

CONFERENCE COMMITTEE REPORT DIGEST FOR ESB 461

Citations Affected: IC 4-1-12; IC 12-7-2; IC 12-15; IC 27-8; IC 27-13.

Synopsis: Federal health care matters. Proposed committee report to SB 461. Provides that a resident may not be required to purchase a health plan. Requires the office of the secretary and the department of insurance to investigate and allows submission of a waiver for a specified provision of the federal Patient Protection and Affordable Care Act (Act). Allows the office of Medicaid policy and planning (office) to request federal approval to change how the state determines Medicaid eligibility for the aged, blind, and disabled. Requires the Indiana check up plan (plan) to include any federally required bench mark services. Allows, instead of requires, the plan to include dental and vision services. Makes the following changes concerning the plan beginning January 1, 2014: (1) changes income eligibility requirements for the plan from 200% to 133%; and (2) removes the requirement that the individual's employer not provide health insurance and that the individual be without health insurance for six months. Allows a nonprofit organization and health insurers to make deposits into a plan participant's account under specified circumstances. Requires a plan participant to contribute at least \$160 per year. Requires a health insurer that provides coverage under the plan until December 31, 2013, to also offer to provide coverage to certain other individuals in a manner consistent with federal law concerning underwriting, rating, and with state approval of the rate. Allows the office to amend the plan in a manner to be used to cover individuals eligible for Medicaid resulting from passage of the act. Amends current health insurance law to specify application of the law in conformity with the act, as amended by the federal Health Care and Education Reconciliation Act of 2010, including provisions concerning coverage of children until age 26, grievances, and rescissions. Requires the office of Medicaid policy and planning (office) to apply to amend the Medicaid state plan to extend Medicaid coverage of family planning services for certain women and men. Makes conforming amendments. **(This committee report returns the language back to as it left the Senate, except that the report: (1) keeps language added in the House concerning prohibiting a requirement that an Indiana resident purchase health coverage; (2) adds language requiring an investigation and waiver request for a specified provision of the Act; (3) changes the individual minimum contribution under the Indiana check-up plan to \$160; (4) removes language referring to pregnancy in the definition of family planning services; and (5) changes the eligibility level for the family planning state plan amendment to 133%.)**

Effective: Upon passage; September 23, 2010 (retroactive); July 1, 2011.

Adopted

Rejected

CONFERENCE COMMITTEE REPORT

MR. SPEAKER:

Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed House Amendments to Engrossed Senate Bill No. 461 respectfully reports that said two committees have conferred and agreed as follows to wit:

that the Senate recede from its dissent from all House amendments and that the Senate now concur in all House amendments to the bill and that the bill be further amended as follows:

- 1 Delete everything after the enacting clause and insert the following:
- 2 SECTION 1. IC 4-1-12 IS ADDED TO THE INDIANA CODE AS
- 3 A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON
- 4 PASSAGE]:
- 5 **Chapter 12. Implementation of the Patient Protection and**
- 6 **Affordable Care Act**
- 7 **Sec. 1. As used in this chapter, "Patient Protection and**
- 8 **Affordable Care Act" refers to the federal Patient Protection and**
- 9 **Affordable Care Act (P.L. 111-148), as amended by the federal**
- 10 **Health Care and Education Reconciliation Act of 2010 (P.L.**
- 11 **111-152), as amended from time to time, and regulations or**
- 12 **guidance issued under those acts.**
- 13 **Sec. 2. As used in the chapter, "health plan" means a policy,**
- 14 **contract, certificate, or agreement offered or issued:**
- 15 **(1) by an entity that assumes or carries insurance risk; and**
- 16 **(2) to provide, deliver, arrange for, pay for, or reimburse the**
- 17 **costs of health care services.**
- 18 **Sec. 3. Notwithstanding any other law, a resident of Indiana**
- 19 **may not be required to purchase coverage under a health plan. A**
- 20 **resident may delegate to the resident's employer the resident's**
- 21 **authority to purchase or decline to purchase coverage under a**
- 22 **health plan.**

1 **Sec. 4. The office of the secretary of family and social services**
 2 **and the department of insurance:**

3 (1) shall investigate; and

4 (2) may apply for a waiver under;

5 **42 U.S.C. 18052 of the Patient Protection and Affordable Care Act.**

6 SECTION 2. IC 12-7-2-82.4 IS ADDED TO THE INDIANA CODE
 7 AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE
 8 UPON PASSAGE]: **Sec. 82.4. "Family planning services", for**
 9 **purposes of IC 12-15-45-1, has the meaning set forth in**
 10 **IC 12-15-45-1(a).**

11 SECTION 3. IC 12-7-2-85.1 IS ADDED TO THE INDIANA CODE
 12 AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE
 13 UPON PASSAGE]: **Sec. 85.1. "Fertilization", for purposes of**
 14 **IC 12-15-45-1, has the meaning set forth in IC 12-15-45-1(b).**

15 SECTION 4. IC 12-7-2-136.5 IS ADDED TO THE INDIANA
 16 CODE AS A **NEW SECTION** TO READ AS FOLLOWS
 17 [EFFECTIVE JULY 1, 2011]: **Sec. 136.5. "Patient Protection and**
 18 **Affordable Care Act" refers to the federal Patient Protection and**
 19 **Affordable Care Act (P.L. 111-148), as amended by the federal**
 20 **Health Care and Education Reconciliation Act of 2010 (P.L.**
 21 **111-152), as amended from time to time, and regulations or**
 22 **guidance issued under those acts.**

23 SECTION 5. IC 12-15-1-5, AS AMENDED BY P.L.99-2007,
 24 SECTION 93, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 25 JULY 1, 2011]: **Sec. 5. (a) The office may enter into an agreement with**
 26 **the Secretary Commissioner of the United States Department of**
 27 **Health and Human Services Social Security Administration** under
 28 which the **Secretary Commissioner** shall accept applications and make
 29 determinations of eligibility for Medicaid for individuals who are aged,
 30 individuals who are blind, and individuals with a disability in
 31 accordance with the standards and criteria established by the state plan
 32 for Medicaid. ~~in effect January 1, 1972.~~

33 **(b) The office may request the United States Department of**
 34 **Health and Human Services to approve Indiana's transition,**
 35 **beginning January 1, 2014, as a state that determines eligibility for**
 36 **individuals who are aged, blind, or disabled under Medicaid based**
 37 **on Section 1634 of the federal Social Security Act.**

38 SECTION 6. IC 12-15-2-6 IS AMENDED TO READ AS
 39 FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 6. (a) Subject to**
 40 **subsection (b), An individual who:**

41 (1) is receiving monthly assistance payments under the federal
 42 Supplemental Security Income program; and

43 (2) meets the income and resource requirements established by
 44 statute or the office unless the state is required to provide medical
 45 assistance to the individual under 42 U.S.C. 1396a(f) or under 42
 46 U.S.C. 1382h;

47 is eligible to receive Medicaid.

