IC 27-13
ARTICLE 13. HEALTH MAINTENANCE ORGANIZATIONS

IC 27-13-1
Chapter 1. Definitions

IC 27-13-1-1
Applicability of definitions
Sec. 1. The definitions in this chapter apply throughout this article.

IC 27-13-1-2
"Admitted asset"
Sec. 2. "Admitted asset" means an asset that may be included in a health maintenance organization's total assets for the purpose of computing the net worth of the health maintenance organization.

IC 27-13-1-3
Repealed
(Repealed by P.L.97-2004, SEC.133.)

IC 27-13-1-4
"Basic health care services"
Sec. 4. (a) "Basic health care services" means the following medically necessary services:
   (1) Preventive care.
   (2) Inpatient and outpatient hospital and physician care.
   (3) Diagnostic laboratory care.
   (4) Diagnostic and therapeutic radiological services.
   (5) Emergency care.
(b) The term does not include the following:
   (1) Mental health services.
   (2) Services for alcohol and drug abuse.
   (3) Dental services.
   (4) Vision services.

IC 27-13-1-5
"Capitated basis"
Sec. 5. "Capitated basis" means fixed per member per month payment or percentage of premium payment under which the provider assumes the full risk for the cost of contracted services without regard to type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.
IC 27-13-1-6
"Carrier"
Sec. 6. "Carrier" refers to any of the following:
(1) A health maintenance organization.
(2) An insurer licensed in Indiana to write Class 1(B) or Class 2(A) lines of insurance.
(3) Any other entity responsible for the payment of benefits or provision of services under a group contract.

IC 27-13-1-7
"Commissioner"
Sec. 7. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

IC 27-13-1-8
"Copayment"
Sec. 8. "Copayment" means an amount, or a percentage of the charge, that an enrollee must pay to receive a specific service that is not fully prepaid.

IC 27-13-1-9
"Coverage"
Sec. 9. "Coverage" means the health care services to which a person is contractually entitled, either directly or indirectly, under a contract with a carrier.

IC 27-13-1-10
"Covered by a health maintenance organization"
Sec. 10. "Covered by a health maintenance organization" means that a person is contractually entitled, either directly or indirectly, to health care services from the health maintenance organization.

IC 27-13-1-10.5
"Credentialing"
Sec. 10.5. "Credentialing" means a process through which a health maintenance organization makes a determination:
(1) based on criteria established by the health maintenance organization; and
(2) concerning whether a provider may serve as a participating provider.

IC 27-13-1-11
"Deductible"
Sec. 11. "Deductible" means the amount that an enrollee is
responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with the health care services.


IC 27-13-1-11.3
"Department"
Sec. 11.3. "Department" refers to the department of insurance.

IC 27-13-1-11.5
"Dialysis facility"
Sec. 11.5. "Dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.
As added by P.L.111-2008, SEC.5.

IC 27-13-1-11.7
"Emergency"
Sec. 11.7. "Emergency" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(1) place an individual's health in serious jeopardy;
(2) result in serious impairment to the individual's bodily functions; or
(3) result in serious dysfunction of a bodily organ or part of the individual.

IC 27-13-1-12
"Enrollee"
Sec. 12. "Enrollee" means a subscriber or a subscriber's dependent who is covered by a health maintenance organization.

IC 27-13-1-13
"Evidence of coverage"
Sec. 13. "Evidence of coverage" means a statement of the essential features and services of the coverage provided by a health maintenance organization.

IC 27-13-1-13.5
"Experimental treatment"
Sec. 13.5. "Experimental treatment" means medical technology or a new application of existing medical technology, including medical
procedures, drugs, and devices for treating a medical condition, illness, or diagnosis that:

(1) is not generally accepted by informed health care professionals in the United States as effective; or
(2) has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

IC 27-13-1-14
"Extension of benefits"

Sec. 14. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following the termination of an enrollee with a total disability on the date of termination.

IC 27-13-1-15
"Grievance"

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.

IC 27-13-1-16
"Group contract"

Sec. 16. "Group contract" means a contract for health care services which by the contract's terms limits eligibility to members of a specified group. A group contract may include coverage for dependents.

IC 27-13-1-17
"Group contract holder"

Sec. 17. "Group contract holder" means the person to whom a group contract has been issued.

IC 27-13-1-18
"Health care services"
Sec. 18. (a) "Health care services" means:
(1) any services provided by individuals licensed under IC 25-5.1, IC 25-10, IC 25-13, IC 25-14, IC 25-22.5, IC 25-23, IC 25-24, IC 25-26, IC 25-27, IC 25-29, IC 25-33, or IC 25-35.6;
(2) services provided as a result of hospitalization;
(3) services incidental to the furnishing of services described in subdivision (1) or (2); or
(4) any other services or goods furnished for the purpose of preventing, alleviating, curing, or healing human illness, physical disability, or injury.

(b) The term does not include any service provided by, from, or through a licensed health care facility in connection with any life care, founder's fee, or other type of prepaid fee contract for residency and health care in a retirement home, community, or facility for elderly persons.


IC 27-13-1-19
"Health maintenance organization"

Sec. 19. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.


IC 27-13-1-20
"In-plan covered services"

Sec. 20. "In-plan covered services" means the following:
(1) Covered health care services that are obtained from a provider who:
(A) is employed by;
(B) is under contract with;
(C) provides health care services to an enrollee referred by; or
(D) is otherwise affiliated with;
the health maintenance organization.
(2) Emergency services.


IC 27-13-1-21
"Individual contract"

Sec. 21. (a) "Individual contract" means a contract for health care services that:
(1) is issued to; and
(2) covers;
an individual.

(b) An individual contract may include coverage for a dependent of the subscriber.
"Insurance producer"
Sec. 21.3. "Insurance producer" means a person who is a licensed insurance producer under IC 27-1-15.6 and who:

1. solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for membership in a health maintenance organization or a prepaid limited health service organization;
2. takes or transmits a membership fee or premium for the policy or contract other than for the insurance producer; or
3. causes the insurance producer to be held out to the public, through advertising or otherwise, as a producer for a health maintenance organization or a prepaid limited health service organization.

"Managed hospital payment basis"
Sec. 21.5. "Managed hospital payment basis" means agreements in which the financial risk is primarily related to the degree of utilization rather than to cost of services.

"Net worth"
Sec. 22. (a) "Net worth" means the excess of total admitted assets over total liabilities.

