



February 22, 2000

ENGROSSED HOUSE BILL No. 1189

DIGEST OF HB 1189 (Updated February 17, 2000 6:17 PM - DI 100)

Citations Affected: IC 16-21; IC 22-2; IC 27-1; IC 27-4; IC 27-7; IC 27-8; IC 27-13; IC 34-30; noncode.

Synopsis: Various insurance matters. Allows a wage assignment for the purpose of paying a premium on a policy of insurance. Requires the insurance commissioner to consider the remediation efforts of a person who has engaged in unfair methods of competition or deceptive acts or practices in the business of insurance when assessing fines and penalties. Provides requirements for cancellation or nonrenewal of residential insurance policies. Requires an insurer to give written notice to the named insured of a transfer of a residential insurance policy. Requires an insurer to notify a residential policyholder regarding coverage for flood damage. Requires a utilization review agent to, under certain circumstances, supply an insured with a written description of the appeals process at the time an adverse utilization review determination is made. Requires an insurer or a utilization review agent to provide written or oral notification to a covered individual that even when health care services meet the health insurance plan's requirements for medical necessity, appropriateness, level of care, or effectiveness, there is no guarantee that payment of the proposed services will be made. Requires an insurer to establish and maintain an internal grievance procedure and an external grievance review procedure. Amends the Indiana HMO law concerning: (1) assumption of a corporate name; (2) reinsurance; (3) powers of domestic HMOs; (4) annual and other filings; (5) uncovered health care expenditures; (6) receivership; and (7) voluntary dissolution.

Effective: Upon passage; July 1, 2000; January 1, 2001.

Fry, Smith M, Brown C, Ulmer

(SENATE SPONSOR — PAUL)

January 10, 2000, read first time and referred to Committee on Insurance, Corporations and Small Business.

January 13, 2000, amended, reported — Do Pass.

January 25, 2000, read second time, ordered engrossed. Engrossed.

January 26, 2000, read third time, passed. Yeas 85, nays 10.

SENATE ACTION

February 1, 2000, read first time and referred to Committee on Insurance and Financial Institutions.

February 21, 2000, amended, reported favorably — Do Pass.

EH 1189—LS 7084/DI 97+



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February 22, 2000

Second Regular Session 111th General Assembly (2000)

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 1999 General Assembly.

ENGROSSED HOUSE BILL No. 1189

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 16-21-3-2 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. The state health
3 commissioner may take action under section 1 of this chapter on any of
4 the following grounds:

- 5 (1) Violation of any of the provisions of this chapter or of the
6 rules adopted under this chapter.
7 (2) Permitting, aiding, or abetting the commission of any illegal
8 act in an institution.
9 (3) Conduct or practice found by the council to be detrimental to
10 the welfare of the patients of an institution.
11 **(4) Conduct that violates IC 27-13-15-3.**

12 SECTION 2. IC 22-2-6-2 IS AMENDED TO READ AS FOLLOWS
13 [EFFECTIVE JULY 1, 2000]: Sec. 2. (a) Any assignment of the wages
14 of an employee is valid only if all of the following conditions are
15 satisfied:

- 16 (1) The assignment is:
17 (A) in writing;

EH 1189—LS 7084/DI 97+



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- 1 (B) signed by the employee personally;
- 2 (C) by its terms revocable at any time by the employee upon
- 3 written notice to the employer; and
- 4 (D) agreed to in writing by the employer.
- 5 (2) An executed copy of the assignment is delivered to the
- 6 employer within ten (10) days after its execution.
- 7 (3) The assignment is made for a purpose described in subsection
- 8 (b).
- 9 (b) A wage assignment under this section may be made for the
- 10 purpose of paying any of the following:
- 11 (1) Premium on a policy of insurance. ~~obtained for the employee~~
- 12 ~~by the employer.~~
- 13 (2) Pledge or contribution of the employee to a charitable or
- 14 nonprofit organization.
- 15 (3) Purchase price of bonds or securities, issued or guaranteed by
- 16 the United States.
- 17 (4) Purchase price of shares of stock, or fractional interests
- 18 therein, of the employing company, or of a company owning the
- 19 majority of the issued and outstanding stock of the employing
- 20 company, whether purchased from such company, in the open
- 21 market or otherwise. However, if such shares are to be purchased
- 22 on installments pursuant to a written purchase agreement, the
- 23 employee has the right under the purchase agreement at any time
- 24 before completing purchase of such shares to cancel said
- 25 agreement and to have repaid promptly the amount of all
- 26 installment payments which theretofore have been made.
- 27 (5) Dues to become owing by the employee to a labor
- 28 organization of which the employee is a member.
- 29 (6) Purchase price of merchandise sold by the employer to the
- 30 employee, at the written request of the employee.
- 31 (7) Amount of a loan made to the employee by the employer and
- 32 evidenced by a written instrument executed by the employee.
- 33 (8) Contributions, assessments, or dues of the employee to a
- 34 hospital service or a surgical or medical expense plan or to an
- 35 employees' association, trust, or plan existing for the purpose of
- 36 paying pensions or other benefits to said employee or to others
- 37 designated by the employee.
- 38 (9) Payment to any credit union, nonprofit organizations, or
- 39 associations of employees of such employer organized under any
- 40 law of this state or of the United States.
- 41 (10) Payment to any person or organization regulated under the
- 42 Uniform Consumer Credit Code (IC 24-4.5) for deposit or credit

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1 to the employee's account by electronic transfer or as otherwise
2 designated by the employee.

3 (11) Premiums on policies of insurance and annuities purchased
4 by the employee on the employee's life.

5 (12) The purchase price of shares or fractional interest in shares
6 in one (1) or more mutual funds.

7 SECTION 3. IC 27-1-23-1 IS AMENDED TO READ AS
8 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. As used in this
9 chapter, the following terms shall have the respective meanings set
10 forth in this section, unless the context shall otherwise require:

11 (a) An "acquiring party" is the specific person by whom an
12 acquisition of control of a domestic insurer or of any corporation
13 controlling a domestic insurer is to be effected, and each person who
14 directly, or indirectly through one (1) or more intermediaries, controls
15 the person specified.

16 (b) An "affiliate" of, or person "affiliated" with, a specific person,
17 is a person that directly, or indirectly through one (1) or more
18 intermediaries, controls, or is controlled by, or is under common
19 control with, the person specified.

20 (c) A "beneficial owner" of a voting security includes any person
21 who, directly or indirectly, through any contract, arrangement,
22 understanding, relationship, revocable or irrevocable proxy, or
23 otherwise has or shares:

24 (1) voting power including the power to vote, or to direct the
25 voting of, the security; or

26 (2) investment power which includes the power to dispose, or to
27 direct the disposition, of the security.

28 (d) "Commissioner" means the insurance commissioner of this state.

29 (e) "Control" (including the terms "controlling", "controlled by", and
30 "under common control with") means the possession, direct or indirect,
31 of the power to direct or cause the direction of the management and
32 policies of a person, whether through the beneficial ownership of
33 voting securities, by contract other than a commercial contract for
34 goods or nonmanagement services, or otherwise, unless the power is
35 the result of an official position or corporate office. Control shall be
36 presumed to exist if any person beneficially owns ten percent (10%) or
37 more of the voting securities of any other person. The commissioner
38 may determine this presumption has been rebutted only by a showing
39 made in the manner provided by section 3(k) of this chapter that
40 control does not exist in fact, after giving all interested persons notice
41 and an opportunity to be heard. Control shall be presumed again to
42 exist upon the acquisition of beneficial ownership of each additional



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1 five percent (5%) or more of the voting securities of the other person.
 2 The commissioner may determine, after furnishing all persons in
 3 interest notice and opportunity to be heard, that control exists in fact,
 4 notwithstanding the absence of a presumption to that effect.

5 (f) "Department" means the department of insurance created by
 6 IC 27-1-1-1.

7 (g) A "domestic insurer" is an insurer organized under the laws of
 8 this state.

9 (h) "Earned surplus" means an amount equal to the unassigned
 10 funds of an insurer as set forth in the most recent annual statement of
 11 an insurer that is submitted to the commissioner, excluding surplus
 12 arising from unrealized capital gains or revaluation of assets.

13 (i) An "insurance holding company system" consists of two (2) or
 14 more affiliated persons, one (1) or more of which is an insurer.

15 (j) "Insurer" has the same meaning as set forth in IC 27-1-2-3,
 16 except that it does not include:

17 (1) agencies, authorities, or instrumentalities of the United States,
 18 its possessions and territories, the Commonwealth of Puerto Rico,
 19 the District of Columbia, or a state or political subdivision of a
 20 state;

21 (2) fraternal benefit societies; or

22 (3) nonprofit medical and hospital service associations.

23 **The term includes a health maintenance organization (as defined**
 24 **in IC 27-13-1-19) and a limited service health maintenance**
 25 **organization (as defined in IC 27-13-1-27).**

26 (k) A "person" is an individual, a corporation, a limited liability
 27 company, a partnership, an association, a joint stock company, a trust,
 28 an unincorporated organization, any similar entity or any combination
 29 of the foregoing acting in concert, but shall not include any securities
 30 broker performing no more than the usual and customary broker's
 31 function.

32 (l) A "policyholder" of a domestic insurer includes any person who
 33 owns an insurance policy or annuity contract issued by the domestic
 34 insurer, any person reinsured by the domestic insurer under a
 35 reinsurance contract or treaty between the person and the domestic
 36 insurer, and any health maintenance organization with which the
 37 domestic insurer has contracted to provide services or protection
 38 against the cost of care.

39 (m) A "subsidiary" of a specified person is an affiliate controlled by
 40 that person directly or indirectly through one or more intermediaries.

41 (n) "Surplus" means the total of gross paid in and contributed
 42 surplus, special surplus funds, and unassigned surplus, less treasury



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stock at cost.

(o) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

SECTION 4. IC 27-4-1-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

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- 1 (4) Entering into any agreement to commit, or individually or by
2 a concerted action committing any act of boycott, coercion, or
3 intimidation resulting or tending to result in unreasonable
4 restraint of, or a monopoly in, the business of insurance.
- 5 (5) Filing with any supervisory or other public official, or making,
6 publishing, disseminating, circulating, or delivering to any person,
7 or placing before the public, or causing directly or indirectly, to
8 be made, published, disseminated, circulated, delivered to any
9 person, or placed before the public, any false statement of
10 financial condition of an insurer with intent to deceive. Making
11 any false entry in any book, report, or statement of any insurer
12 with intent to deceive any agent or examiner lawfully appointed
13 to examine into its condition or into any of its affairs, or any
14 public official to which such insurer is required by law to report,
15 or which has authority by law to examine into its condition or into
16 any of its affairs, or, with like intent, willfully omitting to make a
17 true entry of any material fact pertaining to the business of such
18 insurer in any book, report, or statement of such insurer.
- 19 (6) Issuing or delivering or permitting agents, officers, or
20 employees to issue or deliver, agency company stock or other
21 capital stock, or benefit certificates or shares in any common law
22 corporation, or securities or any special or advisory board
23 contracts or other contracts of any kind promising returns and
24 profits as an inducement to insurance.
- 25 (7) Making or permitting any of the following:
- 26 (A) Unfair discrimination between individuals of the same
27 class and equal expectation of life in the rates or assessments
28 charged for any contract of life insurance or of life annuity or
29 in the dividends or other benefits payable thereon, or in any
30 other of the terms and conditions of such contract; however, in
31 determining the class, consideration may be given to the
32 nature of the risk, plan of insurance, the actual or expected
33 expense of conducting the business, or any other relevant
34 factor.
- 35 (B) Unfair discrimination between individuals of the same
36 class involving essentially the same hazards in the amount of
37 premium, policy fees, assessments, or rates charged or made
38 for any policy or contract of accident or health insurance or in
39 the benefits payable thereunder, or in any of the terms or
40 conditions of such contract, or in any other manner whatever;
41 however, in determining the class, consideration may be given
42 to the nature of the risk, the plan of insurance, the actual or

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1 expected expense of conducting the business, or any other
2 relevant factor.

3 (C) Excessive or inadequate charges for premiums, policy
4 fees, assessments, or rates, or making or permitting any unfair
5 discrimination between persons of the same class involving
6 essentially the same hazards, in the amount of premiums,
7 policy fees, assessments, or rates charged or made for:

8 (i) policies or contracts of reinsurance or joint reinsurance,
9 or abstract and title insurance;

10 (ii) policies or contracts of insurance against loss or damage
11 to aircraft, or against liability arising out of the ownership,
12 maintenance, or use of any aircraft, or of vessels or craft,
13 their cargoes, marine builders' risks, marine protection and
14 indemnity, or other risks commonly insured under marine,
15 as distinguished from inland marine, insurance; or

16 (iii) policies or contracts of any other kind or kinds of
17 insurance whatsoever.