48 (b) An individual who is receiving monthly disability assistance
 49 payments under the federal Supplemental Security Income program or
 50 the federal Social Security Disability Insurance program must meet the
 51 eligibility requirements specified in IC 12-14-15 unless the state is

1 required to provide medical assistance to the individual under 42
2 U.S.C. 1382h.

3 (c) The office may not apply a spend down requirement to an
4 individual who is eligible for medical assistance under 42 U.S.C.
5 1382h.

6 **(d) This section expires December 31, 2013.**

7 SECTION 7. IC 12-15-44.2-4, AS ADDED BY P.L.3-2008,
8 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
9 JULY 1, 2011]: Sec. 4. (a) The plan must include the following in a
10 manner and to the extent determined by the office:

- 11 (1) Mental health care services.
- 12 (2) Inpatient hospital services.
- 13 (3) Prescription drug coverage.
- 14 (4) Emergency room services.
- 15 (5) Physician office services.
- 16 (6) Diagnostic services.
- 17 (7) Outpatient services, including therapy services.
- 18 (8) Comprehensive disease management.
- 19 (9) Home health services, including case management.
- 20 (10) Urgent care center services.
- 21 (11) Preventative care services.
- 22 (12) Family planning services:
 - 23 (A) including contraceptives and sexually transmitted disease
 - 24 testing, as described in federal Medicaid law (42 U.S.C. 1396
 - 25 et seq.); and
 - 26 (B) not including abortion or abortifacients.
- 27 (13) Hospice services.
- 28 (14) Substance abuse services.

29 **(15) A service determined by the secretary to be required by**
30 **federal law as a benchmark service under the federal Patient**
31 **Protection and Affordable Care Act.**

32 (b) The plan ~~must~~ **may** do the following:

- 33 (1) Offer coverage for dental and vision services to an individual
- 34 who participates in the plan.
- 35 (2) Pay at least fifty percent (50%) of the premium cost of dental
- 36 and vision services coverage described in subdivision (1).

37 (c) An individual who receives the dental or vision coverage offered
38 under subsection (b) shall pay an amount determined by the office for
39 the coverage. The office shall limit the payment to not more than five
40 percent (5%) of the individual's annual household income. The
41 payment required under this subsection is in addition to the payment
42 required under section 11(b)(2) of this chapter for coverage under the
43 plan.

44 (d) Vision services offered by the plan must include services
45 provided by an optometrist.

46 (e) The plan must comply with any coverage requirements that
47 apply to an accident and sickness insurance policy issued in Indiana.

48 (f) The plan may not permit treatment limitations or financial
49 requirements on the coverage of mental health care services or
50 substance abuse services if similar limitations or requirements are not
51 imposed on the coverage of services for other medical or surgical

1 conditions.

2 SECTION 8. IC 12-15-44.2-6, AS ADDED BY P.L.3-2008,
3 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
4 JULY 1, 2011]: Sec. 6. **To the extent allowed by federal law**, the plan
5 has the following per participant coverage limitations:

6 (1) An annual individual maximum coverage limitation of three
7 hundred thousand dollars (\$300,000).

8 (2) A lifetime individual maximum coverage limitation of one
9 million dollars (\$1,000,000).

10 SECTION 9. IC 12-15-44.2-9, AS ADDED BY P.L.3-2008,
11 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
12 JULY 1, 2011]: Sec. 9. (a) An individual is eligible for participation in
13 the plan if the individual meets the following requirements:

14 (1) The individual is at least eighteen (18) years of age and less
15 than sixty-five (65) years of age.

16 (2) The individual is a United States citizen and has been a
17 resident of Indiana for at least twelve (12) months.

18 (3) The individual has an annual household income of not more
19 than **the following:**

20 **(A) Effective through December 31, 2013**, two hundred
21 percent (200%) of the federal income poverty level.

22 **(B) Beginning January 1, 2014, one hundred thirty-three**
23 **percent (133%) of the federal income poverty level, based**
24 **on the adjusted gross income provisions set forth in Section**
25 **2001(a)(1) of the federal Patient Protection and Affordable**
26 **Care Act.**

27 (4) **Effective through December 31, 2013**, the individual is not
28 eligible for health insurance coverage through the individual's
29 employer.

30 (5) **Effective through December 31, 2013**, the individual has not
31 had health insurance coverage for at least six (6) months.

32 (b) The following individuals are not eligible for the plan:

33 (1) An individual who participates in the federal Medicare
34 program (42 U.S.C. 1395 et seq.).

35 (2) A pregnant woman for purposes of pregnancy related services.

36 (3) An individual who is **otherwise** eligible for ~~the Medicaid~~
37 ~~program as a disabled person:~~ **medical assistance.**

38 (c) The eligibility requirements specified in subsection (a) are
39 subject to approval for federal financial participation by the United
40 States Department of Health and Human Services.

41 SECTION 10. IC 12-15-44.2-10, AS ADDED BY P.L.3-2008,
42 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
43 JULY 1, 2011]: Sec. 10. (a) An individual who participates in the plan
44 must have a health care account to which payments may be made for
45 the individual's participation in the plan only by the following:

46 (1) The individual.

47 (2) An employer.

48 (3) The state.