(b) For the purposes of subsection (a), "liabilities" does not include fully subordinated debt.

"Out-of-plan covered services"
Sec. 23. (a) "Out-of-plan covered services" means nonemergency, self-referred covered health care services that:

1. are obtained from a provider who is:
   A. not otherwise employed by;
   B. not under contract with; and
   C. not otherwise affiliated with;
   the health maintenance organization; or
2. are obtained from a participating provider without a referral.

(b) The term does not include uncovered services.

"Participating provider"
Sec. 24. "Participating provider" means a provider who, under an express or implied contract with:
(1) the health maintenance organization; or
(2) a contractor of the health maintenance organization or any subcontractor of a contractor of the health maintenance organization;
has agreed to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the health maintenance organization. As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.1.

IC 27-13-1-25
"Person"
Sec. 25. "Person" includes the following:
(1) An individual.
(2) A partnership.
(3) An association.
(4) A trust.
(5) A limited liability company.
(6) A corporation.

IC 27-13-1-26
"Point-of-service product"
Sec. 26. "Point-of-service product" means a product that covers both:
(1) in-plan covered services; and
(2) out-of-plan covered services.

IC 27-13-1-27
"Limited service health maintenance organization"
Sec. 27. "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

IC 27-13-1-27.5
"Primary care provider"
Sec. 27.5. "Primary care provider" means a provider under contract with a health maintenance organization who is designated by the health maintenance organization to coordinate, supervise, or provide ongoing care to an enrollee.

IC 27-13-1-28
"Provider"
Sec. 28. (a) "Provider" means a physician, a hospital, or any other person licensed or authorized to furnish health care services.
(b) The term includes an entity that:
(1) is owned in whole or in part by one (1) or more physicians, hospitals, or other persons licensed or authorized to furnish
health care services; and
(2) was established for purposes of furnishing health care services through:
   (A) contracts; or
   (B) employment agreements;
with one (1) or more physicians, hospitals, or other persons licensed or authorized to furnish health care services.


IC 27-13-1-28.5
"Quality assurance"
Sec. 28.5. "Quality assurance" means the ongoing evaluation of the quality of health care services provided to enrollees.

IC 27-13-1-29
"Receivership"
Sec. 29. "Receivership" means that the health maintenance organization has been placed in receivership under an order of rehabilitation or liquidation by a court with jurisdiction.

IC 27-13-1-30
"Replacement coverage"
Sec. 30. "Replacement coverage" means the coverage provided to a person whose last preceding carrier has ceased providing coverage to that person.

IC 27-13-1-31
"Service area"
Sec. 31. "Service area" means the geographic area within which a health maintenance organization licensed under this article provides or arranges for the delivery of health care services to enrollees.

IC 27-13-1-32
"Subscriber"
Sec. 32. "Subscriber" means:
   (1) an individual whose employment status or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization; or
   (2) in the case of an individual contract, the person in whose name the contract is issued.

IC 27-13-1-33
"Subscriber premiums"
Sec. 33. "Subscriber premiums" means money or any other thing
of value paid or given in consideration to a health maintenance organization, agent, or solicitor on account of or in connection with a contract under which a health maintenance organization provides or arranges for the delivery of health care benefits to enrollees. 

IC 27-13-2
Chapter 2. Establishment of Health Maintenance Organizations

IC 27-13-2-1
Persons applying for certificate of authority
Sec. 1. Notwithstanding any other law, any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization under this article.

IC 27-13-2-2
Certificate of authority required
Sec. 2. (a) A person may not establish or operate a health maintenance organization without obtaining a certificate of authority under this article.
(b) If a participating provider contracts with another provider under a contract that complies with IC 27-13-15 to provide health services on a prepaid basis to enrollees of a health maintenance organization that holds a certificate of authority, neither provider, with respect to the contract is:
   (1) considered to be engaged in the business of insurance; or
   (2) required to obtain a certificate of authority under this article.

IC 27-13-2-3
Foreign entities obtaining certificate of authority
Sec. 3. (a) A foreign corporation, other than a foreign corporation defined under IC 27-1-2-3, may obtain a certificate of authority if the foreign corporation:
   (1) is authorized to do business in Indiana under IC 23-1-49 or IC 23-17-26; and
   (2) complies with this article.
(b) A foreign corporation (as defined in IC 27-1-2-3) may obtain a certificate of authority if the foreign corporation complies with this article.
(c) A foreign or alien health maintenance organization granted a certificate of authority under this section has the same but no greater rights and privileges than a domestic health maintenance organization.

IC 27-13-2-4
Certificate of authority application; verification; form
Sec. 4. An application for a certificate of authority to operate a health maintenance organization must be:
   (1) verified by an officer or authorized representative of the applicant; and
IC 27-13-2-5
Certificate of authority application; requirements
Sec. 5. An application for a certificate of authority to operate a health maintenance organization must set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, partnership agreement, trust agreement, articles of organization, or any other applicable documents, and all amendments to those documents.

(2) A copy of the bylaws, rules and regulations, or similar document regulating the conduct of the internal affairs of the applicant.

(3) A list, on a form acceptable to the commissioner, of the names, addresses, official positions, and biographical information of the persons who are to be responsible for the conduct of the affairs and daily operations of the applicant, including the following:
   (A) All members of the board of directors, board of trustees, executive committee, or other governing board or committee of the applicant.
   (B) The principal officers, if the applicant is a corporation.
   (C) The partners or members, if the applicant is a partnership or an association.
   (D) The manager or, if there is no manager, all members of a limited liability company.

(4) A copy of any contract form that has been made or is to be made between any class of providers and the health maintenance organization.

(5) A copy of any contract that has been made or is to be made between:
   (A) third party administrators, agents, or persons identified under subdivision (3); and
   (B) the health maintenance organization.

(6) A copy of the form of evidence of coverage that is to be issued by the health maintenance organization to an enrollee.

(7) A copy of the form of a group contract, if any, that is to be issued by the health maintenance organization to an employer, a union, a trustee, or another entity.

(8) Financial statements showing the assets, liabilities, and sources of financial support of the applicant, including:
   (A) a copy of the most recent certified financial statement of the applicant; and
   (B) an unaudited current financial statement.