18 However, nothing contained in clause (C) shall be construed to
19 apply to any of the kinds of insurance referred to in clauses (A)
20 and (B) nor to reinsurance in relation to such kinds of insurance.
21 Nothing in clause (A), (B), or (C) shall be construed as making or
22 permitting any excessive, inadequate, or unfairly discriminatory
23 charge or rate or any charge or rate determined by the department
24 or commissioner to meet the requirements of any other insurance
25 rate regulatory law of this state.

26 (8) Except as otherwise expressly provided by law, knowingly
27 permitting or offering to make or making any contract or policy
28 of insurance of any kind or kinds whatsoever, including but not in
29 limitation, life annuities, or agreement as to such contract or
30 policy other than as plainly expressed in such contract or policy
31 issued thereon, or paying or allowing, or giving or offering to pay,
32 allow, or give, directly or indirectly, as inducement to such
33 insurance, or annuity, any rebate of premiums payable on the
34 contract, or any special favor or advantage in the dividends,
35 savings, or other benefits thereon, or any valuable consideration
36 or inducement whatever not specified in the contract or policy; or
37 giving, or selling, or purchasing or offering to give, sell, or
38 purchase as inducement to such insurance or annuity or in
39 connection therewith, any stocks, bonds, or other securities of any
40 insurance company or other corporation, association, limited
41 liability company, or partnership, or any dividends, savings, or
42 profits accrued thereon, or anything of value whatsoever not

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1 specified in the contract. Nothing in this subdivision and
 2 subdivision (7) shall be construed as including within the
 3 definition of discrimination or rebates any of the following
 4 practices:

5 (A) Paying bonuses to policyholders or otherwise abating their
 6 premiums in whole or in part out of surplus accumulated from
 7 nonparticipating insurance, so long as any such bonuses or
 8 abatement of premiums are fair and equitable to policyholders
 9 and for the best interests of the company and its policyholders.

10 (B) In the case of life insurance policies issued on the
 11 industrial debit plan, making allowance to policyholders who
 12 have continuously for a specified period made premium
 13 payments directly to an office of the insurer in an amount
 14 which fairly represents the saving in collection expense.

15 (C) Readjustment of the rate of premium for a group insurance
 16 policy based on the loss or expense experience thereunder, at
 17 the end of the first year or of any subsequent year of insurance
 18 thereunder, which may be made retroactive only for such
 19 policy year.

20 (D) Paying by an insurer or agent thereof duly licensed as such
 21 under the laws of this state of money, commission, or
 22 brokerage, or giving or allowing by an insurer or such licensed
 23 agent thereof anything of value, for or on account of the
 24 solicitation or negotiation of policies or other contracts of any
 25 kind or kinds, to a broker, agent, or solicitor duly licensed
 26 under the laws of this state, but such broker, agent, or solicitor
 27 receiving such consideration shall not pay, give, or allow
 28 credit for such consideration as received in whole or in part,
 29 directly or indirectly, to the insured by way of rebate.

30 (9) Requiring, as a condition precedent to loaning money upon the
 31 security of a mortgage upon real property, that the owner of the
 32 property to whom the money is to be loaned negotiate any policy
 33 of insurance covering such real property through a particular
 34 insurance agent or broker or brokers. However, this subdivision
 35 shall not prevent the exercise by any lender of its or his right to
 36 approve or disapprove of the insurance company selected by the
 37 borrower to underwrite the insurance.

38 (10) Entering into any contract, combination in the form of a trust
 39 or otherwise, or conspiracy in restraint of commerce in the
 40 business of insurance.

41 (11) Monopolizing or attempting to monopolize or combining or
 42 conspiring with any other person or persons to monopolize any

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1 part of commerce in the business of insurance. However,
2 participation as a member, director, or officer in the activities of
3 any nonprofit organization of agents or other workers in the
4 insurance business shall not be interpreted, in itself, to constitute
5 a combination in restraint of trade or as combining to create a
6 monopoly as provided in this subdivision and subdivision (10).
7 The enumeration in this chapter of specific unfair methods of
8 competition and unfair or deceptive acts and practices in the
9 business of insurance is not exclusive or restrictive or intended to
10 limit the powers of the commissioner or department or of any
11 court of review under section 8 of this chapter.

12 (12) Requiring as a condition precedent to the sale of real or
13 personal property under any contract of sale, conditional sales
14 contract, or other similar instrument or upon the security of a
15 chattel mortgage, that the buyer of such property negotiate any
16 policy of insurance covering such property through a particular
17 insurance company, agent, or broker or brokers. However, this
18 subdivision shall not prevent the exercise by any seller of such
19 property or the one making a loan thereon, of his, her, or its right
20 to approve or disapprove of the insurance company selected by
21 the buyer to underwrite the insurance.

22 (13) Issuing, offering, or participating in a plan to issue or offer,
23 any policy or certificate of insurance of any kind or character as
24 an inducement to the purchase of any property, real, personal, or
25 mixed, or services of any kind, where a charge to the insured is
26 not made for and on account of such policy or certificate of
27 insurance. However, this subdivision shall not apply to any of the
28 following:

29 (A) Insurance issued to credit unions or members of credit
30 unions in connection with the purchase of shares in such credit
31 unions.

32 (B) Insurance employed as a means of guaranteeing the
33 performance of goods and designed to benefit the purchasers
34 or users of such goods.

35 (C) Title insurance.

36 (D) Insurance written in connection with an indebtedness and
37 intended as a means of repaying such indebtedness in the
38 event of the death or disability of the insured.

39 (E) Insurance provided by or through motorists service clubs
40 or associations.

41 (F) Insurance that is provided to the purchaser or holder of an
42 air transportation ticket and that:

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- 1 (i) insures against death or nonfatal injury that occurs during
- 2 the flight to which the ticket relates;
- 3 (ii) insures against personal injury or property damage that
- 4 occurs during travel to or from the airport in a common
- 5 carrier immediately before or after the flight;
- 6 (iii) insures against baggage loss during the flight to which
- 7 the ticket relates; or
- 8 (iv) insures against a flight cancellation to which the ticket
- 9 relates.
- 10 (14) Refusing, because of the for-profit status of a hospital or
- 11 medical facility, to make payments otherwise required to be made
- 12 under a contract or policy of insurance for charges incurred by an
- 13 insured in such a for-profit hospital or other for-profit medical
- 14 facility licensed by the state department of health.
- 15 (15) Refusing to insure an individual, refusing to continue to issue
- 16 insurance to an individual, limiting the amount, extent, or kind of
- 17 coverage available to an individual, or charging an individual a
- 18 different rate for the same coverage, solely because of that
- 19 individual's blindness or partial blindness, except where the
- 20 refusal, limitation, or rate differential is based on sound actuarial
- 21 principles or is related to actual or reasonably anticipated
- 22 experience.
- 23 (16) Committing or performing, with such frequency as to
- 24 indicate a general practice, unfair claim settlement practices (as
- 25 defined in section 4.5 of this chapter).
- 26 (17) Between policy renewal dates, unilaterally canceling an
- 27 individual's coverage under an individual or group health
- 28 insurance policy solely because of the individual's medical or
- 29 physical condition.
- 30 (18) Using a policy form or rider that would permit a cancellation
- 31 of coverage as described in subdivision (17).
- 32 (19) Violating IC 27-1-22-25 or IC 27-1-22-26 concerning motor
- 33 vehicle insurance rates.
- 34 (20) Violating IC 27-8-21-2 concerning advertisements referring
- 35 to interest rate guarantees.
- 36 (21) Violating IC 27-8-24.3 concerning insurance and health plan
- 37 coverage for victims of abuse.
- 38 (22) Violating IC 27-1-15.5-3(h).
- 39 (23) Violating IC 27-8-26 concerning genetic screening or testing.
- 40 **(24) Violating IC 27-8-17.5 concerning preauthorization.**

41 SECTION 5. IC 27-4-1-6 IS AMENDED TO READ AS FOLLOWS
 42 [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) If after a hearing under

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1 IC 4-21.5-3, the commissioner determines that the method of
 2 competition or the act or practice in question is defined in section 4 of
 3 this chapter and that the person complained of has engaged in such
 4 method of competition, act, or practice in violation of this chapter, he
 5 shall reduce his findings to writing and shall issue and cause to be
 6 served on the person charged with the violation an order requiring such
 7 person to cease and desist from such method of competition, act, or
 8 practice, and the commissioner may at his discretion order one (1) or
 9 more of the following:

10 (1) Payment of a civil penalty of not more than twenty-five
 11 thousand dollars (\$25,000) for each act or violation ~~but. not to~~
 12 ~~exceed an aggregate penalty of one hundred thousand dollars~~
 13 ~~(\$100,000) in any twelve (12) month period unless~~ **If** the person
 14 knew or reasonably should have known that he was in violation
 15 of this chapter, ~~in which case~~ the penalty may be not more than
 16 fifty thousand dollars (\$50,000) for each act or violation ~~but not~~
 17 ~~to exceed an aggregate penalty of two hundred thousand dollars~~
 18 ~~(\$200,000) in any twelve (12) month period.~~

19 (2) Suspension or revocation of the person's license, or certificate
 20 of authority, if he knew or reasonably should have known he was
 21 in violation of this chapter.

22 **(b) In determining the amount of a civil penalty under**
 23 **subsection (a)(1), the commissioner shall consider the remediation**
 24 **efforts undertaken by the person.**

25 ~~(b)~~ (c) All civil penalties imposed and collected under this section
 26 shall be deposited in the state general fund.

27 SECTION 6. IC 27-7-12 IS ADDED TO THE INDIANA CODE AS
 28 A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 29 JANUARY 1, 2001]:

30 **Chapter 12. Termination of Residential Policies**

31 **Sec. 1. (a) This chapter applies to policies of insurance covering**
 32 **risks to property located in Indiana that take effect or are renewed**
 33 **after June 30, 2000, and that insure loss of or damage to:**

34 (1) real property consisting of not more than four (4)
 35 residential units, one (1) of which is the principal place of
 36 residence of the named insured; or

37 (2) personal property in which the named insured has an
 38 insurable interest where the personal property is:

39 (A) used for personal, family, or household purposes; and

40 (B) within a residential dwelling.

41 **(b) This chapter does not apply to the following:**

42 (1) A policy of inland marine insurance.



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1 (2) The cancellation or nonrenewal of an automobile
2 insurance policy under IC 27-7-6.

3 (3) The cancellation or nonrenewal of a commercial property
4 and casualty insurance policy under IC 27-1-31-2.5.

5 Sec. 2. (a) As used in this chapter, "cancellation" or "cancelled"
6 means a termination of property insurance coverage that occurs
7 during the policy term.

8 (b) As used in this chapter, "nonpayment of premium" means
9 the failure of the named insured to discharge any obligation in
10 connection with the payment of premiums on policies of insurance
11 subject to this chapter, regardless of whether the payments are
12 directly payable to the insurer or its agent or indirectly payable
13 under a premium finance plan or extension of credit. The term
14 includes the failure to pay dues or fees where payment of the dues
15 or fees is a prerequisite to obtaining or continuing property
16 insurance coverage.

17 (c) As used in this chapter, "nonrenewal" or "nonrenewed"
18 means a termination of property insurance coverage that occurs at
19 the end of the policy term.

20 (d) As used in this chapter, "renewal" or "to renew" means the
21 issuance and delivery by an insurer at the end of a policy period of
22 a policy superseding a policy previously issued and delivered by the
23 same insurer, or the issuance and delivery of a certificate or notice
24 extending the term of an existing policy beyond its policy period or
25 term.

26 (e) As used in this chapter, "termination" means a cancellation
27 or nonrenewal. The term does not include:

- 28 (1) the requirement of a reasonable deductible;
 - 29 (2) reasonable changes in the amount of insurance; or
 - 30 (3) reasonable reductions in policy limits or coverage;
- 31 if the requirements or changes are directly related to the hazard
32 involved and are made on the renewal date for the policy.

33 Sec. 3. (a) Notice of cancellation of property insurance coverage
34 by an insurer must:

- 35 (1) be in writing;
- 36 (2) be delivered or mailed to the named insured at the last
37 known address of the named insured;
- 38 (3) state the effective date of the cancellation; and
- 39 (4) be accompanied by a written explanation of the specific
40 reasons for the cancellation.

