

SENATE MOTION

MR. PRESIDENT:

I move that Engrossed House Bill 1749 be amended to read as follows:

- 1 Page 14, line 11, strike "one" and insert "**two**".
- 2 Page 14, line 11, strike "fifty".
- 3 Page 14, line 12, strike "(150%)" and insert "**(200%)**".
- 4 Page 15, between lines 41 and 42, begin a new line blocked left and
- 5 insert:
- 6 "**The maximum credit that may be taken under this subsection is**
- 7 **equal to ninety percent (90%) of assessments paid.**".
- 8 Page 16, between lines 11 and 12, begin a new paragraph and insert:
- 9 "SECTION 7. IC 27-8-10-3 IS AMENDED TO READ AS
- 10 FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 3. (a) An association
- 11 policy issued under this chapter may pay usual and customary charges
- 12 or use other reimbursement systems that are consistent with managed
- 13 care plans, including fixed fee schedules and capitated reimbursement,
- 14 for medically necessary eligible health care services rendered or
- 15 furnished for the diagnosis or treatment of illness or injury that exceed
- 16 the deductible and coinsurance amounts applicable under section 4 of
- 17 this chapter. **However, the amount of reimbursement for a health**
- 18 **care service covered under an association policy may not exceed**
- 19 **the amount of reimbursement for the same health care service**
- 20 **under Medicare plus ten percent (10%).**
- 21 (b) Eligible expenses are the charges for the following health care
- 22 services and articles to the extent furnished by a health care provider
- 23 in an emergency situation or furnished or prescribed by a physician:
- 24 (1) Hospital services, including charges for the institution's most
- 25 common semiprivate room, and for private room only when
- 26 medically necessary, but limited to a total of one hundred eighty
- 27 (180) days in a year.
- 28 (2) Professional services for the diagnosis or treatment of injuries,
- 29 illnesses, or conditions, other than mental or dental, that are
- 30 rendered by a physician or, at the physician's direction, by the
- 31 physician's staff of registered or licensed nurses, and allied health

- 1 professionals.
- 2 (3) The first twenty (20) professional visits for the diagnosis or
3 treatment of one (1) or more mental conditions rendered during
4 the year by one (1) or more physicians or, at their direction, by
5 their staff of registered or licensed nurses, and allied health
6 professionals.
- 7 (4) Drugs and contraceptive devices requiring a physician's
8 prescription.
- 9 (5) Services of a skilled nursing facility for not more than one
10 hundred eighty (180) days in a year.
- 11 (6) Services of a home health agency up to two hundred seventy
12 (270) days of service a year.
- 13 (7) Use of radium or other radioactive materials.
- 14 (8) Oxygen.
- 15 (9) Anesthetics.
- 16 (10) Prostheses, other than dental.
- 17 (11) Rental of durable medical equipment which has no personal
18 use in the absence of the condition for which prescribed.
- 19 (12) Diagnostic X-rays and laboratory tests.
- 20 (13) Oral surgery for:
- 21 (A) excision of partially or completely erupted impacted teeth;
22 (B) excision of a tooth root without the extraction of the entire
23 tooth; or
24 (C) the gums and tissues of the mouth when not performed in
25 connection with the extraction or repair of teeth.
- 26 (14) Services of a physical therapist and services of a speech
27 therapist.
- 28 (15) Professional ambulance services to the nearest health care
29 facility qualified to treat the illness or injury.
- 30 (16) Other medical supplies required by a physician's orders.
- 31 An association policy may also include comparable benefits for those
32 who rely upon spiritual means through prayer alone for healing upon
33 such conditions, limitations, and requirements as may be determined
34 by the board of directors.
- 35 ~~(b)~~ (c) A managed care organization that issues an association
36 policy may not refuse to enter into an agreement with a hospital solely
37 because the hospital has not obtained accreditation from an
38 accreditation organization that:
- 39 (1) establishes standards for the organization and operation of
40 hospitals;
- 41 (2) requires the hospital to undergo a survey process for a fee paid
42 by the hospital; and
- 43 (3) was organized and formed in 1951.
- 44 ~~(e)~~ (d) This section does not prohibit a managed care organization
45 from using performance indicators or quality standards that:
- 46 (1) are developed by private organizations; and
47 (2) do not rely upon a survey process for a fee charged to the