49 **(4) A nonprofit organization if the nonprofit organization:**

50 **(A) is not affiliated with a health care plan; and**

51 **(B) does not contribute more than seventy-five percent**

1 **(75%) of the individual's required payment to the**
 2 **individual's health care account.**

3 **(5) An insurer or a health maintenance organization under a**
 4 **contract with the office to provide health insurance coverage**
 5 **under the plan if the payment:**

6 **(A) is to provide a health incentive to the individual;**

7 **(B) does not count towards the individual's required**
 8 **minimum payment set forth in section 11 of this chapter;**
 9 **and**

10 **(C) does not exceed one thousand one hundred dollars**
 11 **(\$1,100).**

12 (b) The minimum funding amount for a health care account is the
 13 amount required under section 11 of this chapter.

14 (c) An individual's health care account must be used to pay the
 15 individual's deductible for health care services under the plan.

16 (d) An individual may make payments to the individual's health care
 17 account as follows:

18 (1) An employer withholding or causing to be withheld from an
 19 employee's wages or salary, after taxes are deducted from the
 20 wages or salary, the individual's contribution under this chapter
 21 and distributed equally throughout the calendar year.

22 (2) Submission of the individual's contribution under this chapter
 23 to the office to deposit in the individual's health care account in
 24 a manner prescribed by the office.

25 (3) Another method determined by the office.

26 (e) An employer may make, from funds not payable by the employer
 27 to the employee, not more than fifty percent (50%) of an individual's
 28 required payment to the individual's health care account.

29 **(f) A nonprofit corporation may make not more than**
 30 **seventy-five percent (75%) of an individual's required payment to**
 31 **the individual's health care account.**

32 SECTION 11. IC 12-15-44.2-11, AS ADDED BY P.L.3-2008,
 33 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 34 JULY 1, 2011]: Sec. 11. (a) An individual's participation in the plan
 35 does not begin until an initial payment is made for the individual's
 36 participation in the plan. A required payment to the plan for the
 37 individual's participation may not exceed one-twelfth (1/12) of the
 38 annual payment required under subsection (b).

39 (b) To participate in the plan, an individual shall do the following:

40 (1) Apply for the plan on a form prescribed by the office. The
 41 office may develop and allow a joint application for a household.

42 (2) If the individual is approved by the office to participate in the
 43 plan, contribute to the individual's health care account the lesser
 44 of the following:

45 (A) One thousand one hundred dollars (\$1,100) per year, less
 46 any amounts paid by the individual under the:

47 (i) Medicaid program under IC 12-15;

48 (ii) children's health insurance program under IC 12-17.6;
 49 and

50 (iii) Medicare program (42 U.S.C. 1395 et seq.);

51 as determined by the office.

1 **(B) At least one hundred sixty dollars (\$160) per year and**
 2 not more than the following applicable percentage of the
 3 individual's annual household income per year, less any
 4 amounts paid by the individual under the Medicaid program
 5 under IC 12-15, the children's health insurance program under
 6 IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et
 7 seq.) as determined by the office:

8 (i) Two percent (2%) of the individual's annual household
 9 income per year if the individual has an annual household
 10 income of not more than one hundred percent (100%) of the
 11 federal income poverty level.

12 (ii) Three percent (3%) of the individual's annual household
 13 income per year if the individual has an annual household
 14 income of more than one hundred percent (100%) and not
 15 more than one hundred twenty-five percent (125%) of the
 16 federal income poverty level.

17 (iii) Four percent (4%) of the individual's annual household
 18 income per year if the individual has an annual household
 19 income of more than one hundred twenty-five percent
 20 (125%) and not more than one hundred fifty percent (150%)
 21 of the federal income poverty level.

22 (iv) Five percent (5%) of the individual's annual household
 23 income per year if the individual has an annual household
 24 income of more than one hundred fifty percent (150%) and
 25 not more than two hundred percent (200%) of the federal
 26 income poverty level.

27 (c) The state shall contribute the difference to the individual's
 28 account if the individual's payment required under subsection (b)(2) is
 29 less than one thousand one hundred dollars (\$1,100).

30 (d) If an individual's required payment to the plan is not made
 31 within sixty (60) days after the required payment date, the individual
 32 may be terminated from participation in the plan. The individual must
 33 receive written notice before the individual is terminated from the plan.

34 (e) After termination from the plan under subsection (d), the
 35 individual may not reapply to participate in the plan for twelve (12)
 36 months.

37 SECTION 12. IC 12-15-44.2-15, AS ADDED BY P.L.3-2008,
 38 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 39 JULY 1, 2011]: Sec. 15. (a) An insurer or a health maintenance
 40 organization that contracts with the office to provide health insurance
 41 coverage under the plan or an affiliate of an insurer or a health
 42 maintenance organization that contracts with the office to provide
 43 health insurance coverage under the plan shall offer to provide the
 44 same health insurance coverage to an individual who:

45 (1) has not had health insurance coverage during the previous six
 46 (6) months; and

47 (2) meets the eligibility requirements specified in section 9 of this
 48 chapter for participation in the plan but is not enrolled because
 49 the plan has reached maximum enrollment.

50 (b) The insurance underwriting and rating practices applied to
 51 health insurance coverage offered under subsection (a):

1 (1) must not be different from underwriting and rating practices
 2 used for the health insurance coverage provided under the plan;
 3 **and**

4 **(2) must be consistent with the federal Patient Protection and**
 5 **Affordable Care Act.**

6 (c) The state:

7 (1) does not provide funding for health insurance coverage
 8 received under this section; **and**

9 **(2) shall approve the rate applied to the plan in accordance**
 10 **with the federal Patient Protection and Affordable Care Act.**

11 **(d) This section expires December 31, 2013.**

12 SECTION 13. IC 12-15-44.2-20, AS ADDED BY P.L.3-2008,
 13 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 14 JULY 1, 2011]: Sec. 20. (a) The office may establish a health insurance
 15 coverage premium assistance program for individuals who **meet the**
 16 **following:**

17 (1) Have an annual household income of **the following:**

18 **(A) Through December 31, 2013,** not more than two hundred
 19 percent (200%) of the federal income poverty level. ~~and~~

20 **(B) Beginning January 1, 2014, not more than one hundred**
 21 **thirty-three percent (133%) of the federal income poverty**
 22 **level, based on the adjusted gross income provisions set**
 23 **forth in Section 2001(a)(1) of the federal Patient Protection**
 24 **and Affordable Care Act.**

25 (2) Are eligible for health insurance coverage through an
 26 employer but cannot afford the health insurance coverage
 27 premiums.

