

# HOUSE BILL No. 1333

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## DIGEST OF INTRODUCED BILL

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

**Synopsis:** Managed care organization liability. Provides for a duty of ordinary care for health insurance carriers, health maintenance organizations, or other managed care entities when making health care treatment decisions. Makes a health insurance carrier, a health maintenance organization, or other managed care entity liable for harm resulting from health care treatment decisions made without exercising ordinary care. Prohibits a health insurance carrier, a health maintenance organization, or other managed care entity from removing a health care provider from, or renewing the status of the health care provider with, the health care plan for advocating on behalf of the insured or enrollee for appropriate and medically necessary care.  
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**Effective:** July 1, 1999.

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

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Prohibits contract indemnification or hold harmless clauses that apply to the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Establishes the health care appeals program to provide an independent utilization review of a final decision by a health insurance carrier, health maintenance organization, or other managed care entity to deny, reduce, or terminate a benefit. Requires the department of insurance to contract with at least two qualifying independent utilization review agents to provide appeal reviews for the health care appeals program. Provides qualifications that a utilization review agent must meet. Requires a utilization review agent to complete its review and make a determination within 60 days of receiving a completed application for an appeal review and to establish procedures for an expedited review in cases when a delay in receiving a health care service could seriously jeopardize an individual's health or well-being. Requires the utilization review agent to state its findings and recommendations in writing. Makes the decision of the utilization review agent binding on the health insurance carrier, health maintenance organization, or other managed care entity. Provides that all records associated with an appeal review are confidential. Requires the commissioner of the department of insurance to establish a reasonable, per case reimbursement schedule for utilization review agents. Provides that the health insurance carrier, health maintenance organization, or other managed care entity that is the subject of an appeal review is responsible for paying the reasonable expenses of the utilization review agent that conducted the appeal review. Requires the department of insurance to file reports with the general assembly every six months detailing the activity of the health care appeals program.

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Introduced

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.

## HOUSE BILL No. 1333

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

*Be it enacted by the General Assembly of the State of Indiana:*

- 1 SECTION 1. IC 27-14 IS ADDED TO THE INDIANA CODE AS  
2 A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1,  
3 1999]:  
4 **ARTICLE 14. LIABILITY FOR CERTAIN HEALTH CARE**  
5 **TREATMENT DECISIONS**  
6 **Chapter 1. General Provisions and Definitions**  
7 **Sec. 1. The definitions in this chapter apply throughout this**  
8 **article.**  
9 **Sec. 2. "Enrollee" means the following:**  
10 (1) **With respect to a health maintenance organization a:**  
11 (A) **subscriber; or**  
12 (B) **dependent of a subscriber;**  
13 **who is covered by the health maintenance organization.**  
14 (2) **With respect to another managed care entity:**  
15 (A) **an individual who is enrolled in a health care plan; or**



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- 1           **(B) a dependent of an individual described in clause (A)**  
 2           **who is covered by the health care plan.**
- 3           **Sec. 3. "Carrier" means a health insurance carrier, health**  
 4           **maintenance organization, or another managed care entity through**  
 5           **which a health care plan is operated.**
- 6           **Sec. 4. "Commissioner" refers to the insurance commissioner**  
 7           **appointed under IC 27-1-1-2.**
- 8           **Sec. 5. "Department" refers to the department of insurance.**
- 9           **Sec. 6. "Health care plan" means a plan under which a person**  
 10           **undertakes to:**
- 11           **(1) arrange for;**  
 12           **(2) pay for; or**  
 13           **(3) reimburse any part of the cost of;**  
 14           **health care services through a carrier.**
- 15           **Sec. 7. "Health care provider" has the meaning set forth in**  
 16           **IC 34-18-2-14.**
- 17           **Sec. 8. "Health care treatment decision" means a determination**  
 18           **that:**
- 19           **(1) is made when medical services are provided by a health**  
 20           **care plan; and**  
 21           **(2) affects the quality of the diagnosis, care, or treatment**  
 22           **provided to an insured or enrollee of the health care plan.**
- 23           **Sec. 9. "Health insurance" means one (1) or more of the kinds**  
 24           **of insurance described in Class 1(b) and Class 2(a) of IC 27-1-5-1.**
- 25           **Sec. 10. "Health insurance carrier" means an insurer (as**  
 26           **defined in IC 27-1-2-3) that provides health insurance.**
- 27           **Sec. 11. "Health maintenance organization" has the meaning set**  
 28           **forth in IC 27-13-1-19.**
- 29           **Sec. 12. (a) "Managed care entity" means an entity that, on**  
 30           **behalf of or as part of a health care plan:**
- 31           **(1) delivers health care services to a defined enrollee**  
 32           **population;**  
 33           **(2) administers the delivery of health care services to a**  
 34           **defined enrollee population; or**  
 35           **(3) assumes the risk for the delivery of health care services to**  
 36           **a defined enrollee population.**
- 37           **(b) The term does not include:**
- 38           **(1) an employer purchasing coverage or acting on behalf of:**  
 39           **(A) its employees; or**  
 40           **(B) the employees of one (1) or more subsidiaries or**  
 41           **corporations affiliated with the employer; or**  
 42           **(2) a pharmacy that holds a pharmacy permit issued by the**