41 (b) An insurer shall provide written notice of cancellation to the
42 named insured at least:

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- 1 **(1) twenty (20) days before canceling a policy, if the**
- 2 **cancellation occurs more than sixty (60) days after the date of**
- 3 **issuance of the policy;**
- 4 **(2) ten (10) days before canceling a policy, if the cancellation**
- 5 **is for nonpayment of a premium; and**
- 6 **(3) ten (10) days before canceling a policy, if the cancellation**
- 7 **occurs sixty (60) days or less after the date of issuance of the**
- 8 **policy.**

9 **(c) If the policy was procured by an independent agent licensed**
 10 **in Indiana, the insurer shall deliver or mail notice of cancellation**
 11 **to the agent not less than ten (10) days before the insurer delivers**
 12 **or mails the notice to the named insured, unless the obligation to**
 13 **notify the agent is waived in writing by the agent.**

14 **Sec. 4. (a) Notice of nonrenewal by an insurer must:**

- 15 **(1) be in writing;**
- 16 **(2) be delivered or mailed to the named insured at the last**
- 17 **known address of the named insured;**
- 18 **(3) state the insurer's intention not to renew the policy upon**
- 19 **expiration of the current policy period;**
- 20 **(4) be accompanied by a written explanation of the reasons**
- 21 **for the nonrenewal; and**
- 22 **(5) be provided to the named insured at least twenty (20) days**
- 23 **before the expiration of the current policy period.**

24 **(b) If the policy was procured by an independent agent licensed**
 25 **in Indiana, the insurer shall deliver or mail notice of nonrenewal**
 26 **to the agent not less than ten (10) days before the insurer delivers**
 27 **or mails the notice to the named insured, unless the obligation to**
 28 **notify the agent is waived in writing by the agent.**

29 **(c) If an insurer mails or delivers to an insured a renewal notice,**
 30 **bill, certificate, or policy indicating the insurer's willingness to**
 31 **renew a policy and the insured does not respond, the insurer is not**
 32 **required to provide to the insured notice of intention not to renew.**

33 **Sec. 5. (a) The explanation that is required under sections 3 and**
 34 **4 of this chapter must be sufficiently clear so that a reasonable**
 35 **layperson can identify the basis for the insurer's decision without**
 36 **further inquiry.**

37 **(b) If notice is not provided under section 4 of this chapter,**
 38 **coverage is considered to be renewed for the ensuing policy period**
 39 **upon payment of the appropriate premiums under the same terms**
 40 **and conditions, and subject to section 6 of this chapter, until the**
 41 **named insured has accepted replacement coverage with another**
 42 **insurer or until the named insured has agreed to the nonrenewal.**

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1 **Sec. 6. After coverage has been in effect for more than sixty (60)**
2 **days or after the effective date of a renewal policy, a notice of**
3 **cancellation shall not be issued unless cancellation is based on at**
4 **least one (1) of the following:**

- 5 **(1) Nonpayment of a premium.**
- 6 **(2) Discovery of fraud or material misrepresentation made by**
7 **or with the knowledge of the named insured in obtaining the**
8 **policy, continuing the policy, or in presenting a claim under**
9 **the policy.**
- 10 **(3) Discovery of willful or reckless acts or omissions on the**
11 **part of the named insured that increase a hazard insured**
12 **against.**
- 13 **(4) The occurrence of a change in the risk that substantially**
14 **increases a hazard insured against after insurance coverage**
15 **has been issued or renewed.**
- 16 **(5) A violation of any local fire, health, safety, building, or**
17 **construction regulation or ordinance with respect to an**
18 **insured property or the occupancy of the property that**
19 **substantially increases any hazard insured against.**
- 20 **(6) A determination by the commissioner of the department**
21 **of insurance that the continuation of the policy would place**
22 **the insurer in violation of the insurance laws of Indiana.**
- 23 **(7) Real property taxes owing on the insured property have**
24 **been delinquent for two (2) or more years and continue to be**
25 **delinquent at the time notice of cancellation is issued.**

26 **Sec. 7. Termination of property insurance coverage by an**
27 **insurer is prohibited if the termination is based on any of the**
28 **following:**

- 29 **(1) Upon the race, religion, nationality, ethnic group, age, sex,**
30 **or marital status of the applicant or named insured.**
- 31 **(2) Solely upon the lawful occupation or profession of the**
32 **applicant or named insured. However, this provision does not**
33 **apply to an insurer that limits its market to one (1) lawful**
34 **occupation or profession or to several related lawful**
35 **occupations or professions.**
- 36 **(3) Upon the age or location of the residence of the applicant**
37 **or named insured, unless that decision is for a business**
38 **purpose that is not a mere pretext for a decision based on**
39 **factors prohibited in this chapter or any other provision of**
40 **this title.**
- 41 **(4) Upon the fact that another insurer previously declined to**
42 **insure the applicant or terminated an existing policy in which**

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the applicant was the named insured.

(5) Upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

Sec. 8. The named insured must be given notice of a transfer of a policy, including a transfer between insurers within the same insurance group. The notice must:

- (1) be in writing;
- (2) be delivered or mailed to the named insured at the last known address of the named insured;
- (3) be provided to the named insured at least twenty (20) days before the transfer; and
- (4) identify the insurer to which the policy will be transferred.

Sec. 9. (a) The following persons are immune from civil liability for any communication giving notice of or specifying the reasons for a termination or for any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for a termination under this chapter:

- (1) Employees of the department of insurance.
- (2) An insurer or its authorized representative, agent, or employee.
- (3) A licensed insurance agent.
- (4) A person furnishing information to an insurer as to reasons for a termination.

(b) This section does not apply to statements made in bad faith with malice in fact.

SECTION 7. IC 27-7-13 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2001]:

Chapter 13. Required Notice of Flood Coverage in a Residential Policy

Sec. 1. (a) This chapter applies to policies of insurance covering risks to property located in Indiana that are issued or renewed after December 31, 2000, and that insure loss of or damage to:

- (1) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or
- (2) personal property in which the named insured has an insurable interest where the personal property is:
 - (A) used for personal, family, or household purposes; and
 - (B) within a residential dwelling.

(b) This chapter does not apply to the following:

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- (1) A policy of inland marine insurance.
- (2) An automobile insurance policy under IC 27-7-6.
- (3) A commercial property and casualty insurance policy under IC 27-1-31.

Sec. 2. If a policy of insurance described in section 1 of this chapter does not provide coverage for flood damage, the policyholder must be given written notice when the policy is issued or upon the first renewal after December 31, 2000, that coverage for flood damage may be available through the National Flood Insurance Program.

SECTION 8. IC 27-8-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with the commissioner. This section is applicable also to assessment companies and fraternal benefit associations or societies.

(c) No policy of accident and sickness insurance may be issued, nor may any application, rider, or endorsement be used in connection with a policy of accident and sickness insurance, until the expiration of thirty (30) days after it has been filed under subsection (b), unless the commissioner gives his written approval to it before the expiration of the thirty (30) day period.

(d) The commissioner may, within thirty (30) days after the filing of any form under subsection (b), disapprove the form:

- (1) if, in the case of an individual accident and sickness form, the benefits provided therein are unreasonable in relation to the premium charged; or
- (2) if, in the case of an individual, blanket, or group accident and sickness form, it contains a provision or provisions that are unjust,

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1 unfair, inequitable, misleading, or deceptive or that encourage
2 misrepresentation of the policy.

3 (e) If the commissioner notifies the insurer that filed a form that the
4 form does not comply with this section, it is unlawful thereafter for the
5 insurer to issue the form or use it in connection with any policy. In the
6 notice given under this subsection, the commissioner shall specify the
7 reasons for his disapproval and state that a hearing will be granted
8 within twenty (20) days after request in writing by the insurer.

9 (f) The commissioner may at any time, after a hearing of which not
10 less than twenty (20) days written notice has been given to the insurer,
11 withdraw his approval of any form filed under subsection (b) on any of
12 the grounds stated in this section. It is unlawful for the insurer to issue
13 the form or use it in connection with any policy after the effective date
14 of the withdrawal of approval. The notice of any hearing called under
15 this subsection must specify the matters to be considered at the hearing,
16 and any decision affirming disapproval or directing withdrawal of
17 approval under this section must be in writing and must specify the
18 reasons for the decision.

19 (g) Any order or decision of the commissioner under this section is
20 subject to review under IC 4-21.5.

21 **(h) For purposes of this section, an insurer shall combine the**
22 **experience of all policies that are substantially similar with respect**
23 **to type and level of benefits and marketing method issued in this**
24 **state after their fifth duration to calculate uniform percentage rate**
25 **increases for such previously approved, substantially similar**
26 **medical expense insurance policy forms that have experience that**
27 **produces an anticipated lifetime loss ratio at least as high as that**
28 **stated in the actuarial memorandum filed when the policy form**
29 **was originally approved. Nothing in this subsection shall be**
30 **construed to require uniform rates for policies after their fifth**
31 **duration. The purpose of this law is to require uniform percentage**
32 **rate increases for such policies.**

33 SECTION 9. IC 27-8-17-12 IS AMENDED TO READ AS
34 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 12. (a) A utilization
35 review agent shall make available ~~upon request to an enrollee at the~~
36 **time an adverse utilization review determination is made:**

37 **(1) a written description of the appeals procedure by which an**
38 **enrollee or a provider of record may obtain a review of a appeal**
39 **the utilization review determination by the utilization review**
40 **agent; and**

41 **(2) in the case of an enrollee covered under an accident and**
42 **sickness policy or a health maintenance contract described in**

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1 **subsection (d), notice that the enrollee has the right to appeal**
2 **the utilization review determination under IC 27-8-28 or**
3 **IC 27-13-10 and the toll free phone number that the enrollee**
4 **may call to request a review of the determination or obtain**
5 **further information about the right to appeal.**

6 (b) The appeals procedure provided by a utilization review agent
7 must meet the following requirements:

8 (1) On appeal, the determination not to certify an admission, a
9 service, or a procedure as necessary or appropriate must be made
10 by a health care provider licensed in the same discipline as the
11 provider of record.

12 (2) The determination of the appeal of a utilization review
13 determination not to certify an admission, service, or procedure
14 must be completed within thirty (30) days after:

- 15 (A) the appeal is filed; and
- 16 (B) all information necessary to complete the appeal is
17 received.

18 (c) A utilization review agent shall provide an expedited appeals
19 process for emergency or life threatening situations. The determination
20 of an expedited appeal under the process required by this subsection
21 shall be made by a physician and completed within forty-eight (48)
22 hours after:

- 23 (1) the appeal is initiated; and
- 24 (2) all information necessary to complete the appeal is received
25 by the utilization review agent.

26 **(d) If an enrollee is covered under an accident and sickness**
27 **insurance policy (as defined in IC 27-8-28) or a contract issued by**
28 **a health maintenance organization (as defined in IC 27-13-1-19),**
29 **the enrollee's exclusive right to appeal a utilization review**
30 **determination is provided under IC 27-8-28 or IC 27-13-10,**
31 **respectively.**

32 **(e) A utilization review agent shall make available upon request**
33 **a written description of the appeals procedure that an enrollee or**
34 **provider of record may use to obtain a review of a utilization**
35 **review determination by the utilization review agent.**

36 SECTION 10. IC 27-8-17.5 IS ADDED TO THE INDIANA CODE
37 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
38 JANUARY 1, 2001]:

39 **Chapter 17.5. Certification**

40 **Sec. 1. As used in this chapter, "certification" means a**
41 **determination by an insurer or a utilization review agent that the**
42 **proposed provision of health care services has been reviewed, and**

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based on the information provided, meets the health insurance plan's requirements for medical necessity, appropriateness, level of care, or effectiveness.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health insurance plan.

Sec. 3. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

Sec. 4. As used in this chapter, "health insurance plan" means coverage provided under any of the following:

- (1) A hospital or medical expense incurred policy or certificate.
- (2) A health maintenance organization subscriber contract.
- (3) An employer based health insurance arrangement.
- (4) An individual health insurance policy.
- (5) A policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.
- (6) An employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.
- (7) A conversion policy issued under IC 27-8-15-31 or IC 27-8-15-31.1.

Sec. 5. As used in this chapter, "insurer" means any person who provides coverage for health care services in Indiana. The term includes the following:

- (1) A licensed insurance company.
- (2) A health maintenance organization or limited service health maintenance organization.
- (3) A state employee health benefit plan under IC 5-10-8-7.
- (4) Any other person who provides coverage for health care services through a health insurance plan regulated under IC 27.
- (5) Any authorized representative or designee of the insurer.

Sec. 6. An insurer or a utilization review agent shall provide written or oral notification to the covered individual that certification does not guarantee payment of the proposed health care services. Oral notification shall be followed promptly by written notification to the covered individual. This notification shall be in addition to any notification requirements of IC 27-8-17-11.

SECTION 11. IC 27-8-28 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2001]:



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Chapter 28. Internal Grievance Procedures

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the kinds of insurance described in class 1(b) and 2(a) of IC 27-1-5-1.

(b) The term does not include the following:

- (1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.**
- (2) Coverage issued as a supplement to liability insurance.**
- (3) Automobile medical payment insurance.**
- (4) A specified disease policy issued as an individual policy.**
- (5) A limited benefit health insurance policy issued as an individual policy.**
- (6) A short term insurance plan that:**
 - (A) may not be renewed; and**
 - (B) has a duration of not more than six (6) months.**
- (7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.**
- (8) Worker's compensation or similar insurance.**

Sec. 2. As used in this chapter, "commissioner" refers to the commissioner of the Indiana department of insurance.

Sec. 3. As used in this chapter, "covered individual" means an individual who is covered under an accident and sickness insurance policy.

Sec. 4. As used in this chapter, "department" refers to the Indiana department of insurance.

Sec. 5. As used in this chapter, "external grievance" means the independent review under IC 27-8-29 of a grievance filed under this chapter.