28 (b) A program established under this section must:

29 (1) contain eligibility requirements that are similar to the
 30 eligibility requirements of the plan;

31 (2) include a health care account as a component; and

32 (3) provide that an individual's payment:

33 (A) to a health care account; or

34 (B) for a health insurance coverage premium;

35 may not exceed five percent (5%) of the individual's annual
 36 income.

37 SECTION 14. IC 12-15-44.2-21, AS ADDED BY P.L.3-2008,
 38 SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 39 JULY 1, 2011]: Sec. 21. (a) A denial of federal approval and federal
 40 financial participation that applies to any part of this chapter does not
 41 prohibit the office from implementing any other part of this chapter
 42 that:

43 (1) is federally approved for federal financial participation; or

44 (2) does not require federal approval or federal financial
 45 participation.

46 **(b) The secretary may make changes to the plan under this**
 47 **chapter if the changes are required by one (1) of the following:**

48 **(1) The United States Department of Health and Human**
 49 **Services.**

50 **(2) Federal law or regulation.**

51 SECTION 15. IC 12-15-44.2-22 IS ADDED TO THE INDIANA

1 CODE AS A NEW SECTION TO READ AS FOLLOWS
 2 [EFFECTIVE JULY 1, 2011]: **Sec. 22. The office of the secretary**
 3 **may amend the plan in a manner that would allow Indiana to use**
 4 **the plan to cover individuals eligible for Medicaid resulting from**
 5 **passage of the Federal Patient Protection and Affordable Care Act.**

6 SECTION 16. IC 12-15-45 IS ADDED TO THE INDIANA CODE
 7 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 8 UPON PASSAGE]:

9 **Chapter 45. Medicaid Waivers and State Plan Amendments**

10 **Sec. 1. (a) As used in this section, "family planning services"**
 11 **does not include the performance of abortions or the use of a drug**
 12 **or device intended to terminate fertilization.**

13 **(b) As used in this section, "fertilization" means the joining of**
 14 **a human egg cell with a human sperm cell.**

15 **(c) As used in this section, "state amendment plan" refers to an**
 16 **amendment to Indiana's Medicaid State Plan as authorized by**
 17 **Section 1902(a)(10)(A)(ii)(XXI) of the federal Social Security Act**
 18 **(42 U.S.C. 1315).**

19 **(d) Before January 1, 2012, the office shall do the following:**

20 **(1) Apply to the United States Department of Health and**
 21 **Human Services for approval of a state plan amendment to**
 22 **expand the population eligible for family planning services**
 23 **and supplies as permitted by Section 1902(a)(10)(A)(ii)(XXI)**
 24 **of the federal Social Security Act (42 U.S.C. 1315). In**
 25 **determining what population is eligible for this expansion, the**
 26 **state must incorporate the following:**

27 **(A) Inclusion of women and men.**

28 **(B) Setting income eligibility at one hundred thirty-three**
 29 **percent (133%) of the federal income poverty level.**

30 **(C) Adopting presumptive eligibility for services to this**
 31 **population.**

32 **(2) Consider the inclusion of additional:**

33 **(A) medical diagnosis; and**

34 **(B) treatment services;**

35 **that are provided for family planning services in a family**
 36 **planning setting for the population designated in subdivision**
 37 **(1) in the state plan amendment.**

38 **(e) The office shall report concerning its proposed state plan**
 39 **amendment to the Medicaid oversight committee during its 2011**
 40 **interim meetings. The Medicaid oversight committee shall review**
 41 **the proposed state plan amendment. The committee may make an**
 42 **advisory recommendation to the office concerning the proposed**
 43 **state plan amendment.**

44 **(f) The office may adopt rules under IC 4-22-2 to implement this**
 45 **section.**

46 **(g) This chapter expires January 1, 2016.**

47 SECTION 17. IC 27-8-5-1, AS AMENDED BY P.L.173-2007,
 48 SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 49 SEPTEMBER 23, 2010 (RETROACTIVE)]: **Sec. 1. (a) The term**
 50 **"policy of accident and sickness insurance", as used in this chapter,**
 51 **includes any policy or contract covering one (1) or more of the kinds**

1 of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such
 2 policies may be on the individual basis under this section and sections
 3 2 through 9 of this chapter, on the group basis under this section and
 4 sections 16 through 19 of this chapter, on the franchise basis under this
 5 section and section 11 of this chapter, or on a blanket basis under
 6 section 15 of this chapter and (except as otherwise expressly provided
 7 in this chapter) shall be exclusively governed by this chapter.

8 (b) No policy of accident and sickness insurance may be issued or
 9 delivered to any person in this state, nor may any application, rider, or
 10 endorsement be used in connection with an accident and sickness
 11 insurance policy, until a copy of the form of the policy and of the
 12 classification of risks and the premium rates, or, in the case of
 13 assessment companies, the estimated cost pertaining thereto, have been
 14 filed with and reviewed by the commissioner under section 1.5 of this
 15 chapter. This section is applicable also to assessment companies and
 16 fraternal benefit associations or societies.

17 **(c) This chapter shall be applied in conformity with the**
 18 **requirements of the federal Patient Protection and Affordable**
 19 **Care Act (P.L. 111-148), as amended by the federal Health Care**
 20 **and Education Reconciliation Act of 2010 (P.L. 111-152), as in**
 21 **effect on September 23, 2010.**

22 SECTION 18. IC 27-8-5-2, AS AMENDED BY P.L.218-2007,
 23 SECTION 45, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 24 SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 2. (a) No individual
 25 policy of accident and sickness insurance shall be delivered or issued
 26 for delivery to any person in this state unless it complies with each of
 27 the following:

28 (1) The entire money and other considerations for the policy are
 29 expressed in the policy.