(9) A financial feasibility plan that includes the following:
   (A) Detailed enrollment projections.
   (B) The methodology for determining premium rates to be charged during the first twelve (12) months of operations,
certified by an actuary or other qualified person acceptable to the commissioner.
(C) A projection of:
   (i) balance sheets;
   (ii) cash flow statements showing any capital expenditures, purchase and sale of investments, and deposits with the state; and
   (iii) income and expense statements;
anticipated from the start of operations until the organization has had net income for at least one (1) year.
(D) A statement of the sources of working capital as well as any other sources of funding.
(10) If the applicant is not domiciled in Indiana, an executed power of attorney appointing the commissioner, the commissioner's successors in office, and authorized deputies of the commissioner as the true and lawful attorney of the applicant in and for Indiana upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in Indiana may be served.
(11) A statement or map reasonably indicating, on a county-by-county basis, the service area to be served by the health maintenance organization.
(12) A description of the internal procedures to be used by the health maintenance organization for the investigation and resolution of the complaints and grievances of enrollees.
(13) A description of the proposed quality management program of the applicant, including the following:
   (A) The formal organizational structure.
   (B) Methods for developing criteria.
   (C) Procedures for comprehensive evaluation of the quality of care rendered to enrollees.
   (D) Processes to initiate corrective action and reevaluation when deficiencies in provider performance or organizational performance are identified.
(14) A description of the procedures to be implemented to meet the requirements set forth in IC 27-13-12 through IC 27-13-17.
(15) A list of the names, addresses, and license numbers of any providers with whom the health maintenance organization has agreements.
(16) Any other information required by the commissioner to make the determination required under IC 27-13-3.


IC 27-13-2-6
Certificate of authority application; modifications or amendments
Sec. 6. (a) An applicant shall submit to the commissioner any modifications or amendments to the items of information required in an application under section 5 of this chapter.
(b) The commissioner may adopt rules under this section that
provide that any modifications or amendments to the items of information in the application required of a health maintenance organization:

(1) must be submitted to the commissioner before the modification or amendment takes effect:
   (A) for the approval of the commissioner; or
   (B) for the information of the commissioner only; or
(2) must be indicated by the health maintenance organization to the commissioner at the time of the next succeeding site visit or examination of the organization by the department of insurance.

(c) A health maintenance organization shall file any assumed corporate name with the department at least thirty (30) days before assuming the name.


IC 27-13-2-7
Certificate of authority application; approval of modifications or amendments

Sec. 7. Any modification or amendment requiring the approval of the commissioner under rules adopted under section 6 of this chapter is considered approved unless the commissioner disapproves the modification or amendment not more than thirty (30) days after the modification or amendment is submitted. However, the commissioner may postpone the action, if necessary for proper consideration, and if the commissioner gives written notice of the postponement to the applicant before the expiration of the thirty (30) day period.


IC 27-13-2-8
Waiver of rights under bankruptcy laws

Sec. 8. The commissioner may not issue a certificate of authority to operate a health maintenance organization unless the applicant has submitted to the commissioner a written waiver of the health maintenance organization's rights under the federal bankruptcy laws.


IC 27-13-2-9
Prohibited names

Sec. 9. (a) A health maintenance organization established under this article may not:

(1) use as a part of its corporate name the words "United States", "Federal", "government", "official", or any word that would imply that the company is an administrative agency of the state of Indiana or of the United States, or that it is subject to supervision of any department other than the department of insurance; or
(2) take or assume a corporate name the same as, or confusingly similar to, an existing name of any other insurance company or other entity licensed or regulated under IC 27, unless at the
same time:
(A) the other company changes its corporate name or
withdraws from transacting business in Indiana; and
(B) the written consent of the other company, signed and
verified under oath by its secretary, is filed with the
department.

(b) This section does not affect the right of any health maintenance
organization that:
(1) exists under the laws of Indiana as of July 1, 2001;
(2) exists under the laws of Indiana as of July 1, 2001, and
thereafter reorganizes or reincorporates under this article; or
(3) is authorized to transact business in Indiana as of July 1,
2001;
to continue the use of its corporate name.

IC 27-13-2-10
Application of other laws to domestic health maintenance
organizations
Sec. 10. (a) A domestic health maintenance organization that is
admitted to transact business in Indiana shall do the following:
(1) If the health maintenance organization is a domestic health
maintenance organization admitted to transact business in
Indiana after June 30, 2011, comply with IC 27-1-6-21.
(2) If the health maintenance organization changes the physical
location of its home office, provide written notice to the
department and all subscribers at least thirty (30) days before
the location is changed, including the address and telephone
number of the new location.
(b) A domestic health maintenance organization operating under
this article is subject to IC 27-1-7-11.
As added by P.L.11-2011, SEC.37.
IC 27-13-3
Chapter 3. Issuance of Certificates of Authority

IC 27-13-3-1
Satisfaction of requirements
Sec. 1. After receiving a completed application, the commissioner shall issue a certificate of authority to operate a health maintenance organization to the applicant if:
(1) the application fee is received by the commissioner; and
(2) the commissioner is satisfied that the following requirements are met:
   (A) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and have good reputations.
   (B) The health maintenance organization will effectively provide or arrange for the provision of the health care services covered in the health maintenance organization's individual and group contracts on a prepaid basis, through insurance or other means, except to the extent of reasonable requirements for copayments and deductibles.
   (C) The health maintenance organization complies with IC 27-13-12 through IC 27-13-19.


IC 27-13-3-1.5
Approval of certificate of authority
Sec. 1.5. (a) Except as provided in subsection (b), a completed application for a certificate of authority is considered approved one hundred twenty (120) days after the completed application is submitted to the commissioner.
(b) If the commissioner issues an order under IC 27-13-24-3(b) within one hundred twenty (120) days after a completed application is submitted under subsection (a), the review and processing of the application are subject to IC 27-13-24-3 and IC 27-13-24-4.


IC 27-13-3-2
Denial of application
Sec. 2. An application for a certificate of authority may be denied only after the commissioner complies with the requirements set forth in IC 27-13-24.

IC 27-13-4
Chapter 4. Powers of Health Maintenance Organizations

IC 27-13-4-1
General powers

Sec. 1. (a) Subject to section 3 of this chapter, the powers of a health maintenance organization include the following:

1) The purchase, lease, construction, renovation, operation, or maintenance of:
   (A) hospitals and medical facilities;
   (B) equipment for hospitals and medical facilities; and
   (C) other property reasonably required for the principal office of the health maintenance organization or for purposes necessary in the transaction of the business of the organization.

