SENATE BILL No. 455

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-31.

Synopsis: Indiana health care system. Imposes various requirements on the state department of health, department of insurance, office of Medicaid policy and planning, and secretary of family and social services to develop and implement health care initiatives, including chronic care planning, premium assistance, health plan access, quality assurance, data collection and use, and study various health care issues. Requires application for appropriate Medicaid waivers.

Effective: July 1, 2007.

Simpson

January 11, 2007, read first time and referred to Committee on Health and Provider Services.

C o p y

Introduced

First Regular Session 115th General Assembly (2007)

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 2006 Regular Session of the General Assembly.

C o p y

SENATE BILL No. 455

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

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

1 SECTION 1. IC 12-31 IS ADDED TO THE INDIANA CODE AS
2 A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1,
3 2007]:
4 **ARTICLE 31. INDIANA HEALTH CARE SYSTEM**
5 **Chapter 1. Definitions.**
6 **Sec. 1. The definitions in this chapter apply throughout this**
7 **article.**
8 **Sec. 2. "Carrier" means a small employer insurer (as defined in**
9 **IC 27-8-15-15).**
10 **Sec. 3. "Chronic care" means health services provided by a**
11 **health provider for a clinical condition that is expected to last at**
12 **least one (1) year and that requires ongoing clinical management**
13 **to:**
14 **(1) restore the individual to highest function;**
15 **(2) minimize the negative effects of the condition; and**
16 **(3) prevent complications.**
17 **Sec. 4. "Chronic care information system" means the electronic**

data base developed under the chronic care plan that includes information on all cases of a particular disease or health condition in a defined population.

Sec. 5. "Chronic care management" means a system of coordinated health care interventions and communications for an individual with a chronic condition.

Sec. 6. "Chronic care plan" means the state's five (5) year plan for a chronic care infrastructure, prevention of chronic conditions, and a chronic care management program, including an integrated approach to patient self management, community development, health care system and professional practice change, and information technology initiatives.

Sec. 7. "Commissioner" refers to the state health commissioner appointed under IC 16-19-4-2.

Sec. 8. "Covered individual" means an individual entitled to coverage under a health plan.

Sec. 9. "Employee" means an individual who is at least eighteen (18) years of age and is employed by an employer in Indiana.

Sec. 10. "Full-time equivalent" means the number of employees expressed as the number of employee hours worked during a calendar quarter divided by five hundred twenty (520).

Sec. 11. "Health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 12. "Health plan" means:

(1) a policy of accident and sickness insurance;

(2) a health maintenance organization contract;

(3) Indiana health; or

(4) another plan of coverage for health services.

Sec. 13. "Health plan provider" means a person that issues, delivers, or administers a health plan.

Sec. 14. "Health provider" means an individual, partnership, corporation, facility, or institution licensed or certified under Indiana law to provide health services.

Sec. 15. "Health risk assessment" means screening by a health provider to assess an individual's health.

Sec. 16. "Health service" means a medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

Sec. 17. "Immunization" means administration of a vaccine as recommended by the practice guidelines for children and adults established by the Advisory Committee on Immunization Practices to the federal Centers for Disease Control and Prevention.

copy

1 **Sec. 18. "Indiana health" means the plan for coverage of**
2 **primary care, preventive care, chronic care, acute episodic care,**
3 **and hospital services as established in IC 12-31-9 to be provided**
4 **through a policy of accident and sickness insurance or a health**
5 **maintenance organization contract that is offered or issued to an**
6 **individual and meets the requirements of IC 12-31-9.**
7 **Sec. 19. "Office" refers to the office of Medicaid policy and**
8 **planning.**
9 **Sec. 20. "Policy of accident and sickness insurance" has the**
10 **meaning set forth in IC 27-8-5-1.**
11 **Sec. 21. "Preventive care" means health services provided by a**
12 **health provider to identify and treat an individual who has risk**
13 **factors or preclinical disease, but in whom the disease is not**
14 **clinically apparent, including immunizations and screening,**
15 **counseling, treatment, and medication determined by scientific**
16 **evidence to be effective in preventing or detecting a health**
17 **condition.**
18 **Sec. 22. (a) "Primary care" means health services provided by**
19 **a health provider that is:**
20 **(1) specifically trained for and skilled in first-contact and**
21 **continuing care for individuals with signs, symptoms, or**
22 **health concerns; and**
23 **(2) not limited by problem origin, organ system, or diagnosis.**
24 **(b) The term includes prenatal care and the treatment of mental**
25 **illness.**
26 **Sec. 23. "Resident" means an individual domiciled in Indiana.**
27 **Sec. 24. "State department" refers to the state department of**
28 **health established by IC 16-19-1-1.**
29 **Sec. 25. "Uncovered employee" means an employee:**
30 **(1) of an employer that does not offer to pay a part of the cost**
31 **of health coverage for the employer's employees;**
32 **(2) who is not eligible for health coverage offered by an**
33 **employer to another employee; or**
34 **(3) who is offered and is eligible for coverage by the**
35 **employee's employer, but elects not to accept the coverage**
36 **and has no other health coverage under a private or public**
37 **health plan.**
38 **Sec. 26. "Uninsured" means an individual who does not qualify**
39 **for Medicare, Medicaid, or the children's health insurance**
40 **program and:**
41 **(1) has not had health coverage, including hospital and**
42 **physician services, during the twelve (12) months before**

C o p y

1 **applying for premium assistance; or**
2 **(2) lost health coverage during the twelve (12) month period**
3 **before applying for premium assistance for any of the**
4 **following reasons:**
5 **(A) The individual's coverage ended due to:**
6 **(i) loss of employment;**
7 **(ii) death of the principal health plan policyholder or**
8 **subscriber;**
9 **(iii) divorce;**
10 **(iv) no longer qualifying as a dependent under a plan; or**
11 **(v) no longer qualifying for continuation coverage.**
12 **(B) College sponsored health coverage became unavailable**
13 **to the individual because the individual graduated, took a**
14 **leave of absence, or otherwise terminated studies.**
15 **Chapter 2. Administration**
16 **Sec. 1. The secretary is responsible for coordination of the**
17 **provisions of this article among necessary state agencies.**
18 **Sec. 2. (a) The secretary shall ensure that the state agencies**
19 **responsible for development and implementation of this article do**
20 **so in a timely, client focused manner emphasizing quality and**
21 **affordability of health services.**
22 **(b) The secretary shall report to the legislative council, in an**
23 **electronic format under IC 5-14-6, and the governor before**
24 **December 1, 2007, with a five (5) year strategic plan for**
25 **implementing Indiana's health care system reform initiatives**
26 **described in this article, and any recommendations for**
27 **administration or legislation.**
28 **(c) Annually, beginning January 15, 2008, the secretary shall**
29 **report to the legislative council in an electronic format under**
30 **IC 5-14-6 concerning the progress of the reform initiatives.**
31 **Chapter 3. Chronic Care Plan**
32 **Sec. 1. In coordination with the secretary, the commissioner is**
33 **responsible for the development and implementation of a chronic**
34 **care plan.**
35 **Sec. 2. The commissioner shall establish an executive committee**
36 **to advise the commissioner concerning the creation and**
37 **implementation of the chronic care plan as described in this**
38 **chapter.**
39 **Sec. 3. The executive committee shall consist of at least ten (10)**
40 **individuals, including the following:**
41 **(1) A representative of the department of insurance.**
42 **(2) A representative of the state department of health.**