Sec. 6. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding the:

- (1) appropriateness or medical necessity of health care services;**
- (2) availability of participating providers;**
- (3) handling or payment of claims for health care services; or**
- (4) matters pertaining to the contractual relationship between:**
 - (A) a covered individual and an insurer; or**
 - (B) a group policyholder and an insurer;**

and for which the covered individual has a reasonable expectation

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1 that action will be taken to resolve or reconsider the matter that is
2 the subject of dissatisfaction.

3 **Sec. 7.** As used in this chapter, "grievance procedure" means a
4 written procedure established and maintained by an insurer for
5 filing, investigating, and resolving grievances and appeals.

6 **Sec. 8.** As used in this chapter, "insured" means:

7 (1) an individual whose employment status or other status
8 except family dependency is the basis for coverage under a
9 group accident and sickness insurance policy; or

10 (2) in the case of an individual accident and sickness insurance
11 policy, the individual in whose name the policy is issued.

12 **Sec. 9.** As used in this chapter, "insurer" means any person who
13 delivers or issues for delivery an accident and sickness insurance
14 policy or certificate in Indiana.

15 **Sec. 10.** An insurer shall establish and maintain a grievance
16 procedure that complies with the requirements of this chapter for
17 the resolution of grievances initiated by a covered individual.

18 **Sec. 11.** The commissioner may examine the grievance
19 procedure of any insurer.

20 **Sec. 12.** An insurer shall maintain all grievance records received
21 by the insurer after the most recent examination of the insurer's
22 grievance procedure by the commissioner.

23 **Sec. 13. (a)** An insurer shall provide timely, adequate, and
24 appropriate notice to each insured of:

25 (1) the grievance procedure required under this chapter;

26 (2) the external grievance process required under IC 27-8-29;

27 (3) information on how to file:

28 (A) a grievance under this chapter; and

29 (B) a request for an external grievance review under
30 IC 27-8-29; and

31 (4) a toll free telephone number through which a covered
32 individual may contact the insurer at no cost to the covered
33 individual to obtain information and to file grievances.

34 (b) An insurer shall prominently display on all notices to
35 covered individuals the toll free telephone number and the address
36 at which a grievance or request for external grievance review may
37 be filed.

38 **Sec. 14. (a)** A covered individual may file a grievance orally or
39 in writing.

40 (b) An insurer shall make available to covered individuals a toll
41 free telephone number through which a grievance may be filed.
42 The toll free number must:



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- 1 (1) be staffed by a qualified representative of the insurer;
 2 (2) be available for at least forty (40) normal business hours
 3 per week; and
 4 (3) accept grievances in the languages of the major population
 5 groups served by the insurer.
 6 (c) A grievance is considered to be filed on the first date it is
 7 received, either by telephone or in writing.
 8 Sec. 15. (a) An insurer shall establish procedures to assist
 9 covered individuals in filing grievances.
 10 (b) A covered individual may designate a representative to file
 11 a grievance for the covered individual and to represent the covered
 12 individual in a grievance under this chapter.
 13 Sec. 16. (a) An insurer shall establish written policies and
 14 procedures for the timely resolution of grievances filed under this
 15 chapter. The policies and procedures must include the following:
 16 (1) An acknowledgment of the grievance, orally or in writing,
 17 to the covered individual within three (3) business days.
 18 (2) Documentation of the substance of the grievance and any
 19 actions taken.
 20 (3) An investigation of the substance of the grievance,
 21 including any aspects involving clinical care.
 22 (4) Notification to the covered individual of the disposition of
 23 the grievance and the right to appeal.
 24 (5) Standards for timeliness in:
 25 (A) responding to grievances; and
 26 (B) providing notice to covered individuals of:
 27 (i) the disposition of the grievance; and
 28 (ii) the right to appeal;
 29 that accommodates the clinical urgency of the situation.
 30 (b) An insurer shall appoint at least one (1) individual to resolve
 31 a grievance.
 32 (c) A grievance must be resolved as expeditiously as possible,
 33 but not more than twenty (20) business days after receiving all
 34 information reasonably necessary to complete the review. If an
 35 insurer is unable to make a decision regarding the grievance within
 36 the twenty (20) day period due to circumstances beyond the
 37 insurer's control, the insurer shall:
 38 (1) notify, before the twentieth business day, the covered
 39 individual in writing of the reason for the delay; and
 40 (2) issue a written decision regarding the grievance within an
 41 additional ten (10) business days.
 42 (d) An insurer shall notify a covered individual in writing of the



1 resolution of a grievance within five (5) business days after
 2 completing an investigation. The grievance resolution notice must
 3 include the following:

- 4 (1) The decision reached by the insurer.
 5 (2) The reasons, policies, and procedures that are the basis of
 6 the decision.
 7 (3) Notice of the covered individual's right to appeal the
 8 decision.
 9 (4) The department, address, and telephone number through
 10 which a covered individual may contact a qualified
 11 representative to obtain additional information about the
 12 decision or the right to appeal.

13 **Sec. 17. (a) An insurer shall establish written policies and**
 14 **procedures for the timely resolution of appeals of grievance**
 15 **decisions. The procedures for registering and responding to oral**
 16 **and written appeals of grievance decisions must include the**
 17 **following:**

- 18 (1) Written or oral acknowledgment of the appeal not more
 19 than three (3) business days after the appeal is filed.
 20 (2) Documentation of the substance of the appeal and the
 21 actions taken.
 22 (3) Investigation of the substance of the appeal, including any
 23 aspects of clinical care involved.
 24 (4) Notification to the covered individual:
 25 (A) of the disposition of an appeal; and
 26 (B) that the covered individual may have the right to
 27 further remedies allowed by law.
 28 (5) Standards for timeliness in:
 29 (A) responding to an appeal; and
 30 (B) providing notice to covered individuals of:
 31 (i) the disposition of an appeal; and
 32 (ii) the right to initiate an external grievance review
 33 under IC 27-8-29;

34 that accommodate the clinical urgency of the situation.

35 (b) In the case of an appeal of a grievance described in section
 36 6(1) of this chapter, an insurer shall appoint a panel of one (1) or
 37 more qualified individuals to resolve an appeal. The panel must
 38 include one (1) or more individuals who:

- 39 (1) have knowledge in the medical condition, procedure, or
 40 treatment at issue;
 41 (2) are licensed in the same profession as the provider who
 42 proposed, denied, or delivered the health care procedure,



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- 1 treatment, or service;
- 2 (3) are not involved in the matter giving rise to the appeal or
- 3 in the initial investigation of the grievance; and
- 4 (4) do not have a direct business relationship with the covered
- 5 individual or the health care provider who previously
- 6 recommended the health care procedure, treatment, or
- 7 service giving rise to the grievance.
- 8 (c) An appeal of a grievance decision must be resolved as
- 9 expeditiously as possible reflecting the clinical urgency of the
- 10 situation. However, an appeal must be resolved not later than
- 11 forty-five (45) days after the appeal is filed.
- 12 (d) An insurer shall allow a covered individual the opportunity
- 13 to:
- 14 (1) appear in person before; or
- 15 (2) if unable to appear in person, otherwise appropriately
- 16 communicate with;
- 17 the panel appointed under subsection (b).
- 18 (e) An insurer shall notify a covered individual in writing of the
- 19 resolution of an appeal of a grievance within five (5) business days
- 20 after completing the investigation. The appeal resolution notice
- 21 must include the following:
- 22 (1) The decision reached by the insurer.
- 23 (2) The reasons, policies, and procedures that are the basis of
- 24 the decision.
- 25 (3) Notice of the covered individual's right to further remedies
- 26 allowed by law, including the right to external grievance
- 27 review by an independent review organization under
- 28 IC 27-8-29.
- 29 (4) The department, address, and telephone number through
- 30 which a covered individual may contact a qualified
- 31 representative to obtain more information about the decision
- 32 or the right to an external grievance review.
- 33 **Sec. 18. An insurer may not take action against a provider solely**
- 34 **on the basis that the provider represents a covered individual in a**
- 35 **grievance filed under this chapter.**
- 36 **Sec. 19. (a) An insurer shall each year file with the**
- 37 **commissioner a description of the grievance procedure of the**
- 38 **insurer established under this chapter, including:**
- 39 (1) the total number of grievances handled through the
- 40 procedure during the preceding calendar year;
- 41 (2) a compilation of the causes underlying those grievances;
- 42 and

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- 1 **(3) a summary of the final disposition of those grievances.**
- 2 **(b) The information required by subsection (a) must be filed**
- 3 **with the commissioner on or before March 1 of each year. The**
- 4 **commissioner shall:**
- 5 **(1) make the information required to be filed under this**
- 6 **section available to the public; and**
- 7 **(2) prepare an annual compilation of the data required under**
- 8 **subsection (a) that allows for comparative analysis.**
- 9 **(c) The commissioner may require any additional reports as are**
- 10 **necessary and appropriate for the commissioner to carry out the**
- 11 **commissioner's duties under this article.**
- 12 **Sec. 20. The department may adopt rules under IC 4-22-2 to**
- 13 **implement this chapter.**
- 14 SECTION 12. IC 27-8-29 AS ADDED TO THE INDIANA CODE
- 15 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
- 16 JANUARY 1, 2001]:
- 17 **Chapter 29. External Review of Grievances**
- 18 **Sec. 1. As used in this chapter, "accident and sickness insurance**
- 19 **policy" has the meaning set forth in IC 27-8-28-1.**
- 20 **Sec. 2. As used in this chapter, "appeal" means the procedure**
- 21 **described in IC 27-8-28-17.**
- 22 **Sec. 3. As used in this chapter, "commissioner" refers to the**
- 23 **commissioner of the Indiana department of insurance.**
- 24 **Sec. 4. As used in this chapter, "covered individual" has the**
- 25 **meaning set forth in IC 27-8-28-3.**
- 26 **Sec. 5. As used in this chapter, "department" refers to the**
- 27 **Indiana department of insurance.**
- 28 **Sec. 6. As used in this chapter, "external grievance" means the**
- 29 **independent review under this chapter of a grievance filed under**
- 30 **IC 27-8-28.**
- 31 **Sec. 7. As used in this chapter, "grievance" has the meaning set**
- 32 **forth in IC 27-8-28-6.**
- 33 **Sec. 8. As used in this chapter, "grievance procedure" has the**
- 34 **meaning set forth in IC 27-8-28-7.**
- 35 **Sec. 9. As used in this chapter, "insured" has the meaning set**
- 36 **forth in IC 27-8-28-8.**
- 37 **Sec. 10. As used in this chapter, "insurer" has the meaning set**
- 38 **forth in IC 27-8-28-9.**
- 39 **Sec. 11. An insurer shall establish and maintain an external**
- 40 **grievance procedure for the resolution of external grievances**
- 41 **regarding:**
- 42 **(1) an adverse determination of appropriateness;**

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- 1 (2) an adverse determination of medical necessity; or
- 2 (3) a determination that a proposed service is experimental or
- 3 investigational;
- 4 **made by an insurer or an agent of an insurer regarding a service**
- 5 **proposed by the treating physician.**

6 **Sec. 12. (a) An external grievance procedure established under**
 7 **section 11 of this chapter must:**

- 8 (1) allow a covered individual or a covered individual's
- 9 representative to file a written request with the insurer for an
- 10 external grievance review of the insurer's appeal resolution
- 11 under IC 27-8-28-17 not more than forty-five (45) days after
- 12 the covered individual is notified of the resolution; and

- 13 (2) provide for:
 - 14 (A) an expedited external grievance review for a grievance
 - 15 related to an illness, disease, condition, injury, or a
 - 16 disability that would seriously jeopardize the covered
 - 17 individual's:
 - 18 (i) life or health; or
 - 19 (ii) ability to reach and maintain maximum function; or
 - 20 (B) a standard external grievance review for a grievance
 - 21 not described in clause (A).

22 **A covered individual may file not more than one (1) external**
 23 **grievance of an insurer's appeal resolution under this chapter.**

24 **(b) Subject to the requirements of subsection (d), when a request**
 25 **is filed under subsection (a), the insurer shall:**

- 26 (1) select a different independent review organization for each
- 27 external grievance filed under this chapter from the list of
- 28 independent review organizations that are certified by the
- 29 department under section 18 of this chapter; and
- 30 (2) rotate the choice of an independent review organization
- 31 among all certified independent review organizations before
- 32 repeating a selection.