2) Engaging in transactions between affiliated entities, including loans and the transfer of responsibility under any or all contracts:
   (A) between affiliates; or
   (B) between the health maintenance organization and the parent organization of the health maintenance organization.

3) The furnishing of health care services through:
   (A) providers;
   (B) provider associations; and
   (C) agents for providers;
who are under contract with or are employed by the health maintenance organization. The contracts with providers, provider associations, or agents of providers may include fee for service, cost plus, capitation, or other payment or risk-sharing arrangements.

4) Contracting with any person for the performance on behalf of the health maintenance organization of certain functions, including:
   (A) marketing;
   (B) enrollment; and
   (C) administration.

5) Contracting with:
   (A) an insurance company licensed in Indiana;
   (B) an authorized reinsurer; or
   (C) a hospital authorized to conduct business in Indiana;
for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

6) The offering of point-of-service products.

7) The joint marketing of products with:
   (A) an insurance company that is licensed in Indiana; or
   (B) a hospital that is authorized to conduct business in Indiana;
if the company that is offering each product is clearly identified.

8) Administration of the provision of health care services at the
expense of a self-funded plan.

(b) A health maintenance organization may offer any of the following:

(1) Plans that include only basic health care services.
(2) Plans that include basic health care services and other health care services.
(3) Plans that include health care services other than basic health care services so long as at least one (1) of the plans offered by the health maintenance organization includes basic health care services.

(c) Notwithstanding subsection (a)(5), a health maintenance organization may not take credit for reinsurance unless the risk is ceded to a reinsurer qualified under IC 27-6-10.


IC 27-13-4-2
Asset of health maintenance organization as an admitted asset

Sec. 2. Nothing in this chapter qualifies an asset of a health maintenance organization as an admitted asset.


IC 27-13-4-3
Filing notice with commissioner before exercising power; disapproval of exercise of power; exemptions from filing requirement

Sec. 3. (a) A domestic health maintenance organization must file notice with the commissioner, with supporting information that the commissioner deems adequate, before exercising any power granted in:

(1) section 1(a)(1); or
(2) section 1(a)(4);

of this chapter if the proposed transaction is equal to or greater than ten percent (10%) of the health maintenance organization's admitted assets.

(b) A domestic health maintenance organization must file notice with the commissioner, with the supporting information that the commissioner deems adequate, before exercising any power granted in section 1(a)(2), if the proposed transaction is equal to or greater than three percent (3%) of the health maintenance organization's admitted assets.

(c) The commissioner may disapprove an exercise of power referred to in a notice received under subsection (a) or (b) only if, in the opinion of the commissioner, the exercise of the power would:

(1) substantially and adversely affect the financial soundness of the health maintenance organization; and
(2) endanger the ability of the health maintenance organization to meet its obligations.

(d) If the commissioner does not disapprove an exercise of power referred to in a notice received under subsection (a) or (b) within
thirty (30) days after the notice is filed with the commissioner, the exercise of power is considered approved.

(e) The commissioner may adopt rules under IC 4-22-2 exempting from the filing requirement of this section certain activities that have a minimal effect on:
   (1) the financial soundness of the health maintenance organization; and  
   (2) the ability of the health maintenance organization to meet its obligations.

IC 27-13-5
Chapter 5. Fiduciary Responsibilities

IC 27-13-5-1
Persons having fiduciary responsibilities
Sec. 1. Any:
(1) director;
(2) officer;
(3) employee; or
(4) partner;
of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization has a fiduciary responsibility to the organization for the funds.

IC 27-13-5-2
Fidelity bond or fidelity insurance
Sec. 2. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on the directors, officers, employees, and partners referred to in section 1 of this chapter:
(1) in an amount:
   (A) not less than two hundred and fifty thousand dollars ($250,000) for each health maintenance organization; or
   (B) not more than five million dollars ($5,000,000) in the aggregate on behalf of all health maintenance organizations owned by a common parent organization; or
(2) in an amount prescribed by the commissioner.
IC 27-13-6
Chapter 6. Quality Management Programs

IC 27-13-6-1
Procedures; establishment
Sec. 1. (a) A health maintenance organization shall establish procedures based on professionally recognized standards to assess and monitor the health care services provided to enrollees of the organization.
   (b) The procedures established under this section must include mechanisms to implement corrective action when necessary and to assess the availability, accessibility, and continuity of care.

IC 27-13-6-2
Internal quality management program required
Sec. 2. A health maintenance organization shall have an ongoing internal quality management program to monitor and evaluate the health care services it provides, including:
   (1) primary and specialist physician services; and
   (2) ancillary and preventive health care services;
across all institutional and noninstitutional settings.

IC 27-13-6-3
Quality management program requirements
Sec. 3. The quality management program required by section 2 of this chapter must include at least the following:
   (1) A written statement of the scope and purpose of the health maintenance organization's quality management program, including a written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees.
   (2) The organizational structure responsible for quality management activities.
   (3) Any contractual arrangements, when appropriate, for delegation of quality management activities.
   (4) Confidentiality of policies and procedures.
   (5) A system of ongoing evaluation activities.
   (6) A system of focused evaluation activities.
   (7) A system for credentialing providers and performing peer review activities.
   (8) Duties and responsibilities of the designated physician responsible for the quality management activities.

IC 27-13-6-4
Written statement of quality management activities
Sec. 4. The quality management program required by section 2 of this chapter must contain a written statement describing the system
of ongoing quality management activities, including the following:

1. Problem assessment, identification, selection, and study.
2. Corrective action, monitoring, evaluation, and reassessment.
3. Interpretation and analysis of patterns of care rendered to individual patients by individual providers.
4. Comparison between patterns of care, including outcomes, rendered to patients by providers and the cost to the health maintenance organization of that care.
5. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation, and report format.


IC 27-13-6-5
Written plans for correcting insufficient service
Sec. 5. The quality management program required by section 2 of this chapter must contain written plans for taking appropriate corrective action whenever the quality management program determines that:

1. inappropriate or substandard services have been provided; or
2. services that should have been provided were not provided.


IC 27-13-6-6
Patient record system
Sec. 6. A health maintenance organization shall ensure the use and maintenance of an adequate patient record system that will facilitate:

1. documentation and retrieval of clinical information to enable the health maintenance organization to evaluate continuity and coordination of patient care; and
2. the assessment of the quality of health and medical care provided to enrollees.