copy

1 **(3) A representative of the Indiana State Medical Association.**
2 **(4) A representative of the Indiana Hospital and Health**
3 **Association.**
4 **(5) A representative of an accident and sickness insurer.**
5 **(6) A representative of a health maintenance organization.**
6 **(7) A consumer.**
7 **(8) A representative of complementary and alternative**
8 **medicine.**
9 **(9) A primary care health provider who serves low income or**
10 **uninsured residents.**
11 **(10) A representative of the Indiana comprehensive health**
12 **insurance association.**
13 **Sec. 4. The executive committee shall engage a broad range of**
14 **health providers who provide chronic care, health plans,**
15 **professional organizations, community and nonprofit groups,**
16 **consumers, businesses, school corporations, and state and local**
17 **government in developing and implementing the chronic care plan.**
18 **Sec. 5. The chronic care plan must include:**
19 **(1) a description of the chronic care plan, including:**
20 **(A) a method to involve health providers to identify eligible**
21 **patients, including the development and use of a chronic**
22 **care information system, an enrollment process to provide**
23 **incentives and strategies for maximum patient**
24 **participation, and a standard statewide health risk**
25 **assessment for each patient;**
26 **(B) a process for coordinating care among health**
27 **providers;**
28 **(C) a method of increasing communications among health**
29 **providers and patients, including patient education,**
30 **self-management, and follow-up plans;**
31 **(D) educational, wellness, and clinical management**
32 **protocols and tools used by a care management**
33 **organization, including management guideline materials**
34 **for health providers to assist in patient specific**
35 **recommendations;**
36 **(E) process and outcome measures to provide performance**
37 **feedback for health providers and information on the**
38 **quality of care, including patient satisfaction and health**
39 **status outcomes;**
40 **(F) payment methodologies to align reimbursements and**
41 **create financial incentives and rewards for health**
42 **providers to establish management systems for chronic**

C o p y

1 **conditions, to improve health outcomes, and to improve the**
2 **quality of care, including case management fees, pay for**
3 **performance, payment for technical support and data**
4 **entry associated with patient registries, the cost of staff**
5 **coordination within a medical practice, and any reduction**
6 **in a health provider's productivity;**
7 **(G) payment to a care management organization to put the**
8 **care management organization's fee at risk if the care**
9 **management organization is not successful in reducing**
10 **costs to the state;**
11 **(H) a requirement that patient data be shared, to the extent**
12 **allowable under federal law, with the secretary to provide**
13 **information on which to base the health care reform**
14 **initiatives under IC 12-31-2;**
15 **(I) a method for a care management organization to**
16 **participate closely in health care reform initiatives; and**
17 **(J) participation in pharmacy best practices and cost**
18 **control programs, including a multistate purchasing pool**
19 **and a statewide preferred drug list;**
20 **(2) a description of prevention programs and how the**
21 **programs are integrated into communities, with chronic care**
22 **management, and the chronic care plan;**
23 **(3) a plan to develop and implement reimbursement systems**
24 **aligned with the goal of managing the care for individuals**
25 **with or at risk for conditions to improve outcomes and the**
26 **quality of care;**
27 **(4) involvement of public and private groups, health**
28 **providers, health plans, third party administrators,**
29 **associations, and firms to facilitate and assure the**
30 **sustainability of a new system of care;**
31 **(5) involvement of community and consumer groups to**
32 **facilitate and assure the sustainability of health services**
33 **supporting healthy behaviors and good patient**
34 **self-management for the prevention and management of**
35 **chronic conditions;**
36 **(6) alignment of information technology needs with other**
37 **health information technology initiatives;**
38 **(7) use and development of outcome measures and reporting**
39 **requirements, aligned with existing outcome measures in the**
40 **office of the secretary, to assess and evaluate the system of**
41 **chronic care;**
42 **(8) target timelines for inclusion of specific chronic conditions**

C o p y

1 **to be included in the chronic care infrastructure and for**
2 **statewide implementation of the chronic care plan;**
3 **(9) identification of resource needs for implementation and to**
4 **sustain the chronic care plan, and strategies to meet the**
5 **needs; and**
6 **(10) a strategy to ensure statewide participation not later than**
7 **January 1, 2010, by health plans, third party administrators,**
8 **health providers, other professionals, and consumers in the**
9 **chronic care plan, including common outcome measures, best**
10 **practices and protocols, data reporting requirements,**
11 **payment methodologies, and other standards.**
12 **Sec. 6. The chronic care plan must be reviewed biennially and**
13 **amended as necessary to reflect changes in priorities. Amendments**
14 **to the plan must be reported to the legislative council in an**
15 **electronic format under IC 5-14-6.**
16 **Sec. 7. (a) The commissioner shall annually report to the**
17 **legislative council in an electronic format under IC 5-14-6**
18 **concerning the status of implementation of the chronic care plan.**
19 **(b) The report must include:**
20 **(1) the number of participating health plans, health providers,**
21 **and patients;**
22 **(2) the progress for achieving statewide participation in the**
23 **chronic care plan, including the measures established under**
24 **section 5 of this chapter;**
25 **(3) the expenditures and savings for the period;**
26 **(4) the results of health provider and patient satisfaction**
27 **surveys;**
28 **(5) the progress toward creation and implementation of**
29 **privacy and security protocols; and**
30 **(6) other information as requested by the general assembly.**
31 **(c) Surveys used to evaluate the chronic care plan must be**
32 **developed in collaboration with the executive committee**
33 **established under section 2 of this chapter.**
34 **Sec. 8. If statewide participation in the chronic care plan is not**
35 **achieved by January 1, 2010, the commissioner shall evaluate the**
36 **chronic care plan and recommend to the legislative council changes**
37 **necessary to create alternative measures to ensure statewide**
38 **participation by health plans, third party administrators, and**
39 **health providers. The recommendations must be in an electronic**
40 **format under IC 5-14-6.**
41 **Chapter 4. Chronic Care Management Program**
42 **Sec. 1. The secretary shall create a chronic care management**

C o p y

program to be administered or provided by a private entity for individuals who have a chronic condition and are enrolled in Medicaid or the children's health insurance program.

Sec. 2. The chronic care management program may not include individuals who are also eligible for Medicare.

Sec. 3. The secretary shall include a broad range of chronic conditions in the chronic care management program.

Sec. 4. The chronic care management program must be designed to include the components required for the chronic care plan as described in IC 12-31-3-5(1).

Sec. 5. (a) The secretary shall issue a request for proposals for the chronic care management program and shall review the request for proposals with the executive committee and obtain approval from the executive committee before issuance.

(b) A contract entered into as a result of a request for proposals under this section may allow the contracting entity to subcontract services to other entities if subcontracting is cost effective, efficient, or in the best interest of individuals enrolled in the chronic care management program.

