SENATE BILL No. 300

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8-7.4; IC 12-7-2-135.8; IC 12-15-5-1; IC 27-8-10.

Synopsis: State coverage for Papanicolaou tests. Requires a state employee health benefit plan, Medicaid, and a comprehensive health insurance association policy to cover Papanicolaou testing.

Effective: July 1, 2005.

Simpson

January 6, 2005, read first time and referred to Committee on Health and Provider Services.

Introduced

First Regular Session 114th General Assembly (2005)

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 2004 Regular Session of the General Assembly.

SENATE BILL No. 300

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

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

SECTION 1. IC 5-10-8-7.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 7.4. (a) As used in this section, "covered individual" means an individual who is entitled to coverage under a health benefit plan.**

(b) As used in this section, "health benefit plan" refers to a:

(1) self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) contract with a prepaid health care delivery plan entered into under section 7(c) of this chapter.

(c) As used in this section, "Papanicolaou testing" means the collection and examination of cells of the uterine cervix to make a determination regarding the presence of:

(1) cervical cancer;

(2) a viral infection; or

(3) cell changes that indicate increased risk for cervical cancer.

(d) A health benefit plan must provide coverage for Papanicolaou testing.

(e) The coverage required under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to a covered individual than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the health benefit plan.

(f) The coverage required under this section must be provided in addition to any benefits specifically provided for laboratory testing or wellness examinations.

SECTION 2. IC 12-7-2-135.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 135.8. "Papanicolaou testing" means the collection and examination of cells of the uterine cervix to make a determination regarding the presence of:**

(1) cervical cancer;

(2) a viral infection; or

(3) cell changes that indicate increased risk for cervical cancer.

SECTION 3. IC 12-15-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. Except as provided in IC 12-15-2-12, IC 12-15-6, and IC 12-15-21, the following services and supplies are provided under Medicaid:

(1) Inpatient hospital services.

(2) Nursing facility services.

(3) Physician's services, including services provided under IC 25-10-1 and IC 25-22.5-1.

(4) Outpatient hospital or clinic services.

(5) Home health care services.

(6) Private duty nursing services.

(7) Physical therapy and related services.

(8) Dental services.

(9) Prescribed laboratory and x-ray services.

(10) Prescribed drugs and services.

(11) Eyeglasses and prosthetic devices.

(12) Optometric services.

(13) Diagnostic, screening, preventive, and rehabilitative services.

(14) Podiatric medicine services.

(15) Hospice services.

(16) Services or supplies recognized under Indiana law and specified under rules adopted by the office.

(17) Family planning services except the performance of

abortions.

(18) Nonmedical nursing care given in accordance with the tenets and practices of a recognized church or religious denomination to an individual qualified for Medicaid who depends upon healing by prayer and spiritual means alone in accordance with the tenets and practices of the individual's church or religious denomination.

(19) Services provided to individuals described in IC 12-15-2-8 and IC 12-15-2-9.

(20) Services provided under IC 12-15-34 and IC 12-15-32.

(21) Case management services provided to individuals described in IC 12-15-2-11 and IC 12-15-2-13.

(22) Any other type of remedial care recognized under Indiana law and specified by the United States Secretary of Health and Human Services.

(23) Examinations required under IC 16-41-17-2(a)(10).

(24) Papanicolaou testing.

SECTION 4. IC 27-8-10-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federal income poverty level" has the meaning set forth in IC 12-15-2-1.

(j) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;
(B) governmental plan; or
(C) church plan;
or health insurance coverage in connection with any of these plans;
(2) who is not eligible for coverage under:
(A) a group health plan;
(B) Part A or Part B of Title XVIII of the federal Social Security Act; or
(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);
and does not have other health insurance coverage;
(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;
(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and
(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(k) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(l) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(m) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or

central services facility servicing one (1) or more such institutions.

(n) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(o) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(p) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(q) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(r) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(s) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(t) "Medical care payment" means amounts paid for:

(1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

(3) insurance covering medical care referred to in subdivisions (1) and (2).

(u) "Medically necessary" means health care services that the association has determined:

(1) are recommended by a legally qualified physician;

(2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and

(3) are not primarily for the scholastic education or vocational training of the provider or patient.

(v) "Medicare" means Title XVIII of the federal Social Security Act

(42 U.S.C. 1395 et seq.).

(w) "Papanicolaou testing" means the collection and examination of cells of the uterine cervix to make a determination regarding the presence of:

(1) cervical cancer;

(2) a viral infection; or

(3) cell changes that indicate increased risk for cervical cancer.

~~(w)~~ **(x)** "Policy" means a contract, policy, or plan of health insurance.

~~(x)~~ **(y)** "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

~~(y)~~ **(z)** "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

~~(z)~~ **(aa)** "Resident" means an individual who is:

(1) legally domiciled in Indiana for at least twelve (12) months before applying for an association policy; or

(2) a federally eligible individual and legally domiciled in Indiana.

~~(aa)~~ **(bb)** "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

~~(bb)~~ **(cc)** "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

~~(cc)~~ **(dd)** "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

~~(dd)~~ **(ee)** "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

~~(ee)~~ **(ff)** "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 5. IC 27-8-10-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 3. (a) An association

policy issued under this chapter may pay an amount for medically necessary eligible expenses related to the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. Payment under an association policy must be based on one (1) or a combination of the following reimbursement methods, as determined by the board of directors:

(1) The association's usual and customary fee schedule in effect on January 1, 2004. If payment is based on the usual and customary fee schedule in effect on January 1, 2004, the rates of reimbursement under the fee schedule must be adjusted annually by a percentage equal to the percentage change in the Indiana medical care component of the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics during the preceding calendar year.

(2) A health care provider network arrangement. If payment is based on a health care provider network arrangement, reimbursement under an association policy must be made according to:

(A) a network fee schedule for network health care providers and nonnetwork health care providers; and

(B) any additional coinsurance that applies to the insured under the association policy if the insured obtains health care services from a nonnetwork health care provider.

(b) Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

(1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or, at the physician's direction, by the physician's staff of registered or licensed nurses, and allied health professionals.

(3) The first twenty (20) professional visits for the diagnosis or treatment of one (1) or more mental conditions rendered during the year by one (1) or more physicians or, at their direction, by their staff of registered or licensed nurses, and allied health professionals.

(4) Drugs and contraceptive devices requiring a physician's

prescription.

(5) Services of a skilled nursing facility for not more than one hundred eighty (180) days in a year.

(6) Services of a home health agency up to two hundred seventy (270) days of service a year.

(7) Use of radium or other radioactive materials.

(8) Oxygen.

(9) Anesthetics.

(10) Prostheses, other than dental.

(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.

(12) Diagnostic x-rays and laboratory tests.

(13) Oral surgery for:

(A) excision of partially or completely erupted impacted teeth;

(B) excision of a tooth root without the extraction of the entire tooth; or

(C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(14) Services of a physical therapist and services of a speech therapist.

(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.

(16) Other medical supplies required by a physician's orders.

(17) Papanicolaou testing.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon such conditions, limitations, and requirements as may be determined by the board of directors.

(c) A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(d) This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

(e) For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

(f) The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

(g) The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

(h) This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

(i) This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity

and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.

SECTION 6. [EFFECTIVE JULY 1, 2005] **(a) IC 5-10-8-7.4, as added by this act, applies to a health benefit plan that is established, entered into, delivered, amended, or renewed after June 30, 2005.**

(b) IC 27-8-10-3, as amended by this act, applies to an association policy that is issued, delivered, amended, or renewed after June 30, 2005.