IC 27-13-6-7
Reporting quality management program activities
Sec. 7. A health maintenance organization shall establish a mechanism for periodic reporting of quality management program activities to the governing body, providers, and appropriate staff of the organization.


IC 27-13-6-8
Records of proceedings; confidentiality
Sec. 8. A health maintenance organization shall:

1. record the proceedings of formal quality management program activities; and
2. maintain its documentation of the quality management
program in a confidential manner.

IC 27-13-6-9
Inspection of records by commissioner
Sec. 9. The commissioner may inspect the records of a health maintenance organization's quality management program. The health maintenance organization shall cooperate with the inspections by making available to the commissioner the records requested by the commissioner, while protecting the confidentiality of enrollee medical records.

IC 27-13-6-10
Hospital accreditation
Sec. 10. (a) A health maintenance organization may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:
   (1) establishes standards for the organization and operation of hospitals;
   (2) requires the hospital to undergo a survey process for a fee paid by the hospital; and
   (3) was organized and formed in 1951.
(b) This section does not prohibit a health maintenance organization from using performance indicators or quality standards that:
   (1) are developed by private organizations; and
   (2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.
Chapter 7. Requirements for Group Contracts, Individual Contracts, and Evidence of Coverage

Application of certain amendments to chapter
Sec. 0.1. The following amendments to this chapter apply as follows:

1. The addition of sections 15.3 and 16 of this chapter by P.L.170-1999 applies to health maintenance organization contracts that are issued, delivered, or renewed after June 30, 1999.

2. The addition of section 18 of this chapter by P.L.166-2003 applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after December 31, 2003.

3. The amendments made to section 14 of this chapter by P.L.204-2003 apply to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2003.

4. The amendments made to section 14.8 of this chapter by P.L.226-2003 apply to a group or an individual contract with a health maintenance organization that is entered into, delivered, amended, or renewed after June 30, 2003.

5. The amendments made to section 14.5 of this chapter by P.L.196-2005 apply to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2005.

6. The amendments made to section 3 of this chapter by P.L.218-2007 apply to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

7. The addition of section 19 of this chapter by P.L.109-2008 applies to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2008.

As added by P.L.220-2011, SEC.457.

Persons entitled to copies of contracts
Sec. 1. Any holder of a group or an individual contract with a health maintenance organization is entitled to a copy of the group or individual contract.

Deceptive contract provisions prohibited
Sec. 2. A contract or an evidence of coverage referred to in section 1 or section 5 of this chapter may not contain provisions or statements that are unjust, unfair, inequitable, misleading, or
deceptive or that encourage misrepresentation prohibited by IC 27-1-15.6-12 or IC 27-4-1-4.


IC 27-13-7-3
Contract provisions

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.
11. Enrollee grievance procedures.
12. Continuation of coverage provisions.
13. Conversion provisions.
15. Coordination of benefit 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.
22. Provisions regarding reinstatement of a group or an individual contract holder.
23. Grace period provisions.
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-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.


IC 27-13-7-4
Compliance with requirements; ten day grace period
Sec. 4. (a) An individual contract must comply with all provisions of section 3(a) of this chapter and provide for a period of ten (10) days during which the individual entering into the contract with the health maintenance organization may:
(1) examine the contract; and
(2) if the individual decides, return the contract to the health maintenance organization and obtain a refund of the premium paid.
(b) If:
(1) services were received during the ten (10) day period referred to in subsection (a); and
(2) the individual returns the contract to receive a refund of the premium paid;
the individual must pay for the services received during the ten (10) day period.

IC 27-13-7-5
Evidence of coverage
Sec. 5. (a) A subscriber under a group contract must receive an evidence of coverage from:
(1) the group contract holder; or
(2) the health maintenance organization.
(b) A group contract holder or health maintenance organization may provide the evidence of coverage required under subsection (a) in electronic or paper form. The group contract holder or health maintenance organization shall provide the evidence of coverage in paper form upon the request of the subscriber.
(c) A health maintenance organization shall include in the health maintenance organization's enrollment materials information concerning the manner in which a subscriber may:
(1) obtain an evidence of coverage; and
(2) request the evidence of coverage in paper form.

IC 27-13-7-6
Evidence of coverage; prohibited provisions
Sec. 6. The evidence of coverage required by section 5 of this chapter may not contain provisions or statements:
(1) that are unfair, unjust, inequitable, misleading, or deceptive; or
(2) that encourage misrepresentation prohibited by IC 27-1-15.6-12 or IC 27-4-1-4.

IC 27-13-7-7
Evidence of coverage; required statement
Sec. 7. The evidence of coverage required by section 5 of this chapter must contain a clear statement of the matters set forth in section 3(a) of this chapter.


IC 27-13-7-7.5
Prohibition on coverage of abortion; exceptions; coverage through rider or endorsement

Sec. 7.5. (a) A health maintenance organization that provides coverage for basic health care services and that is entered into, delivered, amended, or renewed after December 31, 2014, under a group contract or an individual contract may not provide coverage for abortion, except in the following cases:

(1) The pregnant woman became pregnant through an act of rape or incest.

(2) An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

(b) A health maintenance organization that enters into a group contract or an individual contract described in subsection (a) may offer coverage for abortion through a rider or an endorsement.

As added by P.L.124-2014, SEC.2.

IC 27-13-7-8
Readability standards

Sec. 8. The commissioner may adopt rules under IC 4-22-2 establishing readability standards for individual contracts and evidence of coverage forms.


IC 27-13-7-9
Approval of forms by commissioner

Sec. 9. Subject to sections 10 and 11 of this chapter:

(1) a group or an individual contract;

(2) an evidence of coverage; or

(3) an amendment to:

(A) a group or an individual contract; or

(B) an evidence of coverage;

may not be delivered or issued for delivery in Indiana unless the form has been filed with and approved by the commissioner.


IC 27-13-7-10
Coverage outside Indiana; commissioner's approval not required

Sec. 10. If:

(1) an evidence of coverage that is issued under and incorporated into a contract issued in Indiana is intended for delivery in another state;

(2) the evidence of coverage has been approved for use in the state in which it is to be delivered; and
(3) the evidence of coverage is not delivered in Indiana;
the evidence of coverage need not be submitted to the commissioner
in Indiana for approval.