1 Indiana board of pharmacy under IC 25-26-13.

2 **Sec. 13. "Ordinary care" means the following:**

3 (1) With respect to a carrier, the degree of care that a carrier  
4 of ordinary prudence would use under the same or similar  
5 circumstances.

6 (2) With respect to a person who is an employee, an agent, an  
7 ostensible agent, or a representative of a carrier, the degree  
8 of care that a person of ordinary prudence in the same  
9 profession, specialty, or area of practice as the person would  
10 use under the same or similar circumstances.

11 **Sec. 14. "Person" means an individual, a corporation, a  
12 partnership, a limited liability company, an unincorporated  
13 association, the state, or a political subdivision (as defined in  
14 IC 36-1-2-13).**

15 **Sec. 15. "Program" refers to the health care appeals program.**

16 **Sec. 16. (a) "Utilization review" means a system for prospective,  
17 concurrent, or retrospective review of the medical necessity and  
18 appropriateness of health care services provided or proposed to be  
19 provided to an enrollee.**

20 (b) The term does not include the following:

21 (1) Elective requests for clarification of coverage, eligibility,  
22 or benefits verification.

23 (2) Medical claims review (as defined in IC 27-8-16-4).

24 **Sec. 17. "Utilization review agent" means any entity that  
25 performs utilization review.**

26 **Chapter 2. The Duty of Ordinary Care**

27 **Sec. 1. (a) This chapter does not apply to a carrier that is wholly  
28 owned by a provider (as defined in IC 27-13-1-28).**

29 (b) This chapter does not apply to worker's compensation  
30 insurance coverage under IC 22-3-2 through IC 22-3-6.

31 **Sec. 2. A carrier:**

32 (1) has the duty to exercise ordinary care when making health  
33 care treatment decisions; and

34 (2) is liable for damages in compensation for harm to an  
35 insured or enrollee that is proximately caused by the failure  
36 of the carrier to exercise ordinary care.

37 **Sec. 3. A carrier is liable for damages in compensation for harm  
38 to an insured or enrollee proximately caused by a health care  
39 treatment decision made by an employee, an agent, an ostensible  
40 agent, or a representative of the carrier if, at the time the decision  
41 is made:**

42 (1) the employee, agent, ostensible agent, or representative is

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1 acting on behalf of the carrier; and

2 (2) the carrier:

3 (A) has the right to exercise influence or control over the  
4 employee, agent, ostensible agent, or representative; or

5 (B) is actually exercising influence or control over the  
6 employee, agent, ostensible agent, or representative;

7 resulting in the failure to exercise ordinary care.

8 Sec. 4. In an action based under section 3 of this chapter on a  
9 health care treatment decision allegedly made by an employee, an  
10 agent, an ostensible agent, or a representative of a carrier, it is a  
11 defense that:

12 (1) neither:

13 (A) the carrier; nor

14 (B) the employee, agent, ostensible agent, or representative  
15 for whose conduct the carrier is allegedly liable;

16 controlled, influenced, or participated in the health care  
17 treatment decision in question; and

18 (2) the carrier did not deny or delay payment for any  
19 treatment prescribed or recommended by a health care  
20 provider to the insured or enrollee in question.