- 1 hospital to evaluate performance.
- 2 ~~(d)~~ (e) For purposes of this section, if benefits are provided in the
3 form of services rather than cash payments, their value shall be
4 determined on the basis of their monetary equivalency.
- 5 ~~(e)~~ (f) The following are not eligible expenses in any association
6 policy within the scope of this chapter:
- 7 (1) Services for which a charge is not made in the absence of
8 insurance or for which there is no legal obligation on the part of
9 the patient to pay.
- 10 (2) Services and charges made for benefits provided under the
11 laws of the United States, including Medicare and Medicaid,
12 military service connected disabilities, medical services provided
13 for members of the armed forces and their dependents or for
14 employees of the armed forces of the United States, medical
15 services financed in the future on behalf of all citizens by the
16 United States.
- 17 (3) Benefits which would duplicate the provision of services or
18 payment of charges for any care for injury or disease either:
- 19 (A) arising out of and in the course of an employment subject
20 to a worker's compensation or similar law; or
- 21 (B) for which benefits are payable without regard to fault
22 under a coverage statutorily required to be contained in any
23 motor vehicle or other liability insurance policy or equivalent
24 self-insurance.
- 25 However, this subdivision does not authorize exclusion of charges
26 that exceed the benefits payable under the applicable worker's
27 compensation or no-fault coverage.
- 28 (4) Care which is primarily for a custodial or domiciliary purpose.
- 29 (5) Cosmetic surgery unless provided as a result of an injury or
30 medically necessary surgical procedure.
- 31 (6) Any charge for services or articles the provision of which is
32 not within the scope of the license or certificate of the institution
33 or individual rendering the services.
- 34 ~~(f)~~ (g) The coverage and benefit requirements of this section for
35 association policies may not be altered by any other inconsistent state
36 law without specific reference to this chapter indicating a legislative
37 intent to add or delete from the coverage requirements of this chapter.
- 38 ~~(g)~~ (h) This chapter does not prohibit the association from issuing
39 additional types of health insurance policies with different types of
40 benefits that, in the opinion of the board of directors, may be of benefit
41 to the citizens of Indiana.
- 42 ~~(h)~~ (i) This chapter does not prohibit the association or its
43 administrator from implementing uniform procedures to review the
44 medical necessity and cost effectiveness of proposed treatment,
45 confinement, tests, or other medical procedures. Those procedures may
46 take the form of preadmission review for nonemergency
47 hospitalization, case management review to verify that covered

1 individuals are aware of treatment alternatives, or other forms of
 2 utilization review. Any cost containment techniques of this type must
 3 be adopted by the board of directors and approved by the
 4 commissioner."

5 Page 18, line 25, after "(a)" insert "**A person is not eligible for an**
 6 **association policy if the person is eligible for Medicaid. A person**
 7 **other than a federally eligible individual may not apply for an**
 8 **association policy unless the person has applied for Medicaid not**
 9 **more than sixty (60) days before applying for the association**
 10 **policy.**

11 (b)".

12 Page 18, line 26, strike "(b),".

13 Page 18, line 26, reset in roman "(c),".

14 Page 18, line 33, strike "(b)" and insert "(c)".

15 Page 18, line 33, delete "," and insert "**and subsection (a),**".

16 Page 19, line 15, delete "(c)" and insert "(d)".

17 Page 19, line 25, strike "(d)" and insert "(e)".

18 Page 19, line 41, strike "(e)" and insert "(f)".

19 Page 20, line 12, strike "(f)" and insert "(g)".

20 Page 20, line 12, strike "(g)," and insert "(h),".

21 Page 20, line 14, strike "three (3)" and insert "**six (6)**".

22 Page 20, line 17, strike "three (3)" and insert "**six (6)**".

23 Page 20, line 20, strike "(g)" and insert "(h)".

24 Page 20, line 23, strike "(b)," and insert "(c),".

25 Page 20, line 31, strike "(h)" and insert "(i)".

26 Page 21, between lines 23 and 24, begin a new paragraph and insert:

27 "SECTION 14. [EFFECTIVE JULY 1, 2003] (a) **The Indiana**
 28 **comprehensive health insurance association established by**
 29 **IC 27-8-10-2.1 and the office of Medicaid policy and planning**
 30 **established by IC 12-8-6-1 shall jointly consider the use of all or a**
 31 **part of:**

32 (1) **assessments made under IC 27-8-10; and**

33 (2) **funds, if any, realized by the state due to a reduction in tax**
 34 **credits taken under IC 27-8-10;**

35 **as the nonfederal share of payments under a payment program**
 36 **described in subsection (b).**

37 (b) **In conjunction with the joint efforts described in subsection**
 38 **(a), the association and the office shall consider and, if feasible,**
 39 **develop Medicaid payment programs that, using funding described**
 40 **in subsection (a):**

41 (1) **provide Medicaid add-on payments to providers (as**
 42 **defined in IC 12-7-2-149(2)) or affiliated entities of providers**
 43 **on the basis of the provider's provision of care to individuals**
 44 **covered under an association policy (as defined in**
 45 **IC 27-8-10-1); or**

46 (2) **to the extent permitted by applicable federal Medicaid**
 47 **law, condition a provider's Medicaid payment on the**

1 **provider's tender of funds to the association or another**
2 **nongovernmental entity established to fund care to**
3 **individuals covered under an association policy.**
4 **(c) If mutually agreed, the association and the office may**
5 **implement a payment program developed under subsection (b).**
6 **SECTION 15. [EFFECTIVE JULY 1, 2003] If the amount of**
7 **reimbursement for health care services covered under an Indiana**
8 **comprehensive health insurance association policy is specified**
9 **under a contract with a health care provider, IC 27-8-10-3, as**
10 **amended by this act, applies to a contract specifying the amount of**
11 **reimbursement for health care services that is entered into,**
12 **delivered, amended, or renewed after June 30, 2003."**
13 Renumber all SECTIONS consecutively.
 (Reference is to EHB 1749 as printed March 28, 2003.)

Senator MILLER