IC 27-13-7-11
Filing of form with commissioner; review period; approval;
withdrawal of approval; hearing
Sec. 11. (a) A form required by this chapter must be filed with the
commissioner at least thirty (30) days before the form is:
(1) delivered; or
(2) issued for delivery;
in Indiana.
(b) At any time during the thirty (30) day period referred to in
subsection (a), the commissioner may extend the period for review
for an additional thirty (30) days.
(c) The commissioner must give notice in writing of an extension
of a review period under subsection (b).
(d) If the commissioner does not take action on a form submitted
to the commissioner within the thirty (30) day period and any period
extension, the form is considered approved.
(e) At any time after notice and for cause shown, the
commissioner may withdraw approval of any form, effective thirty
(30) days after notice of the withdrawal of the approval is issued.
(f) When the commissioner:
(1) disapproves a filing; or
(2) withdraws approval of a form;
under this section, the commissioner shall give the health
maintenance organization written notice of the reasons for the
disapproval or withdrawal of approval. The notice must inform the
health maintenance organization that it may, not more than thirty (30)
days after it receives the notice, request a hearing concerning the
disapproval or withdrawal of approval. If the health maintenance
organization requests a hearing not more than thirty (30) days after
it receives the notice, the commissioner shall hold a hearing upon not
less than ten (10) days notice to the health maintenance organization.

IC 27-13-7-12
Additional information required by commissioner
Sec. 12. The commissioner may require the submission of any
information the commissioner considers necessary to determine
whether to approve or disapprove a filing under this chapter.

IC 27-13-7-13
Continuation of coverage statement
Sec. 13. (a) A health maintenance organization must include in
each contract a written statement that if the contract is terminated by
the health maintenance organization, an enrollee who is hospitalized
for a medical or surgical condition on the date of termination will have continuation of coverage for inpatient covered services.

(b) The continuation of coverage referred to in subsection (a) is not required after one (1) of the following occurs:

1. The discharge of the enrollee from the hospital.
2. Sixty (60) days pass after the contract is terminated by the health maintenance organization.
3. The hospitalized enrollee obtains from another carrier coverage that includes the coverage provided by the terminating health maintenance organization.
4. A contract holder terminates the contract with the health maintenance organization, as determined by:
   A. the effective date specified in written communication sent by the contract holder to the health maintenance organization, which effective date shall be at least fifteen (15) days after the date the written communication is placed in the United States mail or sent by facsimile transmission; or
   B. the failure to pay a premium within the grace period permitted under the contract.
5. Termination of an enrollee by a health maintenance organization due to:
   A. the enrollee knowingly providing false information to the health maintenance organization;
   B. the enrollee's failure to comply with the rules of the health maintenance organization stated in the contract; or
   C. the enrollee's failure to pay a premium within the grace period permitted under contract.

(c) In order to satisfy the requirements of subsection (a), a health maintenance organization may provide benefits that exceed the continuation of coverage required by this section, either in the types or time period of health care services covered, or both.

(d) If an enrollee terminates the enrollee's coverage, the health maintenance organization is not required to provide continuation of coverage to that enrollee under this section after the termination.

(e) This section does not apply to a termination of coverage as the result of the receivership of a health maintenance organization.


IC 27-13-7-14

Post-mastectomy coverage

Sec. 14. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.

(b) A contract with a health maintenance organization that provides coverage for a mastectomy must provide coverage as required under 29 U.S.C. 1185b, including coverage for:

1. prosthetic devices; and
2. reconstructive surgery incident to a mastectomy including:
   A. all stages of reconstruction of the breast on which the
mastectomy has been performed; and
(B) surgery and reconstruction of the other breast to produce symmetry;
in the manner determined by the attending physician and the patient to be appropriate.
(c) Coverage required under this section is subject to:
(1) the deductible and coinsurance provisions applicable to a mastectomy; and
(2) all other terms and conditions applicable to other services under the contract.
(d) A health maintenance organization shall provide to an enrollee, at the time that an individual contract or a group contract is entered into and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the health maintenance organization that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.
(e) The coverage required under this section applies to a contract with a health maintenance organization that provides coverage for a mastectomy, regardless of whether an individual who:
(1) underwent a mastectomy; and
(2) is covered under the contract;
was covered under the contract at the time of the mastectomy.
(f) This section does not require a health maintenance organization to provide coverage related to post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.

IC 27-13-7-14.5
Coverage for nonexperimental, surgical treatment of morbid obesity
Sec. 14.5. (a) As used in this section, "health care provider" means a:
(1) physician licensed under IC 25-22.5; or
(2) hospital licensed under IC 16-21;
that provides health care services for surgical treatment of morbid obesity.
(b) As used in this section, "morbid obesity" means:
(1) a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
(2) a body mass index of at least forty (40) kilograms per meter squared without comorbidity.
For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.
(c) Except as provided in subsection (d), a health maintenance organization that provides coverage for basic health care services under a group contract shall offer coverage for nonexperimental, surgical treatment by a health care provider of morbid obesity:
(1) that has persisted for at least five (5) years; and
(2) for which nonsurgical treatment that is supervised by a physician has been unsuccessful for at least six (6) consecutive months.

(d) A health maintenance organization that provides coverage for basic health care services may not provide coverage for surgical treatment of morbid obesity for an enrollee who is less than twenty-one (21) years of age unless two (2) physicians licensed under IC 25-22.5 determine that the surgery is necessary to:
(1) save the life of the enrollee; or
(2) restore the enrollee's ability to maintain a major life activity (as defined in IC 4-23-29-6);
and each physician documents in the enrollee's medical record the reason for the physician's determination.


IC 27-13-7-14.7
Coverage for autism spectrum disorders

Sec. 14.7. (a) As used in this section, "autism spectrum disorder" means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(b) A group contract with a health maintenance organization that provides basic health care services must provide services for the treatment of an autism spectrum disorder of an enrollee. Services provided to an enrollee under this subsection are limited to services that are prescribed by the enrollee's treating physician in accordance with a treatment plan. A health maintenance organization may not deny or refuse to provide services to, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under a group contract to services to an individual solely because the individual is diagnosed with an autism spectrum disorder.

(c) The services required under subsection (b) may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness generally under the contract with the health maintenance organization.