Sec. 6. The secretary shall ensure that the chronic care management program is modified over time to comply with the chronic care plan.

Chapter 5. Chronic Condition Prevention Plan

Sec. 1. (a) Before January 1, 2008, the commissioner shall develop an implementation plan for prevention of chronic conditions and chronic care management that meets the requirements specified in this article for the chronic care plan and the chronic care management program.

(b) The commissioner's implementation plan must be revised periodically to reflect changes to the chronic care plan.

(c) In addition to the chronic care management program, the state department may provide additional care coordination services to appropriate individuals as provided in the chronic care plan.

(d) The office shall:

(1) ensure that Medicaid, Medicaid waiver programs, and the children's health insurance program change payment methodologies to align with the recommendations of the chronic care plan and the request for proposals under IC 12-31-4-5; and

(2) analyze and make recommendations to the secretary and the commissioner concerning Medicaid waivers or waiver

C
o
p
y

modifications needed to implement the chronic care management program.

Sec. 2. As permitted under federal law, the office shall require recertification or reapplication for Medicaid and the children's health insurance program only one (1) time each year.

Sec. 3. The state personnel department shall:

(1) include in any request for proposals for the administration of the state employee health benefit plans under IC 5-10-8 a request for a description of any chronic care management program provided by the entity and how the program aligns with the chronic care plan developed under IC 12-31-3; and

(2) work with the secretary and any state employee association concerning the manner and time in which to align the state employee health benefit plans with the goals and statewide standards developed by the chronic care plan.

Chapter 6. Employer Sponsored Health Benefit Plan Premium Assistance

Sec. 1. (a) Before October 1, 2008, subject to approval by the federal Centers for Medicare and Medicaid Services, the office shall establish a premium assistance program to assist an uninsured individual with a family income less than three hundred percent (300%) of the federal income poverty level, and any dependents, to purchase coverage under an employer sponsored health benefit plan for which the individual is eligible.

(b) The office shall determine whether to include in the premium assistance program, at the request of a child's parents, a child who is eligible for Medicaid or the children's health insurance program.

(c) The office may not require a child to participate in an employer sponsored health benefit plan.

Sec. 2. An individual is eligible for premium assistance under this chapter if the individual:

(1) is an uninsured resident;

(2) has family income that is less than three hundred percent (300%) of the federal income poverty level;

(3) is eligible for coverage under an employer sponsored health benefit plan; and

(4) is at least eighteen (18) years of age and is not claimed on a tax return as a dependent of a resident of another state.

Sec. 3. (a) The premium assistance program established under section 1 of this chapter must provide a subsidy for premiums or cost sharing amounts for an employer sponsored health benefit

C o p y

1 **plan based on the household income of the eligible individual, with**
2 **greater financial assistance provided to an eligible individual with**
3 **a lower family income.**
4 **(b) Until an approved employer sponsored health benefit plan**
5 **is required to meet the standard in section 4 of this chapter, a**
6 **subsidy under this chapter must include premium assistance and**
7 **assistance to cover all cost sharing amounts for chronic care.**
8 **Sec. 4. (a) In consultation with the department of insurance, the**
9 **office shall develop criteria for approving employer sponsored**
10 **health benefit plans to ensure the plans provide comprehensive and**
11 **affordable health coverage when combined with premium**
12 **assistance under this chapter.**
13 **(b) At a minimum, an approved employer sponsored health**
14 **benefit plan must include:**
15 **(1) covered benefits that are substantially similar, as**
16 **determined by the office, to the benefits covered under**
17 **Indiana health; and**
18 **(2) coverage of chronic conditions that is substantially similar**
19 **to coverage of chronic conditions under Indiana health.**
20 **Sec. 5. (a) The office shall determine whether requiring an**
21 **individual to purchase coverage under an approved employer**
22 **sponsored health benefit plan with premium assistance under this**
23 **chapter is more cost effective to the state than coverage of the**
24 **individual under Indiana health with Indiana health assistance**
25 **under IC 12-31-9.**
26 **(b) If providing the individual with assistance to purchase**
27 **Indiana health is determined to be most cost effective under**
28 **subsection (a), the state shall provide the individual the option of**
29 **purchasing Indiana health with Indiana health assistance.**
30 **(c) An individual may purchase Indiana health and receive**
31 **Indiana health assistance until an approved employer sponsored**
32 **health benefit plan has an open enrollment period. However, the**
33 **individual shall enroll in the approved employer sponsored health**
34 **benefit plan to continue to receive assistance in the form of**
35 **premium assistance under this chapter.**
36 **Sec. 6. If the office determines that the funds appropriated for**
37 **the premium assistance program under this chapter are**
38 **insufficient to meet the projected costs of enrolling new program**
39 **participants, the office shall suspend new enrollment in the**
40 **program or restrict enrollment to eligible lower income**
41 **individuals. This section does not affect eligibility for the purchase**
42 **of Indiana health.**

C
o
p
y

1 **Sec. 7. The office shall report monthly to the budget committee**
2 **concerning:**
3 **(1) the number of individuals enrolled in the premium**
4 **assistance program;**
5 **(2) the income levels of the individuals described in**
6 **subdivision (1);**
7 **(3) a description of the range and types of employer sponsored**
8 **health benefit plans that have been approved;**
9 **(4) the percentage of premium and cost sharing amounts paid**
10 **by employers with employees participating in the premium**
11 **assistance program; and**
12 **(5) the net savings or cost of the premium assistance program.**
13 **Chapter 7. Information Technology and Administration**
14 **Sec. 1. The office may, not later than October 1, 2008, enter into**
15 **a contract with one (1) provider of information technology or**
16 **administrative services necessary for application simplification,**
17 **surveys, outreach and enrollment assistance, reporting, and public**
18 **notices and hearings, if necessary, to implement the premium**
19 **assistance program and the Indiana health assistance program,**
20 **and to provide seamless transition of an individual from program**
21 **to program.**
22 **Chapter 8. Indiana Health**
23 **Sec. 1. (a) The secretary shall, not later than July 1, 2008,**
24 **establish Indiana health to provide a program of coverage for**
25 **primary care, preventive care, chronic care, acute episodic care,**
26 **and hospital care health services.**
27 **(b) The benefits for Indiana health must be provided through**
28 **one (1) or more preferred provider health plans with:**
29 **(1) a two hundred fifty dollar ($250) deductible for an**
30 **individual and a five hundred dollar ($500) deductible for a**
31 **family for health services received in network, and a five**
32 **hundred dollar ($500) deductible for an individual and a one**
33 **thousand dollar ($1,000) deductible for a family for health**
34 **services received out of network;**
35 **(2) twenty percent (20%) co-insurance, in and out of network;**
36 **(3) a ten dollar ($10) office visit co-payment;**
37 **(4) prescription drug coverage with:**
38 **(A) no deductible;**
39 **(B) a ten dollar ($10) co-payment for generic drugs;**
40 **(C) a thirty dollar ($30) co-payment for drugs on a**
41 **preferred drug list; and**
42 **(D) a fifty dollar ($50) co-payment for drugs not on a**