30 (2) The time at which the insurance takes effect and terminates is
 31 expressed in the policy.

32 (3) The policy purports to insure only one (1) person, except that
 33 a policy must insure, originally or by subsequent amendment,
 34 upon the application of any member of a family who shall be
 35 deemed the policyholder and who is at least eighteen (18) years
 36 of age, any two (2) or more eligible members of that family,
 37 including husband, wife, dependent children, or any children who
 38 are less than ~~twenty-four (24)~~ **twenty-six (26)** years of age, and
 39 any other person dependent upon the policyholder.

40 (4) The style, arrangement, and overall appearance of the policy
 41 give no undue prominence to any portion of the text, and unless
 42 every printed portion of the text of the policy and of any
 43 endorsements or attached papers is plainly printed in lightface
 44 type of a style in general use, the size of which shall be uniform
 45 and not less than ten point with a lower-case unspaced alphabet
 46 length not less than one hundred and twenty point (the "text" shall
 47 include all printed matter except the name and address of the
 48 insurer, name or title of the policy, the brief description if any,
 49 and captions and subcaptions).

50 (5) The exceptions and reductions of indemnity are set forth in the
 51 policy and, except those which are set forth in section 3 of this

1 chapter, are printed, at the insurer's option, either included with
2 the benefit provision to which they apply, or under an appropriate
3 caption such as "EXCEPTIONS", or "EXCEPTIONS AND
4 REDUCTIONS", provided that if an exception or reduction
5 specifically applies only to a particular benefit of the policy, a
6 statement of such exception or reduction shall be included with
7 the benefit provision to which it applies.

8 (6) Each such form of the policy, including riders and
9 endorsements, shall be identified by a form number in the lower
10 left-hand corner of the first page of the policy.

11 (7) The policy contains no provision purporting to make any
12 portion of the charter, rules, constitution, or bylaws of the insurer
13 a part of the policy unless such portion is set forth in full in the
14 policy, except in the case of the incorporation of or reference to
15 a statement of rates or classification of risks, or short-rate table
16 filed with the commissioner.

17 (8) If an individual accident and sickness insurance policy or
18 hospital service plan contract or medical service plan contract
19 provides that hospital or medical expense coverage of a
20 dependent child terminates upon attainment of the limiting age for
21 dependent children specified in such policy or contract, the policy
22 or contract must also provide that attainment of such limiting age
23 does not operate to terminate the hospital and medical coverage
24 of such child while the child is and continues to be both:

25 (A) incapable of self-sustaining employment by reason of
26 mental retardation or mental or physical disability; and

27 (B) chiefly dependent upon the policyholder for support and
28 maintenance.

29 Proof of such incapacity and dependency must be furnished to the
30 insurer by the policyholder within thirty-one (31) days of the
31 child's attainment of the limiting age. The insurer may require at
32 reasonable intervals during the two (2) years following the child's
33 attainment of the limiting age subsequent proof of the child's
34 disability and dependency. After such two (2) year period, the
35 insurer may require subsequent proof not more than once each
36 year. The foregoing provision shall not require an insurer to
37 insure a dependent who is a child who has mental retardation or
38 a mental or physical disability where such dependent does not
39 satisfy the conditions of the policy provisions as may be stated in
40 the policy or contract required for coverage thereunder to take
41 effect. In any such case the terms of the policy or contract shall
42 apply with regard to the coverage or exclusion from coverage of
43 such dependent. This subsection applies only to policies or
44 contracts delivered or issued for delivery in this state more than
45 one hundred twenty (120) days after August 18, 1969.

46 (b) If any policy is issued by an insurer domiciled in this state for
47 delivery to a person residing in another state, and if the official having
48 responsibility for the administration of the insurance laws of such other
49 state shall have advised the commissioner that any such policy is not
50 subject to approval or disapproval by such official, the commissioner
51 may by ruling require that such policy meet the standards set forth in

1 subsection (a) and in section 3 of this chapter.

2 (c) An insurer may issue a policy described in this section in
3 electronic or paper form. However, the insurer shall:

4 (1) inform the insured that the insured may request the policy in
5 paper form; and

6 (2) issue the policy in paper form upon the request of the insured.

7 SECTION 19. IC 27-8-5-28, AS ADDED BY P.L.218-2007,
8 SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
9 SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 28. A policy of
10 accident and sickness insurance may not be issued, delivered,
11 amended, or renewed unless the policy provides for coverage of a child
12 of the policyholder or certificate holder, upon request of the
13 policyholder or certificate holder, until the date that the child becomes
14 ~~twenty-four (24)~~ **twenty-six (26)** years of age.

15 SECTION 20. IC 27-8-15-27 IS AMENDED TO READ AS
16 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:
17 Sec. 27. **(a) This section shall be applied in conformity with the**
18 **requirements of the federal Patient Protection and Affordable**
19 **Care Act (P.L. 111-148), as amended by the federal Health Care**
20 **and Education Reconciliation Act of 2010 (P.L. 111-152), as in**
21 **effect on September 23, 2010.**

22 **(b)** A health insurance plan provided by a small employer insurer to
23 a small employer must comply with the following:

24 (1) The benefits provided by a plan to an eligible employee
25 enrolled in the plan may not be excluded, limited, or denied for
26 more than nine (9) months after the effective date of the coverage
27 because of a preexisting condition of the eligible employee, the
28 eligible employee's spouse, or the eligible employee's dependent.

29 (2) The plan may not define a preexisting condition, rider, or
30 endorsement more restrictively than as a condition for which
31 medical advice, diagnosis, care, or treatment was recommended
32 or received during the six (6) months immediately preceding the
33 effective date of enrollment in the plan.