33 **(c) The independent review organization chosen under**
 34 **subsection (b) shall assign a medical review professional who is**
 35 **board certified in the applicable specialty for resolution of an**
 36 **external grievance.**

37 **(d) The independent review organization and the medical review**
 38 **professional conducting the external review under this chapter**
 39 **may not have a material professional, familial, financial, or other**
 40 **affiliation with any of the following:**

- 41 (1) The insurer.
- 42 (2) Any officer, director, or management employee of the

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- 1 insurer.
- 2 (3) The physician or the physician's medical group that is
- 3 proposing the service.
- 4 (4) The facility at which the service would be provided.
- 5 (5) The development or manufacture of the principal drug,
- 6 device, procedure, or other therapy that is proposed by the
- 7 treating physician.
- 8 (6) The covered individual requesting the external grievance
- 9 review.
- 10 (e) A covered individual may be required to pay not more than
- 11 twenty-five dollars (\$25) of the costs associated with the services of
- 12 an independent review organization under this chapter. All
- 13 additional costs must be paid by the insurer.
- 14 **Sec. 13. (a) A covered individual who files an external grievance**
- 15 **under this chapter shall:**
 - 16 (1) not be subject to retaliation for exercising the covered
 - 17 individual's right to an external grievance under this chapter;
 - 18 (2) be permitted to utilize the assistance of other individuals,
 - 19 including physicians, attorneys, friends, and family members
 - 20 throughout the review process;
 - 21 (3) be permitted to submit additional information relating to
 - 22 the proposed service throughout the review process; and
 - 23 (4) cooperate with the independent review organization by:
 - 24 (A) providing any requested medical information; or
 - 25 (B) authorizing the release of necessary medical
 - 26 information.
- 27 (b) An insurer shall cooperate with an independent review
- 28 organization selected under section 12(b) of this chapter by
- 29 promptly providing any information requested by the independent
- 30 review organization.
- 31 **Sec. 14. (a) An independent review organization shall:**
 - 32 (1) for an expedited external grievance filed under section
 - 33 12(a)(2)(A) of this chapter, within seventy-two (72) hours
 - 34 after the external grievance is filed; or
 - 35 (2) for a standard appeal filed under section 12(a)(2)(B) of this
 - 36 chapter, within fifteen (15) business days after the appeal is
 - 37 filed;
 - 38 make a determination to uphold or reverse the insurer's appeal
 - 39 resolution under IC 27-8-28-17 based on information gathered
 - 40 from the covered individual or the covered individual's designee,
 - 41 the insurer, and the treating physician, and any additional
 - 42 information that the independent review organization considers

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1 necessary and appropriate.

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

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

6 (2) the terms of the covered individual's accident and sickness
7 insurance policy.

8 (c) The independent review organization shall notify the insurer
9 and the covered individual of the determination made under this
10 section:

11 (1) for an expedited external grievance filed under section
12 12(a)(2)(A) of this chapter, within twenty-four (24) hours
13 after making the determination; and

14 (2) for a standard external grievance filed under section
15 12(a)(2)(B) of this chapter, within seventy-two (72) hours after
16 making the determination.

17 **Sec. 15.** A determination made under section 14 of this chapter
18 is binding on the insurer.

19 **Sec. 16.** (a) If at any time during an external review performed
20 under this chapter, the covered individual submits information to
21 the insurer that is relevant to the insurer's resolution under
22 IC 27-8-28-17 and was not considered by the insurer under
23 IC 27-8-28:

24 (1) the insurer shall reconsider the resolution under
25 IC 27-8-28-17; and

26 (2) the independent review organization shall cease the
27 external review process until the reconsideration under
28 subsection (b) is completed.

29 (b) An insurer to which information is submitted under
30 subsection (a) shall reconsider the resolution under IC 27-8-28-17
31 based on the information and notify the covered individual of the
32 insurer's decision:

33 (1) within seventy-two (72) hours after the information is
34 submitted for a reconsideration related to an illness, disease,
35 condition, injury, or disability that would seriously jeopardize
36 the covered individual's:

37 (A) life or health; or

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

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

41 (c) If the decision reached under subsection (b) is adverse to the
42 covered individual, the covered individual may request that the

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1 independent review organization resume the external review under
2 this chapter.

3 **Sec. 17. This chapter does not add to or otherwise change the**
4 **terms of coverage included in a policy, certificate, or contract**
5 **under which a covered individual receives health care benefits**
6 **under IC 27-8.**

7 **Sec. 18. (a) The department shall establish and maintain a**
8 **process for annual certification of independent review**
9 **organizations.**

10 **(b) The department shall certify a number of independent**
11 **review organizations determined by the department to be sufficient**
12 **to fulfill the purposes of this chapter.**

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

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

18 **(A) must be board certified in the specialty in which a**
19 **covered individual's proposed service would be provided;**

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

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

24 **(D) must not have any history of disciplinary actions or**
25 **sanctions, including:**

26 **(i) loss of staff privileges; or**

27 **(ii) restriction on participation;**

28 **taken or pending by any hospital, government, or**
29 **regulatory body.**

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

32 **(A) timeliness and quality of reviews;**

33 **(B) qualifications and independence of medical review**
34 **professionals;**

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

37 **(D) satisfaction of covered individuals with the procedures**
38 **utilized by the independent review organization, including**
39 **the use of covered individual satisfaction surveys.**

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

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- 1 (A) The number and percentage of determinations made in
2 favor of covered individuals.
- 3 (B) The number and percentage of determinations made in
4 favor of insurers.
- 5 (C) The average time to process a determination.
- 6 (D) Any other information required by the department.
- 7 The information required under this subdivision must be
8 specified for each insurer for which the independent review
9 organization performed reviews during the reporting year.
- 10 (4) Any additional requirements established by the
11 department.
- 12 (d) The department may not certify an independent review
13 organization that is one (1) of the following:
- 14 (1) A professional or trade association of health care
15 providers or a subsidiary or an affiliate of a professional or
16 trade association of health care providers.
- 17 (2) An insurer, health maintenance organization, or health
18 plan association, or a subsidiary or an affiliate of an insurer,
19 health maintenance organization, or health plan association.
- 20 (e) The department may suspend or revoke an independent
21 review organization's certification if the department finds that the
22 independent review organization is not in substantial compliance
23 with the certification requirements under this section.
- 24 (f) The department shall make available to insurers a list of all
25 certified independent review organizations.
- 26 (g) The department shall make the information provided to the
27 department under subsection (c)(3) available to the public in a
28 format that does not identify individual covered individuals.
- 29 Sec. 19. Except as provided in section 18(g) of this chapter,
30 documents and other information created or received by the
31 independent review organization or the medical review
32 professional in connection with an external grievance review under
33 this chapter:
- 34 (1) are not public records;
- 35 (2) may not be disclosed under IC 5-14-3; and
- 36 (3) must be treated in accordance with confidentiality
37 requirements of state and federal law.
- 38 Sec. 20. (a) An insurer shall each year file with the
39 commissioner a description of the grievance procedure of the
40 insurer established under this chapter, including:
- 41 (1) the total number of external grievances handled through
42 the procedure during the preceding calendar year;



- 1 (2) a compilation of the causes underlying those grievances;
- 2 and
- 3 (3) a summary of the final disposition of those grievances;
- 4 for each independent review organization used by the insurer
- 5 during the reporting year.

6 (b) The information required by subsection (a) must be filed
 7 with the commissioner on or before March 1 of each year. The
 8 commissioner shall:

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

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

16 **Sec. 21. (a) An independent review organization is immune from**
 17 **civil liability for actions taken in good faith in connection with an**
 18 **external review under this chapter.**

19 (b) The work product or determination, or both, of an
 20 independent review organization under this chapter are admissible
 21 in a judicial or administrative proceeding. However, the work
 22 product or determination, or both, do not, without other
 23 supporting evidence, satisfy a party's burden of proof or
 24 persuasion concerning any material issue of fact or law.

25 **Sec. 22. If a covered individual has the right to an external**
 26 **review of a grievance under Medicare, the covered individual may**
 27 **not request an external review of the same grievance under this**
 28 **chapter.**

29 **Sec. 23. The department may adopt rules under IC 4-22-2 to**
 30 **implement this chapter.**

31 SECTION 13. IC 27-13-2-3 IS AMENDED TO READ AS
 32 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 3. (a) A foreign
 33 corporation, other than a foreign corporation defined under
 34 IC 27-1-2-3, may obtain a certificate of authority if the foreign
 35 corporation:

- 36 (1) is authorized to do business in Indiana under IC 23-1-49 or
- 37 IC 23-17-26; and
- 38 (2) complies with this article.

39 (b) A foreign corporation (as defined in IC 27-1-2-3) may obtain a
 40 certificate of authority if the foreign corporation complies with this
 41 article.

42 (c) A foreign or alien health maintenance organization granted

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1 **a certificate of authority under this section has the same but no**
 2 **greater rights and privileges than a domestic health maintenance**
 3 **organization.**

4 SECTION 14. IC 27-13-2-6 IS AMENDED TO READ AS
 5 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 6. (a) An applicant
 6 shall submit to the commissioner any modifications or amendments to
 7 the items of information required in an application under section 5 of
 8 this chapter.

9 (b) The commissioner may adopt rules under this section that
 10 provide that any modifications or amendments to the items of
 11 information in the application required of a health maintenance
 12 organization:

13 (1) must be submitted to the commissioner before the
 14 modification or amendment takes effect:

15 (A) for the approval of the commissioner; or

16 (B) for the information of the commissioner only; or

17 (2) must be indicated by the health maintenance organization to
 18 the commissioner at the time of the next succeeding site visit or
 19 examination of the organization by the department of insurance.

20 (c) **A health maintenance organization shall file any assumed**
 21 **corporate name with the department at least thirty (30) days**
 22 **before assuming the name.**

23 SECTION 15. IC 27-13-2-9 IS ADDED TO THE INDIANA CODE
 24 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 25 1, 2000]: Sec. 9. (a) **A health maintenance organization established**
 26 **under this article may not:**

27 (1) **use as a part of its corporate name the words "United**
 28 **States", "Federal", "government", "official", or any word**
 29 **that would imply that the company was an administrative**
 30 **agency of the state of Indiana or of the United States, or is**
 31 **subject to supervision of any department other than the**
 32 **department of insurance; or**

33 (2) **take or assume a corporate name the same as, or**
 34 **confusingly similar to, an existing name of any other**
 35 **insurance company or other entity licensed or regulated**
 36 **under IC 27, unless at the same time:**

37 (A) **the other company changes its corporate name or**
 38 **withdraws from transacting business in Indiana; and**

39 (B) **the written consent of the other company, signed and**
 40 **verified under oath by its secretary, is filed with the**
 41 **department.**

42 (b) **This section does not affect the right of any health**

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1 **maintenance organization that:**

- 2 (1) exists under the laws of Indiana as of July 1, 2000;
 3 (2) exists under the laws of Indiana as of July 1, 2000, and
 4 thereafter reorganizes or reincorporates under this article; or
 5 (3) is authorized to transact business in Indiana as of July 1,
 6 2000;

7 **to continue the use of its corporate name.**

8 SECTION 16. IC 27-13-4-1 IS AMENDED TO READ AS
 9 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) Subject to section
 10 3 of this chapter, the powers of a health maintenance organization
 11 include the following:

12 (1) The purchase, lease, construction, renovation, operation, or
 13 maintenance of:

- 14 (A) hospitals and medical facilities;
 15 (B) equipment for hospitals and medical facilities; and
 16 (C) other property reasonably required for the principal office
 17 of the health maintenance organization or for purposes
 18 necessary in the transaction of the business of the organization.

19 (2) Engaging in transactions between affiliated entities, including
 20 loans and the transfer of responsibility under any or all contracts:

- 21 (A) between affiliates; or
 22 (B) between the health maintenance organization and the
 23 parent organization of the health maintenance organization.

24 (3) The furnishing of health care services through:

- 25 (A) providers;
 26 (B) provider associations; and
 27 (C) agents for providers;

28 who are under contract with or are employed by the health
 29 maintenance organization. The contracts with providers, provider
 30 associations, or agents of providers may include fee for service,
 31 cost plus, capitation, or other payment or risk-sharing
 32 arrangements.

33 (4) Contracting with any person for the performance on behalf of
 34 the health maintenance organization of certain functions,
 35 including:

- 36 (A) marketing;
 37 (B) enrollment; and
 38 (C) administration.

39 (5) Contracting with:

- 40 (A) an insurance company licensed in Indiana;
 41 (B) an authorized reinsurer; or
 42 (C) a hospital authorized to conduct business in Indiana;

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- 1 for the provision of insurance, indemnity, or reimbursement
- 2 against the cost of health care services provided by the health
- 3 maintenance organization.
- 4 (6) The offering of point-of-service products.
- 5 (7) The joint marketing of products with:
- 6 (A) an insurance company that is licensed in Indiana; or
- 7 (B) a hospital that is authorized to conduct business in Indiana;
- 8 if the company that is offering each product is clearly identified.
- 9 (8) Administration of the provision of health care services at the
- 10 expense of a self-funded plan.

11 (b) A health maintenance organization may offer any of the
 12 following:

- 13 (1) Plans that include only basic health care services.
- 14 (2) Plans that include basic health care services and other health
- 15 care services.
- 16 (3) Plans that include health care services other than basic health
- 17 care services so long as at least one (1) of the plans offered by the
- 18 health maintenance organization includes basic health care
- 19 services.