21 Sec. 5. Sections 2 and 3 of this chapter do not obligate a carrier  
22 to provide to an insured or enrollee treatment that is not covered  
23 by the health care plan.

24 Sec. 6. This chapter does not create liability on the part of:

25 (1) an employer;

26 (2) an employer purchasing group; or

27 (3) a pharmacy that holds a pharmacy permit issued by the  
28 Indiana board of pharmacy under IC 25-26-13;

29 that purchases coverage or assumes risk on behalf of its employees.

30 Sec. 7. A carrier may not:

31 (1) remove a physician or other health care provider from its  
32 health care plan; or

33 (2) refuse to renew the status of a physician or other health  
34 care provider with the health care plan;

35 for advocating on behalf of an insured or enrollee for appropriate  
36 and medically necessary health care for the insured or enrollee.

37 Sec. 8. (a) A carrier may not enter into a contract with a:

38 (1) physician, hospital, or other health care provider; or

39 (2) pharmaceutical company;

40 that includes an indemnification or a hold harmless clause applying  
41 to the acts or conduct of the carrier.

42 (b) An indemnification or a hold harmless clause described in

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1 subsection (a) is void.

2 **Sec. 9.** A law prohibiting a carrier from practicing medicine or  
3 being licensed to practice medicine may not be asserted as a  
4 defense by a carrier in an action brought under this chapter.

5 **Sec. 10.** In an action against a carrier under this chapter, a  
6 finding that a physician or another health care provider is an  
7 employee, an agent, an ostensible agent, or a representative of the  
8 carrier may not be based solely on proof that the name of the  
9 physician or other health care provider appears in a listing of  
10 approved physicians or health care providers made available to  
11 insureds or enrollees under a health care plan.

12 **Sec. 11.** (a) Except as provided in subsection (b), a person who  
13 brings an action under this chapter must comply with IC 34-18.

14 (b) If the medical director of a carrier makes a medical decision  
15 that has an adverse effect on an enrollee's health, a complaint  
16 against the medical director must be filed with the medical  
17 licensing board of Indiana under IC 25-22.5-2.

18 **Chapter 3. Health Care Appeals Program**

19 **Sec. 1.** (a) The health care appeals program is established within  
20 the department.

21 (b) The purpose of the program is to provide an independent  
22 utilization review of a final decision by a carrier to deny, reduce,  
23 or terminate benefits in the event that the final decision is contested  
24 by the enrollee.

25 (c) The utilization review may not include any decisions  
26 regarding benefits not covered by the enrollee's carrier.

27 **Sec. 2.** An enrollee may apply to the program for a review of a  
28 decision to deny, reduce, or terminate a benefit if the enrollee:

- 29 (1) completes the carrier's appeals process, if any;  
30 (2) contests the carrier's final decision; and  
31 (3) applies to the department, in a manner determined by the  
32 commissioner, within sixty (60) days of the date of the final  
33 decision issued by the carrier.

34 **Sec. 3.** In an application under section 2(3) of this chapter, the  
35 enrollee must provide the department with the following:

- 36 (1) The name and business address of the carrier.  
37 (2) A brief description of the enrollee's medical condition for  
38 which benefits were denied, reduced, or terminated.  
39 (3) A copy of any information provided by the carrier  
40 regarding its decision to deny, reduce, or terminate the  
41 benefit.  
42 (4) A written consent to obtain any necessary medical records



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1 from the carrier or from any out-of-network provider the  
2 enrollee may have consulted on the matter.

3 (5) An application processing fee of twenty-five dollars (\$25).  
4 The commissioner may reduce or waive this fee in the case of  
5 financial hardship.

6 Sec. 4. (a) The department shall contract with two (2) or more  
7 independent utilization review agents under IC 5-22 that meet the  
8 requirements under subsection (b) to conduct appeal reviews for  
9 the program.

10 (b) In order to provide appeal reviews for the program, a  
11 utilization review agent must:

12 (1) meet the requirements to hold a certificate of registration  
13 as provided in IC 27-8-17;

14 (2) not have a material professional, family, or financial  
15 conflict of interest with:

16 (A) the carrier that is the subject of the complaint;

17 (B) any officer, director, or management employee of the  
18 carrier that is the subject of the complaint;

19 (C) the health care provider that rendered or is proposing  
20 to render the health care service that is under review;

21 (D) the facility where the health care service was provided  
22 or will be provided; and

23 (E) the developer or manufacturer of the principal drug,  
24 device, procedure, or other therapy that is being proposed  
25 for the enrollee; and

26 (3) meet any other requirement determined under rules  
27 established by the department under this chapter.