34 SECTION 21. IC 27-8-15-29 IS AMENDED TO READ AS
35 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:
36 Sec. 29. **(a) This section shall be applied in conformity with the**
37 **requirements of the federal Patient Protection and Affordable**
38 **Care Act (P.L. 111-148), as amended by the federal Health Care**
39 **and Education Reconciliation Act of 2010 (P.L. 111-152), as in**
40 **effect on September 23, 2010.**

41 ~~(a)~~ **(b)** A plan may exclude coverage for a late enrollee or the late
42 enrollee's covered spouse or dependent for not more than fifteen (15)
43 months.

44 ~~(b)~~ **(c)** If a late enrollee or the late enrollee's covered spouse or
45 dependent has a preexisting condition, a plan may exclude coverage for
46 the preexisting condition for not more than fifteen (15) months.

47 ~~(c)~~ **(d)** If a period of exclusion from coverage under subsection ~~(a)~~
48 **(b)** and a preexisting condition exclusion under subsection ~~(b)~~ **(c)** are
49 applicable to the late enrollee, the combined period of exclusion may
50 not exceed fifteen (15) months from the date that the eligible employee
51 enrolls for coverage under the health insurance plan.

1 SECTION 22. IC 27-8-28-6 IS AMENDED TO READ AS
 2 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:
 3 Sec. 6. As used in this chapter, "grievance" means any dissatisfaction
 4 expressed by or on behalf of a covered individual regarding:

- 5 (1) a determination that a service or proposed service is not
 6 appropriate or medically necessary;
 7 (2) a determination that a service or proposed service is
 8 experimental or investigational;
 9 (3) the availability of participating providers;
 10 (4) the handling or payment of claims for health care services; ~~or~~
 11 (5) matters pertaining to the contractual relationship between:
 12 (A) a covered individual and an insurer; or
 13 (B) a group policyholder and an insurer; ~~or~~
 14 **(6) an insurer's decision to rescind an accident and sickness**
 15 **insurance policy;**

16 and for which the covered individual has a reasonable expectation that
 17 action will be taken to resolve or reconsider the matter that is the
 18 subject of dissatisfaction.

19 SECTION 23. IC 27-8-29-12, AS AMENDED BY P.L.3-2008,
 20 SECTION 216, IS AMENDED TO READ AS FOLLOWS
 21 [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 12. An
 22 insurer shall establish and maintain an external grievance procedure for
 23 the resolution of external grievances regarding **the following:**

- 24 (1) **The following determinations made by the insurer or an**
 25 **agent of the insurer regarding a service proposed by the**
 26 **treating health care provider:**

- 27 (A) An adverse determination of appropriateness.
 28 ~~(2) (B)~~ An adverse determination of medical necessity.
 29 ~~(3) (C)~~ A determination that a proposed service is
 30 experimental or investigational. ~~or~~
 31 ~~(4) (D)~~ A denial of coverage based on a waiver described in
 32 IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or
 33 IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

34 made by an insurer or an agent of an insurer regarding a service
 35 proposed by the treating health care provider:

- 36 **(2) The insurer's decision to rescind an accident and sickness**
 37 **insurance policy.**

38 SECTION 24. IC 27-8-29-13, AS AMENDED BY P.L.3-2008,
 39 SECTION 217, IS AMENDED TO READ AS FOLLOWS
 40 [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 13. (a)
 41 An external grievance procedure established under section 12 of this
 42 chapter must:

- 43 (1) allow a covered individual, or a covered individual's
 44 representative, to file a written request with the insurer for an
 45 external grievance review of the insurer's
 46 (A) appeal resolution under IC 27-8-28-17 or
 47 (B) denial of coverage based on a waiver described in
 48 IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or
 49 IC 27-8-5-19.2 (expired July 1, 2007, and repealed);
 50 not more than ~~forty-five (45)~~ **one hundred twenty (120)** days
 51 after the covered individual is notified of the resolution; and

- 1 (2) provide for:
- 2 (A) an expedited external grievance review for a grievance
- 3 related to an illness, a disease, a condition, an injury, or a
- 4 disability if the time frame for a standard review would
- 5 seriously jeopardize the covered individual's:
- 6 (i) life or health; or
- 7 (ii) ability to reach and maintain maximum function; or
- 8 (B) a standard external grievance review for a grievance not
- 9 described in clause (A).

10 A covered individual may file not more than one (1) external grievance

11 of an insurer's appeal resolution under this chapter.

12 (b) Subject to the requirements of subsection (d), when a request is

13 filed under subsection (a), the insurer shall:

- 14 (1) select a different independent review organization for each
- 15 external grievance filed under this chapter from the list of
- 16 independent review organizations that are certified by the
- 17 department under section 19 of this chapter; and
- 18 (2) rotate the choice of an independent review organization
- 19 among all certified independent review organizations before
- 20 repeating a selection.

21 (c) The independent review organization chosen under subsection

22 (b) shall assign a medical review professional who is board certified in

23 the applicable specialty for resolution of an external grievance.

24 (d) The independent review organization and the medical review

25 professional conducting the external review under this chapter may not

26 have a material professional, familial, financial, or other affiliation with

27 any of the following:

- 28 (1) The insurer.
- 29 (2) Any officer, director, or management employee of the insurer.
- 30 (3) The health care provider or the health care provider's medical
- 31 group that is proposing the service.
- 32 (4) The facility at which the service would be provided.
- 33 (5) The development or manufacture of the principal drug, device,
- 34 procedure, or other therapy that is proposed for use by the treating
- 35 health care provider.
- 36 (6) The covered individual requesting the external grievance
- 37 review.

38 However, the medical review professional may have an affiliation

39 under which the medical review professional provides health care

40 services to covered individuals of the insurer and may have an

41 affiliation that is limited to staff privileges at the health facility, if the

42 affiliation is disclosed to the covered individual and the insurer before

43 commencing the review and neither the covered individual nor the

44 insurer objects.

45 (e) A covered individual shall not pay any of the costs associated

46 with the services of an independent review organization under this

47 chapter. All costs must be paid by the insurer.

48 SECTION 25. IC 27-8-29-19 IS AMENDED TO READ AS

49 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:

50 Sec. 19. (a) The department shall establish and maintain a process for

51 annual certification of independent review organizations.