C o p y

1 **preferred drug list;**
2 **(5) out-of-pocket maximums of eight hundred dollars ($800)**
3 **for an individual and one thousand six hundred dollars**
4 **($1,600) for a family for in-network services and one thousand**
5 **five hundred dollars ($1,500) for an individual and three**
6 **thousand dollars ($3,000) for a family for out-of-network**
7 **services; and**
8 **(6) a waiver of the deductible and other cost sharing for**
9 **chronic care for individuals participating in a chronic care**
10 **management program provided under section 2 of this**
11 **chapter and for preventive care.**
12 **Sec. 2. Indiana health shall:**
13 **(1) provide a chronic care management program that has**
14 **criteria substantially similar to the chronic care management**
15 **program established under IC 12-31-4; and**
16 **(2) share enrollee data, to the extent allowed under federal**
17 **law, with the secretary to inform the health care reform**
18 **initiatives under this article.**
19 **Sec. 3. (a) A carrier shall file a letter of intent to provide**
20 **coverage under the carrier's health plans for Indiana health.**
21 **(b) A person may not sell, offer, or renew Indiana health unless**
22 **the person is a carrier and has filed a letter of intent under this**
23 **chapter.**
24 **(c) Notwithstanding any other law, a carrier may use financial**
25 **or other incentives to encourage healthy lifestyles and patient**
26 **self-management for individuals covered by Indiana health.**
27 **(d) Incentives described in subsection (c) must comply with**
28 **health promotion and disease prevention program rules adopted**
29 **by the commissioner.**
30 **Sec. 4. (a) To the extent Indiana health provides coverage for a**
31 **particular health service or for a particular health condition,**
32 **Indiana health must cover the health services and conditions when**
33 **provided by any type of health provider acting within the health**
34 **provider's scope of practice under Indiana law.**
35 **(b) Indiana health may establish a term or condition that places**
36 **a greater financial burden on an individual for access to treatment**
37 **according to the type of health provider that provides the health**
38 **service only if the financial burden is related to the efficacy or cost**
39 **effectiveness of the health service as provided by the health**
40 **provider.**
41 **Sec. 5. Notwithstanding any other law, the commissioner may**
42 **establish a pay for performance demonstration project for carriers**

C o p y

offering Indiana health.
Sec. 6. (a) A carrier shall guarantee acceptance of:
(1) any uninsured individual for any health plan offered by the carrier for Indiana health in Indiana; and
(2) each dependent of an uninsured individual covered under Indiana health.
(b) An individual who is eligible for an employer sponsored health benefit plan may not purchase Indiana health, except as provided in section 7 of this chapter.
(c) An individual must not have coverage under any health plan for at least twelve (12) months before the individual is eligible for coverage under Indiana health.
(d) A dispute regarding eligibility for Indiana health must be resolved by the state department in a manner provided for in rules adopted under IC 4-22-2.
Sec. 7. An individual with a family income that is less than three hundred percent (300%) of the federal income poverty level and who is eligible for an employer sponsored health benefit plan may purchase coverage under Indiana health if:
(1) the individual's employer sponsored health benefit plan is not an approved employer sponsored health benefit plan under IC 12-31-6;
(2) enrolling the individual in an approved employer sponsored health benefit plan with premium assistance under IC 12-31-6 is not cost effective to the state as compared to enrolling the individual in Indiana health combined with Indiana health assistance; or
(3) the individual is eligible for employer sponsored health benefit plan premium assistance under IC 12-31-6, but is unable to enroll in the employer sponsored health benefit plan until the next open enrollment period.
Sec. 8. An individual who loses eligibility for premium assistance under IC 12-31-6 may purchase Indiana health without being uninsured for twelve (12) months.
Sec. 9. An individual who is at least eighteen (18) years of age and is claimed on a tax return as a dependent of a resident of another state is not eligible to purchase Indiana health.
Sec. 10. (a) For a twelve (12) month period from the effective date of coverage, a carrier offering Indiana health may limit coverage of a preexisting condition that existed during the twelve (12) month period before the effective date of coverage, except that the exclusion or limitation does not apply to care of a chronic

C o p y

condition if the individual participates in a chronic care management program.

(b) A carrier shall waive a preexisting condition provision for an individual and dependents of the individual if the individual produces evidence of continuous creditable coverage (as defined in the federal Health Insurance Portability and Accountability Act (26 U.S.C. 9801(c)(1)) during the previous nine (9) months.

(c) If an individual described in subsection (b) has a preexisting condition for which coverage is excluded under Indiana health, the Indiana health exclusion must not continue longer than the remainder of the period for which coverage was excluded under the creditable coverage or twelve (12) months, whichever is less.

(d) In determining a preexisting condition exclusion period under Indiana health, the carrier shall credit prior coverage that occurred without a break in coverage of sixty-three (63) days or more.

Sec. 11. (a) Except as provided in subsection (b), a carrier shall make payments under an Indiana health plan to health providers using the Medicare payment methodologies plus ten percent (10%).

(b) Payments under this section must be indexed to the Medicare economic index developed by the federal Centers for Medicare and Medicaid Services.

(c) Payments for hospital services must be calculated using the Medicare payment methodology adjusted for each hospital to ensure payments at one hundred ten percent (110%) of the hospital's actual cost for services.

(d) Payments under subsection (c) must be indexed to changes in the Medicare payment rules, but must not be lower than one hundred two percent (102%) of the hospital's actual cost for services.

Sec. 12. Payments for chronic care and chronic care management health services must meet the requirements established under IC 12-31-3 and IC 12-31-4.

Sec. 13. If Medicare does not pay for a health service covered under Indiana health, the commissioner shall establish another payment amount for the health service, determined after consultation with affected health providers and health plan providers.

Sec. 14. A carrier offering Indiana health shall renegotiate existing contracts with health providers as necessary to make payments according to the requirements of this chapter.

Sec. 15. Approval of rates and forms for Indiana health plans

C o p y

1 **must be done according to the process established in this chapter**
2 **and the requirements of IC 27, including the following:**
3 **(1) Premium rates must be actuarially determined considering**
4 **differences in the demographics of the populations and the**
5 **different levels and methods of reimbursement for health**
6 **providers.**
7 **(2) A rate or form must not be approved if the rate or form**
8 **contains a provision that is unjust, unfair, inequitable,**
9 **misleading, or contrary to Indiana law.**
10 **(3) A rate must be approved if the rate:**
11 **(A) is sufficient not to threaten the financial safety and**
12 **soundness of the carrier;**
13 **(B) reflects efficient and economical management;**
14 **(C) provides Indiana health at the most reasonable price**
15 **consistent with actuarial review;**
16 **(D) is not unfairly discriminatory; and**
17 **(E) complies with the other requirements of this chapter**
18 **and IC 27.**
19 **(4) A carrier shall, with each rate filing, file a certification by**
20 **a member of the American Academy of Actuaries of the**
21 **carrier's compliance with this chapter.**
22 **Sec. 16. Indiana health must be offered with a rate structure**
23 **that at least differentiates among single person, two person, and**
24 **family rates, and the rates must be guaranteed for twelve (12)**
25 **months from the date the individual enrolls.**
26 **Sec. 17. (a) A carrier offering Indiana health shall use a**
27 **community rating method acceptable to the commissioner to**
28 **determine premiums for Indiana health plans.**
29 **(b) Indiana health plans constitute a separate market and must**
30 **be rated as a distinct pool, separate from other individual or group**
31 **health plan products.**
32 **(c) The following risk classification factors are prohibited from**
33 **use in rating individuals and dependents of individuals for Indiana**
34 **health plans:**
35 **(1) demographic rating, including age and gender rating;**
36 **(2) geographic area rating;**
37 **(3) industry rating;**
38 **(4) medical underwriting and screening;**
39 **(5) experience rating;**
40 **(6) tier rating; or**
41 **(7) durational rating.**
42 **Sec. 18. Indiana health is considered to be an individual health**

