Reprinted
January 26, 2011

SENATE BILL No. 461

DIGEST OF SB 461 (Updated January 25, 2011 2:39 pm - DI 104)

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

Synopsis: Health care reform matters. 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 $100 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 federal Patient Protection and Affordable Care Act (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. Makes conforming amendments.

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

Miller, Lawson C, Simpson

January 12, 2011, read first time and referred to Committee on Health and Provider Services.
January 20, 2011, amended, reported favorably — Do Pass.
January 25, 2011, read second time, amended, ordered engrossed.

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First Regular Session 117th General Assembly (2011)

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 2010 Regular Session of the General Assembly.

SENATE BILL No. 461

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

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

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

SECTION 2. IC 12-15-1-5, AS AMENDED BY P.L.99-2007, SECTION 93, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 5. **(a)** The office may enter into an agreement with the ~~Secretary~~ **Commissioner** of the United States ~~Department of Health and Human Services~~ **Social Security Administration** under which the ~~Secretary~~ **Commissioner** shall accept applications and make determinations of eligibility for Medicaid for individuals who are aged, individuals who are blind, and individuals with a disability in accordance with the standards and criteria established by the state plan

for Medicaid. ~~in effect January 1, 1972.~~

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

SECTION 3. IC 12-15-2-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 6. (a) Subject to subsection (b), An individual who:

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

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

is eligible to receive Medicaid.

(b) An individual who is receiving monthly disability assistance payments under the federal Supplemental Security Income program or the federal Social Security Disability Insurance program must meet the eligibility requirements specified in IC 12-14-15 unless the state is required to provide medical assistance to the individual under 42 U.S.C. 1382h.

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

(d) This section expires December 31, 2013.

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

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

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

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

(1) Offer coverage for dental and vision services to an individual who participates in the plan.

(2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1).

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

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

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

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

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

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

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

SECTION 6. IC 12-15-44.2-9, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 9. (a) An individual is eligible for participation in the plan if the individual meets the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 7. IC 12-15-44.2-10, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 10. (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan only by the following:

(1) The individual.

(2) An employer.

(3) The state.

(4) A nonprofit organization if the nonprofit organization:

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

(B) does not contribute more than seventy-five percent (75%) of the individual's required payment to the individual's health care account.

(5) An insurer or a health maintenance organization under a contract with the office to provide health insurance coverage

under the plan if the payment:

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

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

(C) does not exceed one thousand one hundred dollars ($1,100).

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

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

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

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

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

(3) Another method determined by the office.

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

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

SECTION 8. IC 12-15-44.2-11, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 11. (a) An individual's participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation may not exceed one-twelfth (1/12) of the annual payment required under subsection (b).

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

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

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

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

(i) Medicaid program under IC 12-15;

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

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

as determined by the office.

(B) **At least one hundred dollars ($100) per year and** not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

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

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

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

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

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

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

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

SECTION 9. IC 12-15-44.2-15, AS ADDED BY P.L.3-2008,

SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 15. (a) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

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

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

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

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

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

(c) The state:

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

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

(d) This section expires December 31, 2013.

SECTION 10. IC 12-15-44.2-20, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 20. (a) The office may establish a health insurance coverage premium assistance program for individuals who **meet the following:**

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

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

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

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

(b) A program established under this section must:

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

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

(3) provide that an individual's payment:

(A) to a health care account; or

(B) for a health insurance coverage premium;

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

SECTION 11. IC 12-15-44.2-21, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 21. **(a)** A denial of federal approval and federal financial participation that applies to any part of this chapter does not prohibit the office from implementing any other part of this chapter that:

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

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

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

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

(2) Federal law or regulation.

SECTION 12. IC 12-15-44.2-22 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 22. The office of the secretary may amend the plan in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from passage of the Federal Patient Protection and Affordable Care Act.**

SECTION 13. IC 27-8-5-1, AS AMENDED BY P.L.173-2007, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or

endorsement be used in connection with an accident and sickness insurance policy, until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with and reviewed by the commissioner under section 1.5 of this chapter. This section is applicable also to assessment companies and fraternal benefit associations or societies.

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

SECTION 14. IC 27-8-5-2, AS AMENDED BY P.L.218-2007, SECTION 45, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

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

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

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

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

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

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

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

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

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

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

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

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a child who has mental retardation or a mental or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of

such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

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

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

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

SECTION 15. IC 27-8-5-28, AS ADDED BY P.L.218-2007, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes ~~twenty-four (24)~~ **twenty-six (26)** years of age.

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

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

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

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

SECTION 17. IC 27-8-15-29 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 29. **(a) This section shall be applied in conformity with the requirements of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on September 23, 2010.**

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

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

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

SECTION 18. IC 27-8-28-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 6. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding:

(1) a determination that a service or proposed service is not appropriate or medically necessary;

(2) a determination that a service or proposed service is experimental or investigational;

(3) the availability of participating providers;

(4) the handling or payment of claims for health care services; ~~or~~

(5) matters pertaining to the contractual relationship between:

(A) a covered individual and an insurer; or

(B) a group policyholder and an insurer; **or**

(6) an insurer's decision to rescind an accident and sickness insurance policy;

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

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

(1) **The following determinations made by the insurer or an**

agent of the insurer regarding a service proposed by the treating health care provider:

(A) An adverse determination of appropriateness.