20 (c) **Notwithstanding subsection (a)(5), a health maintenance**
 21 **organization may not take credit for reinsurance unless the risk is**
 22 **ceded to a reinsurer qualified under IC 27-6-10.**

23 SECTION 17. IC 27-13-4-3 IS AMENDED TO READ AS
 24 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 3. (a) A **domestic**
 25 health maintenance organization must file notice with the
 26 commissioner, with supporting information that the commissioner
 27 deems adequate, before exercising any power granted in:

- 28 (1) section 1(a)(1); or
- 29 (2) section 1(a)(4);

30 of this chapter if the proposed transaction is equal to or greater than ten
 31 percent (10%) of the health maintenance organization's admitted assets.

32 (b) A **domestic** health maintenance organization must file notice
 33 with the commissioner, with the supporting information that the
 34 commissioner deems adequate, before exercising any power granted in
 35 section 1(a)(2), if the proposed transaction is equal to or greater than
 36 three percent (3%) of the health maintenance organization's admitted
 37 assets.

38 (c) The commissioner may disapprove an exercise of power referred
 39 to in a notice received under subsection (a) or (b) only if, in the opinion
 40 of the commissioner, the exercise of the power would:

- 41 (1) substantially and adversely affect the financial soundness of
- 42 the health maintenance organization; and

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1 (2) endanger the ability of the health maintenance organization to
2 meet its obligations.

3 (d) If the commissioner does not disapprove an exercise of power
4 referred to in a notice received under subsection (a) or (b) within thirty
5 (30) days after the notice is filed with the commissioner, the exercise
6 of power is considered approved.

7 (e) The commissioner may adopt rules under IC 4-22-2 exempting
8 from the filing requirement of this section certain activities that have
9 a minimal effect on:

- 10 (1) the financial soundness of the health maintenance
- 11 organization; and
- 12 (2) the ability of the health maintenance organization to meet its
- 13 obligations.

14 SECTION 18. IC 27-13-8-1.5 IS ADDED TO THE INDIANA
15 CODE AS A NEW SECTION TO READ AS FOLLOWS
16 [EFFECTIVE JULY 1, 2000]: **Sec. 1.5. (a) Each health maintenance**
17 **organization authorized to conduct business in Indiana and**
18 **required to file an annual statement with the department under**
19 **this chapter shall submit the health maintenance organization's**
20 **statement on the National Association of Insurance Commissioners**
21 **(NAIC) Annual Statement Blank prepared in accordance with**
22 **NAIC Annual Statement Instructions, and following practices and**
23 **procedures prescribed by the most recent NAIC Accounting**
24 **Practices and Procedures Manual.**

25 (b) **To the extent that the NAIC Annual Statement Instructions**
26 **require disclosure under subsection (a) of compensation paid to or**
27 **on behalf of a health maintenance organization's officers, directors,**
28 **or employees, the information may be filed with the department as**
29 **an exhibit separate from the annual statement blank. The**
30 **compensation information described under this subsection shall be**
31 **maintained by the department as confidential and may not be**
32 **made public.**

33 SECTION 19. IC 27-13-8-2, AS AMENDED BY P.L.133-1999,
34 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
35 JULY 1, 2000]: **Sec. 2. (a) In addition to the report required by section**
36 **1 of this chapter, a health maintenance organization shall each year file**
37 **with the commissioner the following:**

- 38 (1) **Audited financial statements of the health maintenance**
- 39 **organization for the preceding calendar year prepared in**
- 40 **conformity with statutory accounting practices prescribed or**
- 41 **otherwise permitted by the department.**
- 42 (2) **A list of participating providers who provide health care**

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1 services to enrollees or subscribers of the health maintenance
2 organization.

3 (3) A description of the grievance procedure of the health
4 maintenance organization:

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

6 (i) the total number of grievances handled through the
7 procedure during the preceding calendar year;

8 (ii) a compilation of the causes underlying those grievances;
9 and

10 (iii) a summary of the final disposition of those grievances;
11 and

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

13 (i) the total number of external grievances handled through
14 the procedure during the preceding calendar year;

15 (ii) a compilation of the causes underlying those grievances;
16 and

17 (iii) a summary of the final disposition of those grievances;
18 for each independent review organization used by the health
19 maintenance organization during the reporting year.

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

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

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

33 (1) make the information required to be filed under this section
34 available to the public; and

35 (2) prepare an annual compilation of the data required under
36 subsection (a)(3) through (a)(5) that allows for comparative
37 analysis.

38 (c) **Upon a determination by a health maintenance**
39 **organization's auditor that the health maintenance organization:**

40 **(1) does not meet the requirements of IC 27-13-12-3; or**

41 **(2) is in the condition described in IC 27-13-24-1(a)(5);**

42 **the health maintenance organization shall notify the commissioner**

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1 **within five (5) business days after the auditor's determination.**

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

5 SECTION 20. IC 27-13-8-4 IS ADDED TO THE INDIANA CODE
6 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
7 1, 2000]: **Sec. 4. (a) This section applies to a domestic health
8 maintenance organization that is authorized to transact business
9 in Indiana.**

10 (b) As used in this section, "NAIC" refers to the National
11 Association of Insurance Commissioners.

12 (c) On or before March 1 of each year, a health maintenance
13 organization shall file with the National Association of Insurance
14 Commissioners and with the department a copy of the health
15 maintenance organization's annual statement convention blank
16 and additional filings prescribed by the commissioner for the
17 preceding year. A health maintenance organization shall also file
18 quarterly statements with the NAIC and with the department, on
19 or before May 15, August 15, and November 15 of each year, in a
20 form prescribed by the commissioner. The information filed with
21 the NAIC under this subsection:

22 (1) must be:

23 (A) in the same format; and

24 (B) of the same scope;

25 as is required by the commissioner under section 1 of this
26 chapter;

27 (2) to the extent required by the NAIC, must include the
28 signed jurat page and the actuarial certification; and

29 (3) must be filed electronically in accordance with NAIC
30 electronic filing specifications.

31 The commissioner may, for good cause shown, grant an exemption
32 from the requirement of this section to domestic health
33 maintenance organizations that operate only in Indiana. If a health
34 maintenance organization files any amendment or addendum to
35 the health maintenance organization's annual statement
36 convention blank or quarterly statement with the commissioner,
37 the health maintenance organization shall also file a copy of the
38 amendment or addendum with the NAIC. Annual and quarterly
39 financial statements are considered filed with the NAIC when
40 delivered to the address designated by the NAIC for the filings,
41 regardless of whether the filing is accompanied by any applicable
42 fee.



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1 (d) The commissioner may, for good cause shown, grant a health
2 maintenance organization an extension of time for the filing
3 required by subsection (c).

4 (e) In the absence of actual malice:

5 (1) members of the NAIC;

6 (2) duly authorized committees, subcommittees, and task
7 forces of members of the NAIC;

8 (3) delegates of members of the NAIC;

9 (4) employees of the NAIC; and

10 (5) other persons responsible for collecting, reviewing,
11 analyzing, and disseminating information developed from the
12 filing of annual statement convention blanks under this
13 section;

14 shall be considered to be acting as agents of the commissioner
15 under the authority of this section and are not subject to civil
16 liability for libel, slander, or any other cause of action by virtue of
17 the collection, review, analysis, or dissemination of the data and
18 information collected from the filings required by this section.

19 (f) The commissioner may suspend, revoke, or refuse to renew
20 the certificate of authority of a health maintenance organization
21 that fails to file the health maintenance organization's annual
22 statement convention blank or quarterly statements with the NAIC
23 or with the department within the time allowed by subsection (c)
24 or (d).

25 SECTION 21. IC 27-13-8-5 IS ADDED TO THE INDIANA CODE
26 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
27 1, 2000]: Sec. 5. (a) The commissioner may impose a civil penalty
28 of five hundred dollars (\$500), after notice and hearing under
29 IC 4-21.5-3, on a health maintenance organization that fails to file
30 an annual statement under this chapter.

31 (b) A domestic health maintenance organization that fails to file
32 an audited annual financial statement under section 2(a)(1) of this
33 chapter before June 1 of each year without obtaining an extension
34 is subject to a civil penalty of fifty dollars (\$50) per day until the
35 report is received by the commissioner.

36 SECTION 22. IC 27-13-13-9 IS ADDED TO THE INDIANA
37 CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 9. (a) As used in this section,
38 "uncovered health care expenditures" means the costs to a health
39 maintenance organization for health care services that:

40 (1) are the obligation of the health maintenance organization;

41 (2) for which the enrollee may be liable in the event of the
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1 health maintenance organization's insolvency; and
 2 (3) for which no alternative arrangements have been made
 3 that are acceptable to the commissioner.
 4 (b) If uncovered health care expenditures exceed ten percent
 5 (10%) of total health care expenditures, a health maintenance
 6 organization shall deposit cash or securities that are acceptable to
 7 the commissioner with:
 8 (1) the commissioner; or
 9 (2) an organization or trustee approved by the commissioner
 10 through which a custodial or controlled account is
 11 maintained.
 12 (c) The deposit made under subsection (b) must have a fair
 13 market value:
 14 (1) calculated on the first day of each month; and
 15 (2) maintained for the remainder of the month;
 16 of not less than one hundred twenty percent (120%) of the health
 17 maintenance organization's outstanding liability for uncovered
 18 health care expenditures for enrollees in Indiana, including
 19 incurred but not reported claims.
 20 (d) The commissioner may require a health maintenance
 21 organization to file periodic reports, including liability for
 22 uncovered health care expenditures and audit opinions, that the
 23 commissioner considers necessary to monitor compliance with this
 24 section.
 25 SECTION 23. IC 27-13-15-2 IS AMENDED TO READ AS
 26 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. If:
 27 (1) the contract between a health maintenance organization and
 28 a participating provider has not been reduced to writing as
 29 required by this chapter; or
 30 (2) the contract fails to contain the provision required by section
 31 ~~1(2)~~ **1(a)(4)** of this chapter;
 32 the participating provider may not collect or attempt to collect from the
 33 subscriber or enrollee any sums that are owed by the health
 34 maintenance organization.
 35 SECTION 24. IC 27-13-15-3 IS AMENDED TO READ AS
 36 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 3. (a) A:
 37 (1) participating provider; or
 38 (2) trustee, an agent, a representative, or an assignee of a
 39 participating provider;
 40 may not **bring or** maintain any legal action against a subscriber or an
 41 enrollee of a health maintenance organization to collect sums owed by
 42 the health maintenance organization.

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1 **(b) Except as provided in subsection (c), if a participating**
 2 **provider of a health maintenance organization brings or maintains**
 3 **a legal action against a subscriber or enrollee for an amount owed**
 4 **to the participating provider by the health maintenance**
 5 **organization, the participating provider is liable to the subscriber**
 6 **or enrollee for costs and attorney's fees incurred by the subscriber**
 7 **or enrollee in defending the legal action.**

8 **(c) A participating provider shall not be liable to the subscriber**
 9 **or enrollee for costs and attorney's fees described in subsection (b)**
 10 **if the participating provider can demonstrate a reasonable basis**
 11 **for believing at the time the legal action was brought and while the**
 12 **legal action was maintained that the health maintenance**
 13 **organization did not owe the sums the participating provider**
 14 **sought to collect from the subscriber or enrollee.**

15 SECTION 25. IC 27-13-18-1 IS AMENDED TO READ AS
 16 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) In the event of
 17 receivership of a health maintenance organization, the commissioner
 18 may order all other carriers that participated in the enrollment process
 19 of the group covered by the organization in receivership at the last
 20 regular enrollment period of the group to offer the enrollees of the
 21 organization in receivership an enrollment period of thirty (30) days
 22 beginning on the date of receivership.

23 (b) Each carrier referred to in subsection (a) shall offer the enrollees
 24 of the health maintenance organization in receivership:

- 25 (1) the same coverage;
- 26 (2) under the same terms; and
- 27 (3) at the same rates;

28 as the carrier had offered at the last regular enrollment period of the
 29 group. The coverage required under this chapter shall begin on the date
 30 of receivership and end on the date the contract period would have
 31 ended had the health maintenance organization not gone into
 32 receivership.

33 **(c) If there is no carrier referred to in subsection (a), or the**
 34 **commissioner determines that there is no carrier referred to in**
 35 **subsection (a) that has adequate or accessible resources, the**
 36 **commissioner shall equitably allocate the:**

- 37 **(1) group contracts of the health maintenance organization in**
 38 **receivership; and**
- 39 **(2) individual contracts of the health maintenance**
 40 **organization in receivership belonging to enrollees who are**
 41 **unable to obtain other coverage;**
 42 **among all health maintenance organizations operating within a**



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1 portion of the service area of the health maintenance organization
2 in receivership. The commissioner shall not allocate individual
3 contracts to a health maintenance organization that does not offer
4 direct individual enrollment.

5 (d) A health maintenance organization to which the
6 commissioner allocates a group contract under subsection (c)(1)
7 shall offer to the group existing coverage that is most similar to the
8 group's coverage with the health maintenance organization in
9 receivership at rates consistent with the successor health
10 maintenance organization's existing rating methodology.