1 (b) The department shall certify a number of independent review
 2 organizations determined by the department to be sufficient to fulfill
 3 the purposes of this chapter.

4 (c) An independent review organization must meet the following
 5 minimum requirements for certification by the department:

6 (1) Medical review professionals assigned by the independent
 7 review organization to perform external grievance reviews under
 8 this chapter:

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

11 (B) must be knowledgeable about a proposed service through
 12 actual clinical experience;

13 (C) must hold an unlimited license to practice in a state of the
 14 United States; and

15 (D) must not have any history of disciplinary actions or
 16 sanctions, including:

17 (i) loss of staff privileges; or

18 (ii) restriction on participation;

19 taken or pending by any hospital, government, or regulatory
 20 body.

21 (2) The independent review organization must have a quality
 22 assurance mechanism to ensure:

23 (A) the timeliness and quality of reviews;

24 (B) the qualifications and independence of medical review
 25 professionals;

26 (C) the confidentiality of medical records and other review
 27 materials; and

28 (D) the satisfaction of covered individuals with the procedures
 29 utilized by the independent review organization, including the
 30 use of covered individual satisfaction surveys.

31 (3) The independent review organization must file with the
 32 department the following information on or before March 1 of
 33 each year:

34 (A) The number and percentage of determinations made in
 35 favor of covered individuals.

36 (B) The number and percentage of determinations made in
 37 favor of insurers.

38 (C) The average time to process a determination.

39 **(D) The number of external grievance reviews terminated**
 40 **due to reconsideration of the insurer before a**
 41 **determination was made.**

42 ~~(E)~~ (E) Any other information required by the department.

43 The information required under this subdivision must be specified
 44 for each insurer for which the independent review organization
 45 performed reviews during the reporting year.

46 **(4) The independent review organization must retain all**
 47 **records related to an external grievance review for at least**
 48 **three (3) years after a determination is made under section 15**
 49 **of this chapter.**

50 ~~(4)~~ (5) Any additional requirements established by the
 51 department.

1 (d) The department may not certify an independent review
2 organization that is one (1) of the following:

3 (1) A professional or trade association of health care providers or
4 a subsidiary or an affiliate of a professional or trade association
5 of health care providers.

6 (2) An insurer, a health maintenance organization, or a health
7 plan association, or a subsidiary or an affiliate of an insurer,
8 health maintenance organization, or health plan association.

9 (e) The department may suspend or revoke an independent review
10 organization's certification if the department finds that the independent
11 review organization is not in substantial compliance with the
12 certification requirements under this section.

13 (f) The department shall make available to insurers a list of all
14 certified independent review organizations.

15 (g) The department shall make the information provided to the
16 department under subsection (c)(3) available to the public in a format
17 that does not identify individual covered individuals.

18 SECTION 26. IC 27-13-1-15 IS AMENDED TO READ AS
19 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:
20 Sec. 15. "Grievance" means a written complaint submitted in
21 accordance with the formal grievance procedure of a health
22 maintenance organization by or on behalf of:

23 (1) the enrollee or subscriber regarding any aspect of the health
24 maintenance organization relative to the enrollee or subscriber; **or**

25 (2) **an individual who would be an enrollee or a subscriber**
26 **under an individual contract or a group contract regarding**
27 **the health maintenance organization's decision to rescind the**
28 **individual contract or group contract.**

29 SECTION 27. IC 27-13-7-3, AS AMENDED BY P.L.218-2007,
30 SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
31 SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 3. (a) A contract
32 referred to in section 1 of this chapter must clearly state the following:

33 (1) The name and address of the health maintenance organization.

34 (2) Eligibility requirements.

35 (3) Benefits and services within the service area.

36 (4) Emergency care benefits and services.

37 (5) Any out-of-area benefits and services.

38 (6) Copayments, deductibles, and other out-of-pocket costs.

39 (7) Limitations and exclusions.

40 (8) Enrollee termination provisions.

41 (9) Any enrollee reinstatement provisions.

42 (10) Claims procedures.

43 (11) Enrollee grievance procedures.

44 (12) Continuation of coverage provisions.

45 (13) Conversion provisions.

46 (14) Extension of benefit provisions.

47 (15) Coordination of benefit provisions.

48 (16) Any subrogation provisions.

49 (17) A description of the service area.

50 (18) The entire contract provisions.

51 (19) The term of the coverage provided by the contract.

- 1 (20) Any right of cancellation of the group or individual contract
 2 holder.
 3 (21) Right of renewal provisions.
 4 (22) Provisions regarding reinstatement of a group or an
 5 individual contract holder.
 6 (23) Grace period provisions.
 7 (24) A provision on conformity with state law.
 8 (25) A provision or provisions that comply with the:
 9 (A) guaranteed renewability; and
 10 (B) group portability;
 11 requirements of the federal Health Insurance Portability and
 12 Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).
 13 (26) That the contract provides, upon request of the subscriber,
 14 coverage for a child of the subscriber until the date the child
 15 becomes ~~twenty-four (24)~~ **twenty-six (26)** years of age.
 16 (b) For purposes of subsection (a), an evidence of coverage which
 17 is filed with a contract may be considered part of the contract.
 18 SECTION 28. IC 27-13-10.1-1 IS AMENDED TO READ AS
 19 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:
 20 Sec. 1. A health maintenance organization shall establish and maintain
 21 an external grievance procedure for the resolution of grievances
 22 regarding **the following**:
 23 (1) **The following determinations made by the health**
 24 **maintenance organization or an agent of the health**
 25 **maintenance organization regarding a service proposed by the**
 26 **treating physician**:
 27 (A) An adverse utilization review determination (as defined in
 28 IC 27-8-17-8).
 29 ~~(2) (B)~~ (B) An adverse determination of medical necessity. ~~or~~
 30 ~~(3) (C)~~ (C) A determination that a proposed service is
 31 experimental or investigational.
 32 ~~made by a health maintenance organization or an agent of a health~~
 33 ~~maintenance organization regarding a service proposed by the treating~~
 34 ~~physician~~:
 35 (2) **The health maintenance organization's decision to rescind**
 36 **an individual contract or a group contract.**
 37 SECTION 29. IC 27-13-10.1-2 IS AMENDED TO READ AS
 38 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:
 39 Sec. 2. (a) An external grievance procedure established under section
 40 1 of this chapter must:
 41 (1) allow an enrollee or the enrollee's representative to file a
 42 written request with the health maintenance organization for an
 43 appeal of the health maintenance organization's grievance
 44 resolution under IC 27-13-10-8 not later than ~~forty-five (45)~~ **one**
 45 **hundred twenty (120)** days after the enrollee is notified of the
 46 resolution under IC 27-13-10-8; and
 47 (2) provide for:
 48 (A) an expedited appeal for a grievance related to an illness,
 49 a disease, a condition, an injury, or a disability that would
 50 seriously jeopardize the enrollee's:
 51 (i) life or health; or