~~(2)~~ **(B)** An adverse determination of medical necessity.

~~(3)~~ **(C)** A determination that a proposed service is experimental or investigational. ~~or~~

(4) A denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

~~made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.~~

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

SECTION 20. IC 27-8-29-13, AS AMENDED BY P.L.3-2008, SECTION 217, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual, or a covered individual's representative, to file a written request with the insurer for an external grievance review of the insurer's

(A) appeal resolution under IC 27-8-28-17 or

(B) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed);

not more than ~~forty-five (45)~~ **one hundred twenty (120)** days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

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

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

(1) select a different independent review organization for each external grievance filed under this chapter from the list of

independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

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

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

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

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

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

SECTION 21. IC 27-8-29-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 19. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

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

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

(1) Medical review professionals assigned by the independent

review organization to perform external grievance reviews under this chapter:

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

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

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

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

(i) loss of staff privileges; or

(ii) restriction on participation;

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

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

(A) the timeliness and quality of reviews;

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

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

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

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

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

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

(C) The average time to process a determination.

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

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

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

(4) The independent review organization must retain all records related to an external grievance review for at least three (3) years after a determination is made under section 15

of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Eligibility requirements.

(3) Benefits and services within the service area.

(4) Emergency care benefits and services.

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

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

(7) Limitations and exclusions.

(8) Enrollee termination provisions.
(9) Any enrollee reinstatement provisions.
(10) Claims procedures.
(11) Enrollee grievance procedures.
(12) Continuation of coverage provisions.
(13) Conversion provisions.
(14) Extension of benefit provisions.
(15) Coordination of benefit provisions.
(16) Any subrogation provisions.
(17) A description of the service area.
(18) The entire contract provisions.
(19) The term of the coverage provided by the contract.
(20) Any right of cancellation of the group or individual contract holder.
(21) Right of renewal provisions.
(22) Provisions regarding reinstatement of a group or an individual contract holder.
(23) Grace period provisions.
(24) A provision on conformity with state law.
(25) A provision or provisions that comply with the:
(A) guaranteed renewability; and
(B) group portability;
requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).
(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the date the child becomes ~~twenty-four (24)~~ **twenty-six (26)** years of age.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

SECTION 24. IC 27-13-10.1-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 1. A health maintenance organization shall establish and maintain an external grievance procedure for the resolution of grievances regarding **the following:**

(1) **The following determinations made by the health maintenance organization or an agent of the health maintenance organization regarding a service proposed by the treating physician:**
(A) An adverse utilization review determination (as defined in IC 27-8-17-8).
~~(2)~~ **(B)** An adverse determination of medical necessity. ~~or~~
~~(3)~~ **(C)** A determination that a proposed service is

experimental or investigational.

~~made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by the treating physician.~~

(2) The health maintenance organization's decision to rescind an individual contract or a group contract.

SECTION 25. IC 27-13-10.1-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 2. (a) An external grievance procedure established under section 1 of this chapter must:

(1) allow an enrollee or the enrollee's representative to file a written request with the health maintenance organization for an appeal of the health maintenance organization's grievance resolution under IC 27-13-10-8 not later than ~~forty-five (45)~~ **one hundred twenty (120)** days after the enrollee is notified of the resolution under IC 27-13-10-8; and

(2) provide for:

(A) an expedited appeal for a grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard appeal for a grievance not described in clause (A).

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

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

(1) select a different independent review organization for each appeal filed under this chapter from the list of independent review organizations that are certified by the department under section 8 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

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

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

(1) The health maintenance organization.

(2) Any officer, director, or management employee of the health maintenance organization.

(3) The physician or the physician's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.

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

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

SECTION 26. IC 27-13-10.1-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 23, 2010 (RETROACTIVE)]: Sec. 8. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

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

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

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

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

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

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

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

(i) loss of staff privileges; or

(ii) restriction on participation;

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

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

(A) timeliness and quality of reviews;

(B) qualifications and independence of medical review professionals;

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

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

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

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

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

(C) The average time to process a determination.

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

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

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

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

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

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

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

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

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

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

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

SECTION 27. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 461, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 4, line 3, delete "Effective through December 31, 2013, the" and insert "The".

and when so amended that said bill do pass.

(Reference is to SB 461 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 10, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 461 be amended to read as follows:

Page 4, line 38, delete "fifty percent (50%)" and insert "**seventy-five percent (75%)**".

Page 5, line 25, delete "fifty" and insert "**seventy-five**".

Page 5, line 26, delete "(50%)" and insert "**(75%)**".

Page 6, line 6, delete "sixty dollars ($60)" and insert "**one hundred dollars ($100)**".

(Reference is to SB 461 as printed January 21, 2011.)

MILLER