(d) A health maintenance organization that enters into an individual contract that provides basic health care services must offer to provide services for the treatment of an autism spectrum disorder of an enrollee. Services provided to an enrollee under this subsection are limited to services that are prescribed by the enrollee's treating physician in accordance with a treatment plan. A health maintenance organization may not deny or refuse to provide services to, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to services to an individual solely because the individual is diagnosed with an autism spectrum disorder.
The services that must be offered under subsection (d) may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness generally under the contract with the health maintenance organization.


IC 27-13-7-14.8
Treatment limitations or financial requirements on coverage of services for mental illness

Sec. 14.8. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the contract with the health maintenance organization. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a group or individual contract with a health maintenance organization that:

(1) is issued, entered into, or renewed after December 31, 1999; and

(2) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to a legal business entity that has obtained an exemption under IC 27-8-5-15.7.

(d) A group or individual contract with a health maintenance organization may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) A health maintenance organization that enters into an individual contract or a group contract that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual contract with a health maintenance organization to offer mental health benefits.


IC 27-13-7-15
Dental care provisions required

Sec. 15. (a) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(b) As used in this section, "enrollee" means an enrollee who is a child or an individual:
(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and
(2) who:
   (A) has a record of; or
   (B) is regarded as;
   having an impairment described in subdivision (1).
(c) A health maintenance organization that provides basic health care services shall include coverage under the terms and conditions of the benefits contract for anesthesia and hospital charges for an enrollee for dental care if the mental or physical condition of the enrollee requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the enrollee's condition under general anesthesia constitutes appropriate treatment.
(d) A health maintenance organization may:
   (1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and
   (2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.
(e) This section does not apply to treatment rendered for temporal mandibular joint disorders (TMJ).
As added by P.L.189-1999, SEC.3.
IC 27-13-7-15.3
Breast cancer screening mammography
Sec. 15.3. (a) As used in this section, "breast cancer screening mammography" has the meaning set forth in IC 27-8-14-2.
(b) As used in this section, "woman at risk" has the meaning set forth in IC 27-8-14-5.
(c) Except as provided in subsection (g), a health maintenance organization issued a certificate of authority in Indiana shall provide breast cancer screening mammography as a covered service under every group contract that provides coverage for basic health care services.
(d) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section must include the following:
   (1) If the enrollee is at least thirty-five (35) years of age but less than forty (40) years of age and a female, coverage for at least one (1) baseline breast cancer screening mammography performed upon the enrollee before the enrollee becomes forty (40) years of age.
(2) If the enrollee is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed upon the enrollee every year.
(3) If the enrollee is at least forty (40) years of age and a female, one (1) breast cancer screening mammography performed upon the enrollee every year.
(4) Any additional mammography views that are required for proper evaluation.
(5) Ultrasound services, if determined medically necessary by the physician treating the enrollee.

(e) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section may not be subject to a contract provision that is less favorable to an enrollee or a subscriber than contract provisions applying to physical illness generally under the health maintenance organization contract.

(f) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

(g) In the case of coverage that is not employer based, the health maintenance organization must offer to provide the coverage described in subsections (c) through (f).

As added by P.L.170-1999, SEC.5.

IC 27-13-7-16
Prostate specific antigen test
Sec. 16. (a) As used in this section, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

(b) Except as provided in subsection (f), a health maintenance organization issued a certificate of authority in Indiana shall provide prostate specific antigen testing as a covered service under every group contract that provides coverage for basic health care services.

(c) Except as provided in subsection (f), the coverage required under subsection (b) must include the following:

(1) At least one (1) prostate specific antigen test annually for a male enrollee who is at least fifty (50) years of age.
(2) At least one (1) prostate specific antigen test annually for a male enrollee who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

(d) Except as provided in subsection (f), the coverage that a health maintenance organization must provide under this section may not be subject to a contract provision that is less favorable to an enrollee than a contract provision applying to physical illness generally under the health maintenance organization contract.

(e) Except as provided in subsection (f), the coverage that a health maintenance organization must provide under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.
IC 27-13-7-17
Colorectal cancer testing coverage

Sec. 17. (a) As used in this section, "colorectal cancer testing" means examinations and laboratory tests for cancer for any nonsymptomatic enrollee, in accordance with the current American Cancer Society guidelines.

(b) Except as provided in subsection (e), a health maintenance organization issued a certificate of authority in Indiana shall provide colorectal cancer testing as a covered service under every group contract that provides coverage for basic health care services.

(c) For an enrollee who is:
   (1) at least fifty (50) years of age; or
   (2) less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society;
the colorectal cancer testing required under this section must meet the requirements set forth in subsection (d).

(d) An enrollee may not be required to pay a copayment for the colorectal cancer examination and laboratory testing benefit that is greater than a copayment established for similar benefits under a group contract. If the group contract does not cover a similar covered service, the copayment may not be set at a level that materially diminishes the value of the colorectal cancer examination and laboratory testing benefit required under this section.

(e) In the case of coverage that is not employer based, the health maintenance organization is required only to offer to provide the colorectal cancer testing described in subsections (b) through (d) as a covered service under a proposed group contract providing coverage for basic health care services.

IC 27-13-7-18
Inherited metabolic disease coverage

Sec. 18. (a) As used in this section, "inherited metabolic disease" means a disease:

   (1) caused by inborn errors of amino acid, organic acid, or urea cycle metabolism; and
   (2) treatable by the dietary restriction of one (1) or more amino acids.

(b) As used in this section, "medical food" means a formula that is:

   (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
   (2) formulated to be consumed or administered enterally under
the direction of a physician.

(c) A group health maintenance organization contract that provides coverage for basic health care services must provide coverage for medical food that is:

(1) medically necessary; and

(2) prescribed for an enrollee by the enrollee's treating physician for treatment of the enrollee's inherited metabolic disease.

(d) The coverage that must be provided under this section shall not be subject to dollar limits, copayments, or deductibles that are less favorable to an enrollee than the dollar limits, copayments, or deductibles that apply to coverage for:

(1) prescription drugs generally under the group contract, if prescription drugs are covered under the group contract; or

(2) physical illness generally under the group contract, if prescription drugs are not covered under the group contract.

As added by P.L.166-2003, SEC.3.

IC 27-13-7-19

Coverage for orthotic devices and prosthetic devices

Sec. 19. (a) As used in this section, "orthotic device" means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

(b) As used in this section, "prosthetic device" means an artificial leg or arm.