11 (e) A health maintenance organization to which the
12 commissioner allocates individual contracts under subsection (c)(2)
13 shall offer to the enrollee existing individual or conversion
14 coverage that is most similar to the enrollee's coverage with the
15 health maintenance organization in receivership at rates consistent
16 with the successor health maintenance organization's existing
17 rating methodology.

18 SECTION 26. IC 27-13-22-1 IS AMENDED TO READ AS
19 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) A licensed
20 insurer or a hospital authorized to conduct business in Indiana may,
21 either directly or through a subsidiary or an affiliate, organize and
22 operate a health maintenance organization under this article.

23 (b) This section does not apply to a health maintenance
24 organization granted a certificate of authority under this article
25 before July 1, 2000.

26 SECTION 27. IC 27-13-23-8 IS ADDED TO THE INDIANA
27 CODE AS A NEW CHAPTER TO READ AS FOLLOWS
28 [EFFECTIVE JULY 1, 2000]: Sec. 8. A health maintenance
29 organization shall file a copy of any examination report filed by the
30 insurance commissioner of another state during the preceding
31 calendar year with the annual statement required under
32 IC 27-13-8-1.

33 SECTION 28. IC 27-13-32-1 IS AMENDED TO READ AS
34 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) This section does
35 not apply to a health maintenance organization or a limited service
36 health maintenance organization that is a foreign corporation. or is
37 owned by a foreign corporation.

38 (b) As used in this section, "foreign corporation" means a
39 corporation organized or reorganized under the law of a state or
40 jurisdiction other than Indiana.

41 (c) A person may not acquire control, as that term is defined in
42 IC 27-1-23-1, of a health maintenance organization or a limited service

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1 health maintenance organization unless:

2 (1) that person complies with the requirements of IC 27-1-23-2;

3 and

4 (2) the acquisition is approved by the commissioner under the
5 procedure set forth in IC 27-1-23-2.

6 SECTION 29. IC 27-13-32.5 IS ADDED TO THE INDIANA
7 CODE AS A NEW CHAPTER TO READ AS FOLLOWS
8 [EFFECTIVE JULY 1, 2000]:

9 **Chapter 32.5. Voluntary Dissolution**

10 **Sec. 1. Upon authorization of voluntary dissolution by the board**
11 **of directors and any shareholders entitled to vote in respect of the**
12 **voluntary dissolution, the board of directors shall:**

13 (1) cause a notice that the health maintenance organization is
14 about to be dissolved to be published at least once in a
15 newspaper of general circulation, printed and published in the
16 English language, in the county in which the principal office
17 of the health maintenance organization is located, and at least
18 once in a newspaper of general circulation, printed and
19 published in the English language in the city of Indianapolis,
20 Marion County, Indiana;

21 (2) cause a copy of the publication under subdivision (1) to be
22 mailed to each subscriber;

23 (3) file a copy of the publication under subdivision (1) with the
24 department; and

25 (4) file a certified copy of the articles of dissolution with the
26 department and present to the department the certificate of
27 authority issued or renewed under IC 27-13-3-1 for
28 cancellation.

29 The department shall file the certified copy of the articles of
30 dissolution, cancel the certificate of authority, endorse the
31 cancellation on the certificate, and return the canceled certificate
32 of authority to the health maintenance organization or its
33 representatives.

34 **Sec. 2. The dissolution of a health maintenance organization**
35 **under this chapter does not alter the rights of an enrollee under**
36 **IC 27-13-7-13.**

37 SECTION 30. IC 27-13-34-7 IS AMENDED TO READ AS
38 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 7. (a) After December
39 31, 1994, a person, corporation, partnership, limited liability company,
40 or other entity may not operate a limited service health maintenance
41 organization in Indiana without obtaining and maintaining a certificate
42 of authority from the commissioner under this chapter.



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1 (b) A for-profit or nonprofit corporation organized under the laws
 2 of another state, other than a foreign corporation defined under
 3 IC 27-1-2-3, may obtain a certificate of authority to operate a limited
 4 service health maintenance organization in Indiana if the foreign
 5 corporation is authorized to do business in Indiana under IC 23-1-49 or
 6 IC 23-17-26 and complies with this chapter.

7 (c) A foreign corporation (as defined in IC 27-1-2-3) may obtain a
 8 certificate of authority to operate a limited service health maintenance
 9 organization in Indiana if the foreign corporation complies with this
 10 chapter.

11 (d) **A foreign or alien limited service health maintenance**
 12 **organization granted a certificate of authority under this chapter**
 13 **has the same but not greater rights and privileges than a domestic**
 14 **limited service health maintenance organization.**

15 SECTION 31. IC 34-30-2-114.5 IS ADDED TO THE INDIANA
 16 CODE AS A NEW SECTION TO READ AS FOLLOWS
 17 [EFFECTIVE JULY 1, 2000]: **Sec. 114.5. IC 27-7-12-7 (Concerning**
 18 **communications regarding termination of a homeowner's**
 19 **insurance policy).**

20 SECTION 32. IC 34-30-2-116.7 IS ADDED TO THE INDIANA
 21 CODE AS A NEW SECTION TO READ AS FOLLOWS
 22 [EFFECTIVE JULY 1, 2000]: **Sec. 116.7. IC 27-8-29-21 (Concerning**
 23 **independent review organizations).**

24 SECTION 33. IC 34-30-2-119.3 IS ADDED TO THE INDIANA
 25 CODE AS A NEW SECTION TO READ AS FOLLOWS
 26 [EFFECTIVE JULY 1, 2000]: **Sec. 119.3. IC 27-13-8-4 (Concerning**
 27 **data and information collected from health maintenance**
 28 **organization filings).**

29 SECTION 34. [EFFECTIVE JULY 1, 2000] (a) **Notwithstanding**
 30 **IC 27-8-28-19 and IC 27-8-29-20, both as added by this act, the**
 31 **information required under IC 27-8-28-19 and IC 27-8-29-20, both**
 32 **as added by this act, must be filed beginning March 1, 2002.**

33 (b) **This SECTION expires June 30, 2004.**

34 SECTION 35. **An emergency is declared for this act.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1189, 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 2, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 2. IC 22-2-6-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. (a) Any assignment of the wages of an employee is valid only if all of the following conditions are satisfied:

- (1) The assignment is:
 - (A) in writing;
 - (B) signed by the employee personally;
 - (C) by its terms revocable at any time by the employee upon written notice to the employer; and
 - (D) agreed to in writing by the employer.
- (2) An executed copy of the assignment is delivered to the employer within ten (10) days after its execution.
- (3) The assignment is made for a purpose described in subsection (b).

(b) A wage assignment under this section may be made for the purpose of paying any of the following:

- (1) Premium on a policy of insurance. ~~obtained for the employee by the employer.~~
- (2) Pledge or contribution of the employee to a charitable or nonprofit organization.
- (3) Purchase price of bonds or securities, issued or guaranteed by the United States.
- (4) Purchase price of shares of stock, or fractional interests therein, of the employing company, or of a company owning the majority of the issued and outstanding stock of the employing company, whether purchased from such company, in the open market or otherwise. However, if such shares are to be purchased on installments pursuant to a written purchase agreement, the employee has the right under the purchase agreement at any time before completing purchase of such shares to cancel said agreement and to have repaid promptly the amount of all installment payments which theretofore have been made.
- (5) Dues to become owing by the employee to a labor organization of which the employee is a member.
- (6) Purchase price of merchandise sold by the employer to the employee, at the written request of the employee.

EH 1189—LS 7084/DI 97+



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(7) Amount of a loan made to the employee by the employer and evidenced by a written instrument executed by the employee.

(8) Contributions, assessments, or dues of the employee to a hospital service or a surgical or medical expense plan or to an employees' association, trust, or plan existing for the purpose of paying pensions or other benefits to said employee or to others designated by the employee.

(9) Payment to any credit union, nonprofit organizations, or associations of employees of such employer organized under any law of this state or of the United States.

(10) Payment to any person or organization regulated under the Uniform Consumer Credit Code (IC 24-4.5) for deposit or credit to the employee's account by electronic transfer or as otherwise designated by the employee.

(11) Premiums on policies of insurance and annuities purchased by the employee on the employee's life.

(12) The purchase price of shares or fractional interest in shares in one (1) or more mutual funds."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1189 as introduced.)

FRY, Chair

Committee Vote: yeas 13, nays 1.

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COMMITTEE REPORT

Mr. President: The Senate Committee on Insurance and Financial Institutions, to which was referred House Bill No. 1189, 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:

Replace the effective date in SECTION 6 with "[EFFECTIVE UPON PASSAGE]".

Replace the effective date in SECTIONS 7 through 8 with "[EFFECTIVE JANUARY 1, 2001]".

Replace the effective date in SECTIONS 11 through 13 with "[EFFECTIVE JANUARY 1, 2001]".

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

"SECTION 1. IC 16-21-3-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. The state health commissioner may take action under section 1 of this chapter on any of the following grounds:

- (1) Violation of any of the provisions of this chapter or of the rules adopted under this chapter.
- (2) Permitting, aiding, or abetting the commission of any illegal act in an institution.
- (3) Conduct or practice found by the council to be detrimental to the welfare of the patients of an institution.
- (4) **Conduct that violates IC 27-13-15-3.**"

Page 1, delete lines 1 through 17.

Page 2, delete lines 1 through 10.

Page 3, delete lines 23 through 42.

Page 4, delete lines 1 through 41.

Page 12, line 33, delete "preauthorization" and insert "**certification**".

Page 12, line 36, reset in roman "the".

Page 12, line 36, delete "a person has".

Page 12, line 37, delete "engaged in a".

Page 12, line 37, after "competition" delete ",".

Page 12, line 37, reset in roman "or the".

Page 12, line 37, after "act" delete ",".

Page 12, line 37, reset in roman "in question".

Page 12, line 38, reset in roman "is defined".

Page 12, line 38, delete "described".

Page 12, line 38, reset in roman "of this chapter and that the person".

EH 1189—LS 7084/DI 97+



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- Page 12, reset in roman line 39.
- Page 12, line 40, reset in roman "practice in violation".
- Page 12, line 40, delete "or 8".
- Page 12, line 40, reset in roman "he shall reduce his findings to".
- Page 12, line 41, reset in roman "writing and shall".
- Page 12, line 41, delete "or has otherwise violated this chapter, the".
- Page 12, line 42, delete "commissioner may".
- Page 13, line 5, reset in roman "twenty-five".
- Page 13, line 5, delete "fifty".
- Page 13, line 6, reset in roman "(\$25,000)".
- Page 13, line 6, delete "(\$50,000)".
- Page 13, line 6, strike "but" and insert ".".
- Page 13, line 7, strike "not to exceed an aggregate penalty of".
- Page 13, line 7, delete "five".
- Page 13, line 7, strike "hundred thousand".
- Page 13, line 8, strike "dollars".
- Page 13, line 8, delete "(\$500,000)".
- Page 13, line 8 strike "in any twelve (12) month period".
- Page 13, line 9, strike "unless" and insert "**If**".
- Page 13, line 10, strike "in which case".
- Page 13, line 11, reset in roman "fifty".
- Page 13, line 11, delete "one hundred".
- Page 13, line 11, reset in roman "(\$50,000)".
- Page 13, line 12, delete "(\$100,000)".
- Page 13, line 12, strike "but not to exceed an" and insert ".".
- Page 13, line 13, strike "aggregate penalty of".
- Page 13, line 13, delete "one million".
- Page 13, line 13, strike "dollars".
- Page 13, line 14, delete "(\$1,000,000)".
- Page 13, line 14, strike "in any twelve (12) month period.".
- Page 13, line 15, delete "Restitution or other remedial measures as determined".
- Page 13, delete line 16.
- Page 13, line 17, delete "(3)".
- Page 13, run in lines 15 through 17.
- Page 13, between lines 19 and 20, begin a new paragraph and insert:
"(b) In determining the amount of a civil penalty under subsection (a)(1), the commissioner shall consider the remediation efforts undertaken by the person."
- Page 13, line 20, strike "(b)" and insert "(c)".
- Page 14, line 22, delete "and includes the transfer of a policy between" and insert ".".

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Page 14, line 23, delete "insurers within the same insurance group."

Page 15, line 6, after "an" insert "**independent**".

Page 15, line 16, delete "and".

Page 15, line 17, delete "specific".

Page 15, line 18, delete "." and insert "**; and**".

Page 15, between lines 18 and 19, begin a new line block indented and insert:

"(5) be provided to the named insured at least twenty (20) days before the expiration of the current policy period."

Page 15, line 19, after "an" insert "**independent**".

Page 15, line 29, delete "and specific".

Page 15, line 31, delete "Generalized terms used in the".

Page 15, delete lines 32 through 37.

Page 17, between lines 5 and 6, begin a new paragraph and insert:

"Sec. 8. The named insured must be given notice of a transfer of a policy, including a transfer between insurers within the same insurance group. The notice must:

(1) be in writing;

(2) be delivered or mailed to the named insured at the last known address of the named insured;

(3) be provided to the named insured at least twenty (20) days before the transfer; and

(4) identify the insurer to which the policy will be transferred."

