievances filed by
 27 enrollees after January 1, 2000.**

28 (b) **IC 27-13-10.1, as added by this act, applies to grievances
 29 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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SENATE MOTION

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

Page 3, between lines 34 and 35, begin a new paragraph and insert:

"SECTION 3. IC 27-13-9-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) A health maintenance organization shall notify an enrollee in writing of the termination of:

- (1) the provider who currently provides primary health care services to that enrollee; **and**
- (2) any other participating provider seen by the enrollee during the previous year.**

(b) After the termination of the provider who provided primary health care services to an enrollee, the health maintenance organization shall assist the enrollee in transferring to another participating primary care provider."

Page 11, between lines 21 and 22, begin a new paragraph and insert:

"SECTION 8. IC 27-13-34-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: 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 27-13-8-2(a)(5) concerning reports.
- (2) IC 27-13-9-3 concerning termination of providers.**
- (3) IC 27-13-10-1 through IC 27-13-10-3 concerning grievance procedures.
- ~~(4)~~ **(4)** IC 27-13-11 concerning investments.
- ~~(5)~~ **(5)** IC 27-13-15-1(a)(2) through IC 27-13-15-1(a)(3) concerning gag clauses in contracts.
- ~~(6)~~ **(6)** IC 27-13-21 concerning producers.
- ~~(7)~~ **(7)** IC 27-13-29 concerning statutory construction and relationship to other laws.
- ~~(8)~~ **(8)** IC 27-13-30 concerning public records.
- ~~(9)~~ **(9)** IC 27-13-31 concerning confidentiality of medical information and limitation of liability.
- ~~(10)~~ **(10)** IC 27-13-36-5 and IC 27-13-36-6 concerning referrals to out of network providers and continuation of care.
- ~~(11)~~ **(11)** IC 27-13-40 concerning comparison sheets of services provided by the limited service health maintenance organization.

Renumber all SECTIONS consecutively.

(Reference is to EHB 1309 as printed April 6, 1999.)

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SENATE MOTION

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

Page 6, line 33, before "." insert "**under this chapter**".

Page 6, line 34, delete "When" and insert "**Subject to the requirements of subsection (d), when**".

Page 6, line 35, delete "select".

Page 6, line 36, delete "an" and insert "**select a different**".

Page 6, line 36, before "from" insert "**for each appeal filed under this chapter**".

Page 6, line 39, delete "a different independent review organization for each" and insert "**rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.**".

Page 6, delete lines 40 through 41.

Page 7, line 5, delete "or".

Page 7, line 5, delete "conflict" and insert ", **or other affiliation**".

Page 7, line 6, delete "of interest".

Page 7, line 16, delete "a contractual" and insert "**an affiliation**".

Page 7, line 17, delete "relationship".

Page 7, line 20, delete "relationship or".

Page 7, line 21, after "organization" insert "**before commencing the review and neither the enrollee nor the health maintenance organization objects**".

Page 8, line 21, delete "organization," and insert "**organization and**".

Page 8, line 21, delete ", and the department".

Page 8, line 30, delete "However, the".

Page 8, delete lines 31 through 32.

Page 8, line 34, delete "obtains new" and insert "**submits**".

Page 8, line 34, after "information" insert "**to the health maintenance organization that is relevant to the health maintenance organization's resolution under IC 27-13-10-8 and was**".

Page 8, line 37, delete "the enrollee shall submit the information to".

Page 8, line 38, delete "for reconsideration of" and insert "**shall reconsider**".

Page 9, line 23, delete "may have a sufficient" and insert "**shall certify a**".

Page 9, line 24, delete "certified at any one (1) time as".

Page 9, line 25, after "department" insert "**to be sufficient to fulfill the purposes of this chapter**".

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Page 10, line 29, after "subsidiary" insert "**or an affiliate**".

Page 10, line 31, after "insurer" insert "**, health maintenance organization,**".

Page 10, line 31, after "subsidiary" insert "**or an affiliate**".

Page 10, line 32, after "insurer" insert "**, health maintenance organization,**".

Page 11, line 3, delete "organization," and insert "**organization or**".

Page 11, line 3, delete "professional," and insert "**professional**".

Page 11, line 4, delete "or the department".

Page 11, line 13, delete "A health maintenance organization is immune from civil" and insert "**The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy any party's burden of proof or persuasion concerning any material issue of fact or law.**".

Page 11, delete lines 14 through 16.

Page 11, line 25, delete "health maintenance organizations and".

(Reference is to EHB 1309 as printed April 6, 1999.)

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