C
o
p
y

1 **plan for purposes of Indiana law, but is not subject to IC 27-8-5.**
2 **Sec. 19. (a) Indiana health must not be sold before October 1,**
3 **2008. Rates and forms may be filed and approved before October**
4 **1, 2008, and marketing and sales targeted to an effective date of**
5 **October 1, 2008, may occur as determined by the commissioner.**
6 **(b) A letter of intent, proposed rates, and proposed forms must**
7 **be filed by a carrier as required by this chapter.**
8 **(c) A carrier shall notify the department that the carrier intends**
9 **to offer Indiana health by filing written notice of intent not later**
10 **than thirty (30) days after the effective date of emergency Indiana**
11 **health rules adopted under IC 4-22-2-37.1.**
12 **(d) Forms must be filed with the department of insurance,**
13 **initially not later than five (5) months after the letter of intent**
14 **described in subsection (c), and upon any change. Forms may not**
15 **be used until the forms are approved by the department of**
16 **insurance. The department of insurance shall notify the carrier not**
17 **later than forty-five (45) days after a form is filed whether the**
18 **form meets the requirements of this chapter and IC 27.**
19 **(e) Rates must be filed with the department of insurance before**
20 **use and initially not later than five (5) months after the letter of**
21 **intent described in subsection (c). Thereafter, rates must be filed**
22 **at least annually on a schedule and in a manner established by rule.**
23 **The department of insurance shall notify the carrier not later than**
24 **forty-five (45) days after rates are filed whether the rates meet the**
25 **requirements of this chapter and IC 27.**
26 **(f) The insurance commissioner shall provide a hearing under**
27 **IC 4-21.5 for a denial of a rate or form filing.**
28 **(g) A carrier may discontinue sales of Indiana health upon at**
29 **least six (6) months written notice to the insurance commissioner.**
30 **Following the notice, the insurance commissioner may approve**
31 **premium rates adjusted by the average Indiana individual health**
32 **plan trends for cost and utilization for the previous six (6) months**
33 **if there are any individuals who continue to be covered by Indiana**
34 **health for whom the carrier does not have approved premium**
35 **rates.**
36 **Chapter 9. Indiana Health Assistance Program**
37 **Sec. 1. The Indiana health assistance program is established to**
38 **provide uninsured residents financial assistance in purchasing**
39 **Indiana health.**
40 **Sec. 2. Except as provided in sections 3 and 4 of this chapter, an**
41 **individual is eligible for Indiana health assistance if the individual**
42 **is an uninsured resident who is not eligible for coverage under an**

C
o
p
y

1 **approved employer sponsored health benefit plan.**
2 **Sec. 3. (a) An individual who is eligible for coverage under an**
3 **employer sponsored health benefit plan is eligible for the Indiana**
4 **health assistance program only if the individual is not approved for**
5 **premium assistance IC 12-31-6 or if it is more cost effective to the**
6 **state for the individual to purchase Indiana health with Indiana**
7 **health assistance than for the state to provide premium assistance**
8 **under IC 12-31-6.**
9 **(b) An individual may receive temporary Indiana health**
10 **assistance until the individual is able to enroll in an approved**
11 **employer sponsored health benefit plan and receive premium**
12 **assistance under IC 12-31-6.**
13 **Sec. 4. An individual is not eligible for Indiana health assistance**
14 **if the individual is at least eighteen (18) years old and is claimed on**
15 **a tax return as a dependent of a resident of another state.**
16 **Sec. 5. An individual who is covered under Medicaid, the**
17 **children's health insurance program, or receives premium**
18 **assistance under IC 12-31-6 during the (12) months immediately**
19 **preceding the individual's application for Indiana health assistance**
20 **is not required to wait twelve (12) months to be eligible for Indiana**
21 **health assistance.**
22 **Sec. 6. The secretary shall adopt rules under IC 4-22-2 to**
23 **establish specific criteria to demonstrate eligibility consistent with**
24 **the requirements essential for federal financial participation,**
25 **including criteria for and proof of residency, income, and**
26 **insurance status.**
27 **Sec. 7. If the secretary determines that the funds appropriated**
28 **for Indiana health assistance are insufficient to meet the projected**
29 **costs of enrolling new program participants, the secretary shall**
30 **suspend new enrollment in the program or restrict enrollment to**
31 **eligible lower income individuals.**
32 **Sec. 8. The secretary shall provide assistance to individuals**
33 **eligible under this chapter to purchase Indiana health. The amount**
34 **of the assistance is the difference between the premium for Indiana**
35 **health and the individual's contribution determined under section**
36 **9 of this chapter.**
37 **Sec. 9. (a) Subject to amendment in each biennial budget, the**
38 **secretary shall establish individual and family contribution**
39 **amounts for Indiana health under this chapter for the first year of**
40 **Indiana health assistance and shall index the contributions in**
41 **future years to the overall growth in spending per enrollee in**
42 **Indiana health.**

C
o
p
y

1 **(b) The secretary shall establish family contributions by income**
2 **bracket based on the individual contribution amounts and the**
3 **average family size.**
4 **(c) During fiscal year 2009, for the Indiana health plan offered**
5 **at the lowest cost, the individual's contribution must be as**
6 **established in subsection (d). The secretary shall determine the**
7 **percentages that the amounts in subsection (d) are of the lowest**
8 **cost Indiana health plan and set the individual's contribution for**
9 **any other plan at the percentage for the income level. In years**
10 **following fiscal year 2009, after adjusting the individual premiums**
11 **in subsection (d), the same methodology must be used to determine**
12 **the individual premiums for other plans.**
13 **(d) An individual's contribution for the lowest cost Indiana**
14 **health plan is as follows:**
15 **(1) For an individual with a family income less than or equal**
16 **to two hundred percent (200%) of the federal income poverty**
17 **level the contribution is sixty dollars ($60) per month.**
18 **(2) For an individual with a family income greater than two**
19 **hundred percent (200%) and less than or equal to two**
20 **hundred twenty-five percent (225%) of the federal income**
21 **poverty level the contribution is ninety dollars ($90) per**
22 **month.**
23 **(3) For an individual with a family income greater than two**
24 **hundred twenty-five percent (225%) and less than or equal to**
25 **two hundred fifty percent (250%) of the federal income**
26 **poverty level the contribution is one hundred ten dollars**
27 **($110) per month.**
28 **(4) For an individual with a family income greater than two**
29 **hundred fifty percent (250%) and less than or equal to two**
30 **hundred seventy-five percent (275%) of the federal income**
31 **poverty level the contribution is one hundred twenty-five**
32 **dollars ($125) per month.**
33 **(5) For an individual with a family income greater than two**
34 **hundred seventy-five percent (275%) and less than or equal**
35 **to three hundred percent (300%) of the federal income**
36 **poverty level the contribution is one hundred thirty-five**
37 **dollars ($135) per month.**
38 **(6) For an individual with a family income greater than three**
39 **hundred percent (300%) of the federal income poverty level**
40 **the contribution is the actual cost of Indiana health.**
41 **Chapter 10. Administration of Indiana Health and the Indiana**
42 **Health Assistance Program**