Page 17, line 6, delete "8." and insert "**9.**".

Page 17, line 40, delete ":" and insert "**, the policyholder must be given written notice when the policy is issued or upon the first renewal after December 31, 2000, that coverage for flood damage may be available through the National Flood Insurance Program."**

Page 17, delete lines 41 through 42.

Page 18, delete lines 1 through 3.

Page 19, delete lines 14 through 35, begin a new paragraph and insert:

"(h) For purposes of this section, an insurer shall combine the experience of all policies that are substantially similar with respect to type and level of benefits and marketing method issued in this state after their fifth duration to calculate uniform percentage rate increases for such previously approved, substantially similar medical expense insurance policy forms that have experience that produces an anticipated lifetime loss ratio at least as high as that stated in the actuarial memorandum filed when the policy form was originally approved. Nothing in this subsection shall be



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construed to require uniform rates for policies after their fifth duration. The purpose of this law is to require uniform percentage rate increases for such policies.

SECTION 9. IC 27-8-17-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 12. (a) A utilization review agent shall make available ~~upon request to an enrollee at the time an adverse utilization review determination is made:~~

(1) a written description of the appeals procedure by which an enrollee or a provider of record may ~~obtain a review of a appeal~~ **the utilization review determination by the utilization review agent; and**

(2) **in the case of an enrollee covered under an accident and sickness policy or a health maintenance contract described in subsection (d), notice that the enrollee has the right to appeal the utilization review determination under IC 27-8-28 or IC 27-13-10 and the toll free phone number that the enrollee may call to request a review of the determination or obtain further information about the right to appeal.**

(b) The appeals procedure provided by a utilization review agent must meet the following requirements:

(1) On appeal, the determination not to certify an admission, a service, or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record.

(2) The determination of the appeal of a utilization review determination not to certify an admission, service, or procedure must be completed within thirty (30) days after:

(A) the appeal is filed; and

(B) all information necessary to complete the appeal is received.

(c) A utilization review agent shall provide an expedited appeals process for emergency or life threatening situations. The determination of an expedited appeal under the process required by this subsection shall be made by a physician and completed within forty-eight (48) hours after:

(1) the appeal is initiated; and

(2) all information necessary to complete the appeal is received by the utilization review agent.

(d) If an enrollee is covered under an accident and sickness insurance policy (as defined in IC 27-8-28) or a contract issued by a health maintenance organization (as defined in IC 27-13-1-19), the enrollee's exclusive right to appeal a utilization review

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determination is provided under IC 27-8-28 or IC 27-13-10, respectively.

(e) A utilization review agent shall make available upon request a written description of the appeals procedure that an enrollee or provider of record may use to obtain a review of a utilization review determination by the utilization review agent."

Page 19, line 39, delete "Preauthorization" and insert "Certification".

Page 19, delete lines 40 through 42, begin a new paragraph and insert:

"Sec. 1. As used in this chapter, "certification" means a determination by an insurer or a utilization review agent that the proposed provision of health care services has been reviewed, and based on the information provided, meets the health insurance plan's requirements for medical necessity, appropriateness, level of care, or effectiveness.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health insurance plan.

Sec. 3. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

Sec. 4. As used in this chapter, "health insurance plan" means coverage provided under any of the following:

- (1) A hospital or medical expense incurred policy or certificate.
- (2) A health maintenance organization subscriber contract.
- (3) An employer based health insurance arrangement.
- (4) An individual health insurance policy.
- (5) A policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.
- (6) An employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.
- (7) A conversion policy issued under IC 27-8-15-31 or IC 27-8-15-31.1.

Sec. 5. As used in this chapter, "insurer" means any person who provides coverage for health care services in Indiana. The term includes the following:

- (1) A licensed insurance company.
- (2) A health maintenance organization or limited service health maintenance organization.
- (3) A state employee health benefit plan under IC 5-10-8-7.
- (4) Any other person who provides coverage for health care



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services through a health insurance plan regulated under IC 27.

(5) Any authorized representative or designee of the insurer.

Sec. 6. An insurer or a utilization review agent shall provide written or oral notification to the covered individual that certification does not guarantee payment of the proposed health care services. Oral notification shall be followed promptly by written notification to the covered individual. This notification shall be in addition to any notification requirements of IC 27-8-17-11."

Delete page 20.

Page 21, delete lines 1 through 11.

Page 21, line 17, delete ":".

Page 21, line 18, delete "(1)".

Page 21, line 19, delete "; and" and insert ".".

Page 21, run in lines 17 through 19.

Page 21, delete line 20.

Page 21, after line 42, begin a new paragraph and insert:

"Sec. 5. As used in this chapter, "external grievance" means the independent review under IC 27-8-29 of a grievance filed under this chapter."

Page 22, line 1, delete "5." and insert "6."

Page 22, line 4, delete "availability, delivery,".

Page 22, line 4, after "appropriateness" delete ",".

Page 22, line 4, delete "quality" and insert "medical necessity".

Page 22, between lines 5 and 6, begin a new line block indented and insert:

"(2) availability of participating providers;".

Page 22, line 6, delete "(2)" and insert "(3)".

Page 22, line 7, delete "(3)" and insert "(4)".

Page 22, line 14, delete "6" and insert "7".

Page 22, line 17, delete "7" and insert "8".

Page 22, line 23, delete "8" and insert "9".

Page 22, line 26, delete "9. (a)" and insert "10."

Page 22, delete lines 29 through 42.

Page 23, delete lines 1 through 7.

Page 23, line 8, delete "10" and insert "11".

Page 23, line 10, delete "11" and insert "12".

Page 23, line 13, delete "12" and insert "13".

Page 23, line 16, delete "review" and insert "grievance".

Page 23, line 19, after "external" insert "grievance".

Page 23, line 25, after "external" insert "grievance".



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- Page 23, line 26, delete "13" and insert "14".
- Page 23, line 38, delete "14" and insert "15".
- Page 24, line 1, delete "15" and insert "16".
- Page 24, line 21, delete "the grievance is" and insert "**receiving all information reasonably necessary to complete the review.**".
- Page 24, line 22, delete "filed."
- Page 24, line 42, delete "16" and insert "17".
- Page 25, line 19, delete "appeal" and insert "**grievance review under IC 27-8-29**".
- Page 25, line 21, delete "Except for grievances that have previously been appealed".
- Page 25, line 22, delete "under IC 27-8-17, in" and insert "**In**".
- Page 25, run in lines 1 through 22.
- Page 25, line 22, delete "regarding the proposal,".
- Page 25, delete line 23.
- Page 25, line 24, delete "service," and insert "**of a grievance described in section 6(1) of this chapter,**".
- Page 25, run in lines 22 through 24.
- Page 26, line 8, delete "grievance" and insert "**appeal**".
- Page 26, line 14, after "to" insert "**external grievance**".
- Page 26, line 19, delete "appeal" and insert "**external grievance review**".
- Page 26, line 20, delete "17" and insert "18".
- Page 26, line 23, delete "18" and insert "19".
- Page 26, line 41, delete "19" and insert "20".
- Page 27, between lines 6 and 7, begin a new paragraph and insert: "**Sec. 2. As used in this chapter, "appeal" means the procedure described in IC 27-8-28-17.**".
- Page 27, line 7, delete "2" and insert "3".
- Page 27, line 9, delete "3" and insert "4".
- Page 27, line 11, delete "4" and insert "5".
- Page 27, between lines 12 and 13, begin a new paragraph and insert: "**Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a grievance filed under IC 27-8-28.**".
- Page 27, line 13, delete "5" and insert "7".
- Page 27, line 14, delete "IC 27-8-28-5" and insert "**IC 27-8-28-6**".
- Page 27, line 15, delete "6" and insert "8".
- Page 27, line 16, delete "IC 27-8-28-6" and insert "**IC 27-8-28-7**".
- Page 27, line 17, delete "7" and insert "9".
- Page 27, line 18, delete "IC 27-8-28-7" and insert "**IC 27-8-28-8**".
- Page 27, line 19, delete "8" and insert "10".

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Page 27, line 20, delete "IC 27-8-28-8" and insert "**IC 27-8-28-9**".

Page 27, line 21, delete "9" and insert "**11**".

Page 27, line 22, after "of" insert "**external**".

Page 27, line 23, delete "utilization review determination (as defined in" and insert "**determination of appropriateness;**".

Page 27, delete line 24.

Page 27, line 30, delete "10" and insert "**12**".

Page 27, line 31, delete "9" and insert "**11**".

Page 27, line 34, delete "appeal" and insert "**external grievance review**".

Page 27, line 34, delete "grievance" and insert "**appeal**".

Page 27, line 35, delete "IC 27-8-28-16" and insert "**IC 27-8-28-17**".

Page 27, line 38, delete "appeal" and insert "**external grievance review**".

Page 28, line 1, delete "appeal" and insert "**external grievance review**".

Page 28, line 3, delete "appeal" and insert "**external grievance**".

Page 28, line 4, delete "grievance" and insert "**appeal**".

Page 28, line 8, delete "appeal" and insert "**external grievance**".

Page 28, line 10, delete "16" and insert "**18**".

Page 28, line 17, delete "appeal" and insert "**external grievance**".

Page 28, between lines 30 and 31, begin a new line block indented and insert:

"(6) The covered individual requesting the external grievance review."

Page 28, delete lines 31 through 37.

Page 28, line 42, delete "11" and insert "**13**".

Page 28, line 42, delete "appeal" and insert "**external grievance**".

Page 29, line 3, delete "appeal" and insert "**external grievance**".

Page 29, line 14, delete "10(b)" and insert "**12(b)**".

Page 29, line 17, delete "12" and insert "**14**".

Page 29, line 18, delete "appeal" and insert "**external grievance**".

Page 29, line 18, delete "10(a)(2)(A)" and insert "**12(a)(2)(A)**".

Page 29, line 19, delete "appeal" and insert "**external grievance**".

Page 29, line 21, delete "10(a)(2)(B)" and insert "**12(a)(2)(B)**".

Page 29, line 24, delete "grievance" and insert "**appeal**".

Page 29, line 25, delete "IC 27-8-28-16" and insert "**IC 27-8-28-17**".

Page 29, line 39, delete "appeal" and insert "**external grievance**".

Page 29, line 39, delete "10(a)(2)(A)" and insert "**12(a)(2)(A)**".

Page 29, line 42, delete "appeal" and insert "**external grievance**".

Page 29, line 42, delete "10(a)(2)(B)" and insert "**12(a)(2)(B)**".

Page 30, line 3, delete "13" and insert "**15**".



- Page 30, line 3, delete "12" and insert "14".
- Page 30, line 5, delete "14" and insert "16".
- Page 30, line 8, delete "IC 27-8-28-16" and insert "IC 27-8-28-17".
- Page 30, line 11, delete "IC 27-8-28-16" and insert "IC 27-8-28-17".
- Page 30, line 16, delete "IC 27-8-28-16" and insert "IC 27-8-28-17".
- Page 30, line 31, delete "15" and insert "17".
- Page 30, line 35, delete "16" and insert "18".
- Page 32, line 15, delete "17" and insert "19".
- Page 32, line 15, delete "16(g)" and insert "18(g)".
- Page 32, line 18, after "external" insert "grievance".
- Page 32, line 24, delete "18" and insert "20".
- Page 33, line 2, delete "19" and insert "21".
- Page 33, line 11, delete "20" and insert "22".
- Page 33, line 15, delete "21" and insert "23".
- Page 41, line 29, delete "If" and insert "**Except as provided in subsection (c), if**".
- Page 41, between lines 34 and 35, begin a new paragraph and insert:
"(c) A participating provider shall not be liable to the subscriber or enrollee for costs and attorney's fees described in subsection (b) if the participating provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that the health maintenance organization did not owe the sums the participating provider sought to collect from the subscriber or enrollee."
- Page 42, line 22, after "receivership." insert "**The commissioner shall not allocate individual contracts to a health maintenance organization that does not offer direct individual enrollment.**".
- Page 42, line 35, delete "A successor health maintenance organization".
- Page 42, delete lines 36 through 38.
- Page 45, line 1, delete "IC 27-8-29-19" and insert "IC 27-8-29-21".
- Page 45, line 9, delete "IC 27-8-28-18" and insert "IC 27-8-28-19".
- Page 45, line 9, delete "IC 27-8-29-18" and insert "IC 27-8-29-20".
- Page 45, line 10, delete "IC 27-8-28-18" and insert "IC 27-8-28-19".
- Page 45, line 10, delete "IC 27-8-29-18" and insert "IC 27-8-29-20".
- Page 45, after line 12, begin a new paragraph and insert:
"SECTION 36. An emergency is declared for this act."

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Renumber all SECTIONS consecutively.
and when so amended that said bill do pass.

(Reference is to HB 1189 as printed January 14, 2000.)

PAUL, Chairperson

Committee Vote: Yeas 5, Nays 4.

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