- 1 (ii) ability to reach and maintain maximum function; or
 2 (B) a standard appeal for a grievance not described in clause
 3 (A).

4 An enrollee may file not more than one (1) appeal of a health
 5 maintenance organization's grievance resolution under this chapter.

6 (b) Subject to the requirements of subsection (d), when a request is
 7 filed under subsection (a), the health maintenance organization shall:

- 8 (1) select a different independent review organization for each
 9 appeal filed under this chapter from the list of independent review
 10 organizations that are certified by the department under section 8
 11 of this chapter; and
 12 (2) rotate the choice of an independent review organization
 13 among all certified independent review organizations before
 14 repeating a selection.

15 (c) The independent review organizations shall assign a medical
 16 review professional who is board certified in the applicable specialty
 17 for resolution of an appeal.

18 (d) The independent review organization and the medical review
 19 professional conducting the external review under this chapter may not
 20 have a material professional, familial, financial, or other affiliation with
 21 any of the following:

- 22 (1) The health maintenance organization.
 23 (2) Any officer, director, or management employee of the health
 24 maintenance organization.
 25 (3) The physician or the physician's medical group that is
 26 proposing the service.
 27 (4) The facility at which the service would be provided.
 28 (5) The development or manufacture of the principal drug, device,
 29 procedure, or other therapy that is proposed by the treating
 30 physician.

31 However, the medical review professional may have an affiliation
 32 under which the medical review professional provides health care
 33 services to enrollees of the health maintenance organization and may
 34 have an affiliation that is limited to staff privileges at the health facility
 35 if the affiliation is disclosed to the enrollee and the health maintenance
 36 organization before commencing the review and neither the enrollee
 37 nor the health maintenance organization objects.

38 (e) The enrollee may be required to pay not more than twenty-five
 39 dollars (\$25) of the costs associated with the services of an independent
 40 review organization under this chapter. All additional costs must be
 41 paid by the health maintenance organization.

42 SECTION 30. IC 27-13-10.1-8 IS AMENDED TO READ AS
 43 FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]:
 44 Sec. 8. (a) The department shall establish and maintain a process for
 45 annual certification of independent review organizations.

46 (b) The department shall certify a number of independent review
 47 organizations determined by the department to be sufficient to fulfill
 48 the purposes of this chapter.

49 (c) An independent review organization shall meet the following
 50 minimum requirements for certification by the department:

- 51 (1) Medical review professionals assigned by the independent

1 review organization to perform external grievance reviews under
2 this chapter:

3 (A) must be board certified in the specialty in which an
4 enrollee's proposed service would be provided;

5 (B) must be knowledgeable about a proposed service through
6 actual clinical experience;

7 (C) must hold an unlimited license to practice in a state of the
8 United States; and

9 (D) must have no history of disciplinary actions or sanctions
10 including:

11 (i) loss of staff privileges; or

12 (ii) restriction on participation;

13 taken or pending by any hospital, government, or regulatory
14 body.

15 (2) The independent review organization must have a quality
16 assurance mechanism to ensure the:

17 (A) timeliness and quality of reviews;

18 (B) qualifications and independence of medical review
19 professionals;

20 (C) confidentiality of medical records and other review
21 materials; and

22 (D) satisfaction of enrollees with the procedures utilized by the
23 independent review organization, including the use of enrollee
24 satisfaction surveys.

25 (3) The independent review organization must file with the
26 department the following information before March 1 of each
27 year:

28 (A) The number and percentage of determinations made in
29 favor of enrollees.

30 (B) The number and percentage of determinations made in
31 favor of health maintenance organizations.

32 (C) The average time to process a determination.

33 **(D) The number of external grievance reviews terminated
34 due to reconsideration of the health maintenance
35 organization before a determination was made.**

36 ~~(E)~~ (E) Any other information required by the department.

37 The information required under this subdivision must be specified
38 for each health maintenance organization for which the
39 independent review organization performed reviews during the
40 reporting year.

41 **(4) The independent review organization must retain all
42 records related to an external grievance review for at least
43 three (3) years after a determination is made under section 4
44 of this chapter.**

45 ~~(5)~~ (5) Any additional requirements established by the
46 department.

47 (d) The department may not certify an independent review
48 organization that is one (1) of the following:

49 (1) A professional or trade association of health care providers or
50 a subsidiary or an affiliate of a professional or trade association
51 of health care providers.

1 (2) A health insurer, health maintenance organization, or health
2 plan association or a subsidiary or an affiliate of a health insurer,
3 health maintenance organization, or health plan association.

4 (e) The department may suspend or revoke an independent review
5 organization's certification if the department finds that the independent
6 review organization is not in substantial compliance with the
7 certification requirements under this section.

8 (f) The department shall make available to health maintenance
9 organizations a list of all certified independent review organizations.

10 (g) The department shall make the information provided to the
11 department under subsection (c)(3) available to the public in a format
12 that does not identify individual enrollees.

13 **SECTION 31. An emergency is declared for this act.**

 (Reference is to ESB 461 as reprinted April 13, 2011.)

Conference Committee Report
on
Engrossed Senate Bill 461

Signed by:

Senator Miller
Chairperson

Representative Brown T

Senator Simpson

Representative Brown C

Senate Conferees

House Conferees