C
o
p
y

1 **Sec. 1. The secretary shall engage in an aggressive enrollment**
2 **strategy for Indiana health and the Indiana health assistance**
3 **program, including the following:**
4 **(1) The secretary shall establish a toll-free telephone**
5 **assistance line to provide information and enrollment**
6 **assistance on Indiana health and Indiana health assistance.**
7 **(2) The secretary shall ensure that individuals may receive**
8 **forms or other enrollment information from the carriers**
9 **offering Indiana health.**
10 **Sec. 2. An individual applying for or enrolled in Indiana health**
11 **assistance and who is aggrieved by an adverse decision of the**
12 **secretary may file a complaint with the secretary who shall provide**
13 **the individual with a hearing under IC 4-21.5.**
14 **Chapter 11. Indiana Health Fund**
15 **Sec. 1.The Indiana health fund is established for the purpose of**
16 **funding this article. The fund shall be administered by the**
17 **secretary.**
18 **Sec. 2. The expenses of administering the fund shall be paid**
19 **from money in the fund.**
20 **Sec. 3. The treasurer of state shall invest the money in the fund**
21 **not currently needed to meet the obligations of the fund in the same**
22 **manner as other public money may be invested. Interest that**
23 **accrues from these investments shall be deposited in the fund.**
24 **Sec. 4. Money in the fund at the end of a state fiscal year does**
25 **not revert to the state general fund.**
26 **Sec. 5. The proceeds from grants, donations, contributions,**
27 **taxes, appropriations, and any other source of revenue must be**
28 **deposited in the fund.**
29 **Chapter 12. Commission on Health Care Reform**
30 **Sec. 1. The commission on health care reform is established to**
31 **determine legislative and administrative action necessary to**
32 **achieve health care reform.**
33 **Sec. 2. The commission consists of the following members:**
34 **(1) Four (4) members of the house of representatives,**
35 **appointed by the speaker of the house of representatives, not**
36 **more than two (2) of whom represent the same political party.**
37 **One (1) member appointed under this subdivision shall serve**
38 **as chairperson of the commission in even numbered years.**
39 **(2) Four (4) members of the senate, appointed by the**
40 **president pro tempore of the senate, not more than two (2) of**
41 **whom represent the same political party. One (1) member**
42 **appointed under this subdivision shall serve as chairperson of**

C o p y

1 **the commission in odd numbered years.**
2 **Sec. 3. The commission shall operate under the policies**
3 **governing study committees adopted by the legislative council.**
4 **Sec. 4. The affirmative votes of a majority of the voting**
5 **members appointed to the committee are required for the**
6 **committee to take action on any measure, including final reports.**
7 **Sec. 5. From July 1, 2007, through June 30, 2008, the committee**
8 **shall:**
9 **(1) monitor the development, implementation, and ongoing**
10 **operation of health care reform initiatives under this article;**
11 **(2) study areas of health care reform as required by the**
12 **general assembly; and**
13 **(3) receive input and make recommendations, not later than**
14 **October 31, 2008, to the legislative council in an electronic**
15 **format under IC 5-14-6 regarding the long term development**
16 **of policies and programs designed to ensure that, by 2011,**
17 **Indiana has an integrated system of care that provides all**
18 **residents with access to affordable, high quality health**
19 **coverage that is financed in a fair and equitable manner.**
20 **Sec. 6. This chapter expires December 31, 2008.**
21 **Chapter 13. Immunizations**
22 **Sec. 1. (a) If funding is available under the Indiana health fund,**
23 **the secretary shall provide payment for any resident to receive**
24 **immunizations without cost to the resident.**
25 **(b) The secretary is the secondary payer to Medicaid, Medicare,**
26 **the children's health insurance program, and any public program**
27 **that covers immunizations.**
28 **Sec. 2. (a) The commissioner shall study methods to ensure that**
29 **all residents have access to immunizations.**
30 **(b) In conducting the study under subsection (a), the**
31 **commissioner shall consult with the secretary, the office, the**
32 **department of insurance and other interested parties.**
33 **(c) The study must include the following:**
34 **(1) Effective strategies for improving immunization rates,**
35 **including options for:**
36 **(A) enhancing access to vaccination services in medical and**
37 **public health settings; and**
38 **(B) strengthening school and child care immunization**
39 **requirements.**
40 **(2) Recommendations for expanding immunization programs**
41 **to adults.**
42 **(3) Recommendations for improving quality assurance and**

C
o
p
y

quality improvement in assuring proper vaccine storage and handling, measuring immunization coverage rates, and addressing barriers to coverage.
(4) Options for sustainable funding for the purchase and administration of vaccines, including:
(A) equitable sharing of cost of the state's immunization program between public and private resources; and
(B) payment by the state of a reasonable fee to health providers for individuals receiving coverage for immunizations through Indiana health.
(d) The commissioner shall report the findings and recommendations of the study to the legislative council in an electronic format under IC 5-14-6 not later than January 15, 2008.
Chapter 14. Hospital Uncompensated Care Study
Sec. 1. (a) The commissioner and the insurance commissioner, in consultation with representatives of the Indiana Hospital and Health Association, third party payers, other interested parties, and consumers, shall review the uncompensated care and bad debt policies of Indiana's hospitals and recommend a standard statewide uniform uncompensated care and bad debt policy.
(b) The standard policy must include criteria for payment forgiveness for the cost of health services received by low income patients, criteria for a sliding scale payment amount for patients with family incomes less than certain income levels, a method for calculating the amount of health services received by the patient, and other criteria necessary for ensuring that health services received by uninsured and underinsured patients is billed in a uniform and consistent manner.
(c) In addition to a standard policy, the commissioners may recommend:
(1) reasons for and a method of approving deviations from the standard policy by a hospital; or
(2) a set of standard policies to be applied to hospitals based on particular criteria, such as a designation as a critical access hospital, the income median in an area, or other rationale.
Sec. 2. (a) The commissioners, in consultation with the representatives listed in section 1(a) of this chapter, shall determine a fair and thorough method for calculating and reporting information about uncompensated health services and bad debt to the state department to ensure accurate accounting in hospital budgets and other health care facility planning, as well as collecting information about the types of patients accessing

C
o
p
y

uncompensated health services or who are unable to pay for the health services received.

(b) The commissioners shall consider collecting information about each patient receiving health services, including the patient's primary insurance status and employer, the actual cost of the health services received, any amount paid for the health services, and any discounts provided to the patient by the hospital.