28 Sec. 5. The department shall establish a procedure for  
29 transmitting a completed application for an appeal review to the  
30 utilization review agent.

31 Sec. 6. A utilization review agent shall promptly review the  
32 relevant medical records of the enrollee to determine the  
33 appropriate, medically necessary health care services the enrollee  
34 should receive based on:

35 (1) applicable, generally accepted practice guidelines  
36 developed by:

37 (A) the federal government; and

38 (B) national or professional medical societies, boards, or  
39 associations; and

40 (2) any applicable clinical protocols or practice guidelines  
41 developed by the carrier.

42 Sec. 7. (a) Except as provided in subsection (b), a utilization

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1 review agent must complete its review and make its determination  
 2 within sixty (60) days of receiving a completed application for an  
 3 appeal review or within less time as prescribed by the  
 4 commissioner.

5 (b) The commissioner shall require each utilization review agent  
 6 to establish procedures to provide for an expedited review of a  
 7 carrier's denial, reduction, or termination of a benefit decision  
 8 when a delay in receiving the health care service could seriously  
 9 jeopardize the health or well-being of the enrollee.

10 Sec. 8. Upon completing an appeal review under this chapter,  
 11 the utilization review agent shall:

12 (1) state its findings in writing; and

13 (2) determine whether the carrier's denial, reduction, or  
 14 termination of benefits deprived the enrollee of medically  
 15 necessary services covered by the enrollee's health care plan.

16 Sec. 9. (a) If a utilization review agent determines that the  
 17 denial, reduction, or termination of benefits deprived an enrollee  
 18 of medically necessary covered services, the utilization review  
 19 agent shall make a recommendation to the enrollee and the carrier  
 20 regarding the appropriate, medically necessary health care  
 21 services the enrollee should receive.

22 (b) A recommendation received by the carrier under this section  
 23 is binding on the carrier.

24 (c) Upon receiving a recommendation under subsection (a), the  
 25 carrier shall promptly notify the enrollee and the commissioner  
 26 about what action the carrier will take with respect to the  
 27 recommendation.

28 (d) If the enrollee does not agree with:

29 (1) the utilization review agent's findings and  
 30 recommendations; or

31 (2) the carrier's proposed action on the recommendations;  
 32 the enrollee may seek the desired health care services outside the  
 33 enrollee's health care plan at the enrollee's own expense.

34 Sec. 10. (a) If the commissioner determines that a carrier  
 35 exhibits a pattern of noncompliance with the recommendations of  
 36 utilization review agents, the department shall review the carrier's  
 37 utilization review program to ensure that the carrier is in  
 38 compliance with all relevant laws and rules.

39 (b) If the department determines that the carrier is in violation  
 40 of patient rights or other relevant rules, the department may  
 41 impose penalties or sanctions on the carrier under rules adopted  
 42 under this chapter.



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**Sec. 11. (a) The following are confidential:**

- (1) An enrollee's medical records provided for an appeal review under this chapter.**
- (2) The findings and recommendations of a utilization review agent made under this chapter.**

**(b) The materials described in subsection (a) may be used only by the department, the utilization review agent, and the affected carrier for the purposes described in this chapter.**

**Sec. 12. The commissioner shall establish a reasonable, per case reimbursement schedule for utilization review agents.**

**Sec. 13. (a) The carrier that is the subject of an appeal review is responsible for paying the reasonable expenses of the utilization review agent that conducted the appeal review.**

**(b) The utilization review agent shall:**

- (1) present to the carrier for payment a detailed account of the expenses incurred by the utilization review agent; and**
- (2) provide a copy of the detailed account of expenses to the commissioner.**

**Sec. 14. At least one (1) time every six (6) months the department shall submit a report to the general assembly detailing the activities of the program, including the number of appeal reviews conducted, the outcome of each appeal review, and the costs associated with administering the program.**

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

**SECTION 2. [EFFECTIVE JULY 1, 1999] IC 27-14-2, as added by this act, applies to causes of action arising after June 30, 1999.**

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