Sec. 3. The commissioners shall report findings and recommendations to the legislative council in an electronic format under IC 5-14-6 not later than January 15, 2008.

Chapter 15. Individual Health Plan Market Study

Sec. 1. The department of insurance, in consultation with individual health plan providers, shall, not later than January 15, 2008, recommend to the legislative council in an electronic format under IC 5-14-6 the best method to consolidate the individual health plan market into a single risk pool of insured residents with access to health plans equivalent to or better than Indiana health plans.

Chapter 16. Health Care Reform Report

Sec. 1. Not later than January 15, 2010, the secretary shall report to the legislative council in an electronic format under IC 5-14-6, concerning:

(1) the percentage of uninsured residents and the number of insured residents by coverage type based on a survey conducted by the state department;

(2) an analysis of the trends of Indiana health costs and trends in the revenue sources for Indiana health;

(3) the feasibility of allowing individuals who are not uninsured and employers to purchase coverage under Indiana health plans at full premium cost; and

(4) the number of individuals enrolled in any chronic care management program which complies with the requirements of this article, including individuals covered by private health plans.

Chapter 17. Healthy Lifestyle Discounts

Sec. 1. A carrier shall use a community rating method acceptable to the commissioner of the department of insurance to determine premiums for small group plans. Except as provided in subdivision (2), the following risk classification factors may not be used in rating small groups, employees$_2$ or members of small groups, and dependents of the employees or members:

(1) demographic rating, including age and gender rating;

C o p y

(2) geographic area rating;
(3) industry rating;
(4) medical underwriting and screening;
(5) experience rating;
(6) tier rating; or
(7) durational rating.

Sec. 2. (a) The insurance commissioner shall adopt rules under IC 4-22-2 to establish standards and a process for permitting a carrier to use one (1) or more risk classifications in the carrier's community rating method. However, the premium charged may not deviate above or below the community rate filed by the carrier by more than twenty percent (20%) and the rules may not permit any medical underwriting and screening.

(b) The rules adopted under subsection (a) must permit a carrier to establish rewards, premium discounts, rebates, or otherwise waive or modify applicable copayments, deductibles, or other cost sharing amounts in return for adherence by an insured to programs of health promotion and disease prevention.

Sec. 3. The commissioner and the insurance commissioner shall develop health promotion and disease prevention rules under IC 4-22-2, including:
(1) limiting a reward, discount, rebate, or waiver or modification of cost sharing amounts to not more than a total of fifteen percent (15%) of the cost of the premium for the applicable coverage tier, provided that the sum of rate deviations described in section 2(a) of this chapter does not exceed thirty percent (30%);
(2) a design that promotes good health or prevents disease for individuals in the program and is not used solely to impose higher costs on an individual based on a health factor;
(3) provides that the reward under the program is available to all similarly situated individuals;
(4) provides a reasonable alternative standard to obtain the reward to any individual for whom obtaining the reward is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and discloses in all plan materials that describe the discount program the availability of a reasonable alternative standard;
(5) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence based medical practices;

C o p y

1 **(6) standards and procedures for evaluating an individual's**
2 **adherence to programs of health promotion and disease**
3 **prevention; and**
4 **(7) other standards and procedures necessary or desirable to**
5 **carry out the purposes of this chapter.**
6 **Sec. 4. An individual health plan provider shall use a community**
7 **rating method acceptable to the insurance commissioner to**
8 **determine premiums for individual health plans. Except as**
9 **provided in section 2 of this chapter, the following risk**
10 **classification factors are prohibited from use in rating individuals**
11 **and dependents:**
12 **(1) demographic rating, including age and gender rating;**
13 **(2) geographic area rating;**
14 **(3) industry rating;**
15 **(4) medical underwriting and screening;**
16 **(5) experience rating;**
17 **(6) tier rating; or**
18 **(7) durational rating.**
19 **Sec. 5. (a) The insurance commissioner shall adopt rules under**
20 **IC 4-22-2 to establish standards and a process for permitting**
21 **individual health plan providers to use one (1) or more risk**
22 **classifications in the individual health plan provider's community**
23 **rating method if the premium charged does not deviate above or**
24 **below the community rate filed by the individual health plan**
25 **provider by more than twenty percent (20%).**
26 **(b) Rules adopted under subsection (a):**
27 **(1) may not permit medical underwriting and screening, and**
28 **the need for affordability and accessibility of health plan**
29 **coverage must be considered in adopting the rules; and**
30 **(2) must permit an individual health plan provider to**
31 **establish rewards, premium discounts, rebates, or otherwise**
32 **waive or modify applicable copayments, deductibles, or other**
33 **cost sharing amounts in return for adherence by a covered**
34 **individual to programs of health promotion and disease**
35 **prevention.**
36 **Sec. 6. (a) The commissioner shall consult with the insurance**
37 **commissioner in the development and adoption of health**
38 **promotion and disease prevention rules under IC 4-22-2.**
39 **(b) The rules adopted under subsection (a) must:**
40 **(1) limit a reward, discount, rebate, or waiver or modification**
41 **of cost sharing amounts to not more than a total of fifteen**
42 **percent (15%) of the cost of the premium for the applicable**

C o p y

1 **coverage tier, if the sum of rate deviations does not exceed**
2 **thirty percent (30%);**
3 **(2) be designed to promote good health or prevent disease for**
4 **individuals in the program and not be used to impose higher**
5 **costs on an individual based on a health factor;**
6 **(3) provide that a reward under the program is available to**
7 **all similarly situated individuals;**
8 **(4) provide a reasonable alternative standard to obtain a**
9 **reward to an individual for whom it is unreasonably difficult,**
10 **due to a medical condition or other reasonable mitigating**
11 **circumstance, to satisfy the otherwise applicable standard for**
12 **the discount and disclose in all plan materials that describe**
13 **the discount program the availability of a reasonable**
14 **alternative standard;**
15 **(5) include standards and procedures for health promotion**
16 **and disease prevention programs based on the best scientific,**
17 **evidence based medical practices;**
18 **(6) include standards and procedures for evaluating an**
19 **individual's adherence to programs of health promotion and**
20 **disease prevention; and**
21 **(7) include other standards and procedures necessary to**
22 **implement this chapter.**
23 **Chapter 18. Common Claims and Procedures and Health Care**
24 **Data**
25 **Sec. 1. Not later than July 1, 2009, the commissioner and the**
26 **insurance commissioner shall adopt rules under IC 4-22-2 to**
27 **establish common claim forms and procedures for use by all health**
28 **providers in submitting claims to health plan providers and**
29 **Indiana health plan carriers.**
30 **Sec. 2. The commissioner shall establish and maintain a unified**
31 **health care data base to enable the commissioner to do the**
32 **following:**
33 **(1) Determine the capacity and distribution of existing**
34 **resources.**
35 **(2) Identify health care needs and inform health care policy.**
36 **(3) Evaluate the effectiveness of intervention programs on**
37 **improving patient outcomes.**
38 **(4) Compare costs between various treatment settings and**
39 **approaches.**
40 **(5) Provide information to consumers and purchasers of**
41 **health care.**
42 **(6) Improve the quality and affordability of patient health**

C
o
p
y

1 **care and health care coverage.**
2 **Sec. 3. (a) The program must include a consumer health care**
3 **price and quality information system designed to make available**
4 **to consumers transparent health care price information, quality**
5 **information, and other information determined by the**
6 **commissioner to be necessary to provide individuals sufficient**
7 **information to make economically sound and medically**
8 **appropriate decisions.**
9 **(b) The commissioner may collaborate with other state agencies**
10 **and interested parties to implement the requirement of subsection**
11 **(a).**
12 **(c) The commissioner may require a health plan provider that**
13 **covers at least five percent (5%) of individuals covered by health**
14 **plans in Indiana to file with the commissioner a consumer health**
15 **care price and quality information plan in accordance with rules**
16 **adopted by the commissioner under IC 4-22-2.**
17 **(d) The commissioner shall adopt rules under IC 4-22-2 that the**
18 **commissioner determines necessary to implement this chapter. The**
19 **rules:**
20 **(1) may permit the gradual implementation of the consumer**
21 **health care price and quality information system, beginning**
22 **with health care price and quality information that the**
23 **commissioner determines is most needed by consumers or**
24 **that can be most practically provided to the consumer in an**
25 **understandable manner;**
26 **(2) shall permit health plan providers to use security measures**
27 **designed to allow covered individuals access to price and**
28 **other information without disclosing trade secrets to**
29 **individuals and entities that are not covered individuals; and**
30 **(3) shall avoid unnecessary duplication of efforts relating to**
31 **price and quality reporting by health plan providers, health**
32 **providers, and others.**
33 **Sec. 4. Health plan providers, health providers, and government**
34 **agencies shall electronically file reports, data, schedules, statistics,**
35 **or other information determined by the commissioner to be**
36 **necessary to implement this chapter. The information may include:**
37 **(1) health coverage claims and enrollment information used**
38 **by health plan providers, including cross matched claims data**
39 **on requested covered individuals;**
40 **(2) information related to health provider budget reviews;**
41 **(3) covered individual information necessary to determine**
42 **third party liability for health services provided; and**

C
o
p
y

1 **(4) other information related to health costs, prices, quality,**
2 **utilization, or resources, as required by the commissioner.**
3 **Sec. 5. The collection, storage, and release of health care data**
4 **and statistical information described in this chapter and subject to**
5 **the federal Health Insurance Portability and Accountability Act**
6 **are governed exclusively by the rules adopted in 45 CFR 160 and**
7 **45 CFR 164.**
8 **Sec. 6. Health plan providers that produce Health Employer**
9 **Data and Information Set data shall annually submit the**
10 **information to the commissioner in a form prescribed by the**
11 **commissioner**
12 **Sec. 7. Health plan providers shall accept electronic claims**
13 **submitted in the federal Centers for Medicare and Medicaid**
14 **Services format for UB 92 or HCFA 1500 records, as amended by**
15 **the Centers for Medicare and Medicaid Services.**
16 **Sec. 8. (a) The commissioner shall collaborate with the secretary**
17 **and interested parties to develop a comprehensive health care**
18 **information system, including:**
19 **(1) formulation of a description of data sets to be included in**
20 **the comprehensive health care information system;**
21 **(2) criteria and procedures for the development of limited use**
22 **data sets;**
23 **(3) criteria and procedures to ensure that limited use data sets**
24 **that comply with the federal Health Insurance Portability and**
25 **Accountability Act are accessible; and**
26 **(4) a proposed time frame for the creation of the**
27 **comprehensive health care information system.**
28 **(b) To the extent allowed by the federal Health Insurance**
29 **Portability and Accountability Act, the data described in this**
30 **chapter must be available as a resource for health plan providers,**
31 **employers, health providers, purchasers of health services, and**
32 **state agencies to continuously review health care utilization,**
33 **expenditures, and performance in Indiana**
34 **(c) In presenting data for public access, comparative**
35 **considerations must be made regarding geography, demographics,**
36 **general economic factors, and institutional size.**
37 **(d) Consistent with federal Health Insurance Portability and**
38 **Accountability Act, and subject to terms and conditions prescribed**
39 **by the commissioner, the state department has access to the data**
40 **base for use in the development of a statewide health information**
41 **and health care quality improvement plan.**
42 **(e) The comprehensive health care information system may not**

C o p y

1 **publicly disclose data that contains personally identifiable**
2 **information.**
3 **(f) The commissioner may adopt rules under IC 4-22-2 to**
4 **implement this chapter.**
5 **Chapter19. Master Provider Index**
6 **Sec. 1. Not later than September 1, 2007, a work group**
7 **composed of interested parties must be convened by the state**
8 **department for the purpose of making recommendations for the**
9 **creation of a master provider index designed to assure uniform and**
10 **consistent identification and cross reference of all health providers**
11 **in Indiana.**
12 **Sec. 2. The work group shall:**
13 **(1) compile recommendations regarding data fields that must**
14 **be included in a database that allows for comprehensive cross**
15 **referencing of multiple unique identification codes applied to**
16 **health providers through licensure, credentialing, and billing**
17 **and claims processing mechanisms to support the**
18 **implementation of health information exchange and public**
19 **health and policy research, analysis, and planning;**
20 **(2) provide cost and time estimates for development and**
21 **implementation of the index; and**
22 **(3) develop recommendations for governance of the index and**
23 **the relationship of the index to other state health information**
24 **data systems, technologies, and records.**
25 **Sec. 3. The work group shall, not later than January 15, 2008,**
26 **report to the legislative council in an electronic format under**
27 **IC 5-14-6 concerning the information described in section 2 of this**
28 **chapter and the work group's recommendations regarding creating**
29 **and sustaining a master provider index.**
30 SECTION 2. [EFFECTIVE JULY 1, 2007] **(a) As used in this**
31 **SECTION, "office" refers to the office of Medicaid policy and**
32 **planning established by IC 12-8-6-1.**
33 **(b) As used in this SECTION, "waiver" refers to a Medicaid**
34 **waiver approved by the federal Centers for Medicare and**
35 **Medicaid Services (42 U.S.C. 1396 et seq.).**
36 **(c) Before September 1, 2007, the office shall seek approval from**
37 **the federal Centers for Medicare and Medicaid Services for any**
38 **waiver necessary to assist in implementation of IC 12-31, as added**
39 **by this act.**
40 **(d) The office may not implement the waiver until the office files**
41 **an affidavit with the governor attesting that the federal waiver**
42 **applied for under this SECTION is in effect. The office shall file the**

C
o
p
y

1 **affidavit under this subsection not later than five (5) days after the**
2 **office is notified that the waiver is approved.**
3 **(e) If the federal Centers for Medicare and Medicaid Services**
4 **approves the waiver requested under this SECTION and the**
5 **governor receives the affidavit filed under subsection (d), the office**
6 **shall implement the waiver not more than sixty (60) days after the**
7 **governor receives the affidavit.**
8 **(f) The office may adopt rules under IC 4-22-2 necessary to**
9 **implement this SECTION.**

C
o
p
y