(c) An individual contract or a group contract that provides coverage for basic health care services must provide coverage for orthotic devices and prosthetic devices, including repairs or replacements, that:

(1) are provided or performed by a person that is:

(A) accredited as required under 42 U.S.C. 1395m(a)(20); or

(B) a qualified practitioner (as defined in 42 U.S.C. 1395m(h)(1)(F)(iii));

(2) are determined by the enrollee's physician to be medically necessary to restore or maintain the enrollee's ability to perform activities of daily living or essential job related activities; and

(3) are not solely for comfort or convenience.

(d) The:

(1) coverage required under subsection (c) must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program (42 U.S.C. 1395 et seq.); and

(2) reimbursement under the coverage required under subsection (c) must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

This subsection does not require a deductible under an individual contract or a group contract to be equal to a deductible under the federal Medicare program.

(e) Except as provided in subsections (f) and (g), the coverage
required under subsection (c):
   (1) may be subject to; and
   (2) may not be more restrictive than;
the provisions that apply to other benefits under the individual contract or group contract.
   (f) The coverage required under subsection (c) may be subject to utilization review, including periodic review, of the continued medical necessity of the benefit.
   (g) Any lifetime maximum coverage limitation that applies to prosthetic devices and orthotic devices:
       (1) must not be included in; and
       (2) must be equal to;
the lifetime maximum coverage limitation that applies to all other items and services generally under the individual contract or group contract.
   (h) For purposes of this subsection, "items and services" does not include preventive services for which coverage is provided under a high deductible health plan (as defined in 26 U.S.C. 220(c)(2) or 26 U.S.C. 223(c)(2)). The coverage required under subsection (c) may not be subject to a deductible, copayment, or coinsurance provision that is less favorable to an enrollee than the deductible, copayment, or coinsurance provisions that apply to other items and services generally under the individual contract or group contract.


IC 27-13-7-20
Prohibition on chemotherapy coverage limitations
Sec. 20. (a) This section applies to an individual contract or a group contract that provides coverage for both of the following:
   (1) Orally administered cancer chemotherapy.
   (2) Cancer chemotherapy that is administered intravenously or by injection.
   (b) As used in this section, "cancer chemotherapy" means medication that is prescribed by a physician to kill or slow the growth of cancer cells.
   (c) Coverage for orally administered cancer chemotherapy under an individual contract or a group contract must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for cancer chemotherapy that is administered intravenously or by injection under the individual contract or group contract.


IC 27-13-7-20.2
Coverage for care related to cancer clinical trials
Sec. 20.2. (a) As used in this section, "care method" means the use of a particular drug or device in a particular manner.
   (b) As used in this section, "clinical trial" means a Phase I, II, III, or IV research study:
(1) that is conducted:
   (A) using a particular care method to prevent, diagnose, or treat a cancer for which:
      (i) there is no clearly superior, noninvestigational alternative care method; and
      (ii) available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any noninvestigational alternative care method;
   (B) in a facility where personnel providing the care method to be followed in the research study have:
      (i) received training in providing the care method;
      (ii) expertise in providing the type of care required for the research study; and
      (iii) experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and
   (C) to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and
   (2) that is approved or funded by one (1) of the following:
      (A) A National Institutes of Health institute.
      (B) A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center.
      (C) The federal Food and Drug Administration.
      (D) The United States Department of Veterans Affairs.
      (E) The United States Department of Defense.
      (F) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.
      (G) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(c) As used in this section, "nonparticipating provider" means a health care provider that has not entered into an agreement described in IC 27-13-1-24.

(d) As used in this section, "routine care cost" means the cost of medically necessary services related to the care method that is under evaluation in a clinical trial. The term does not include the following:
   (1) The health care service, item, or investigational drug that is the subject of the clinical trial.
   (2) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
   (3) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
   (4) An investigational drug or device that has not been approved
for market by the federal Food and Drug Administration.
(5) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted.
(6) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
(7) A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.
(e) An individual contract or a group contract must provide coverage for routine care costs that are incurred in the course of a clinical trial if the individual contract or group contract would provide coverage for the same routine care costs not incurred in a clinical trial.
(f) The coverage that must be provided under this section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the individual contract or group contract, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by participating providers and nonparticipating providers.
(g) This section does not do any of the following:
(1) Require a health maintenance organization to provide coverage for clinical trial services rendered by a participating provider.
(2) Prohibit a health maintenance organization from providing coverage for clinical trial services rendered by a participating provider.
(3) Require reimbursement under an individual contract or a group contract for services that are rendered in a clinical trial by a nonparticipating provider at the same rate of reimbursement that would apply to the same services rendered by a participating provider.
(h) This section does not create a cause of action against a person for any harm to an enrollee resulting from a clinical trial.

IC 27-13-7-21
High breast density
Sec. 21. (a) As used in this section, "high breast density" means a condition in which there is a greater amount of breast and connective tissue in comparison to fat in the breast.
(b) An individual contract or a group contract that provides coverage for basic health care services must provide coverage for an appropriate medical screening, test, or examination for a female enrollee who is at least forty (40) years of age and who has been determined to have high breast density.
As added by P.L.126-2013, SEC.5.
IC 27-13-8
Chapter 8. Annual Report

IC 27-13-8-0.1
Application of certain amendments to chapter
Sec. 0.1. The amendments made to section 2 of this chapter by P.L.133-1999 apply to external grievances filed by enrollees after January 1, 2000.
As added by P.L.220-2011, SEC.458.

IC 27-13-8-1
Filing
Sec. 1. On or before March 1 of each year, a health maintenance organization must file with the commissioner a report that covers the preceding calendar year. The report must be:
   (1) made on forms prescribed by the commissioner; and
   (2) verified by at least two (2) principal officers of the health maintenance organization.

IC 27-13-8-1.5
Preparation of annual statement
Sec. 1.5. (a) Each health maintenance organization authorized to conduct business in Indiana and required to file an annual statement with the department under this chapter shall prepare the health maintenance organization's statement:
   (1) on the National Association of Insurance Commissioners (NAIC) Annual Statement Blank;
   (2) in accordance with NAIC Annual Statement Instructions; and
   (3) following practices and procedures prescribed by the most recent NAIC Accounting Practices and Procedures Manual.
   (b) To the extent that the NAIC Annual Statement Instructions require disclosure under subsection (a) of compensation paid to or on behalf of a health maintenance organization's officers, directors, or employees, the information may be filed with the department as an exhibit separate from the annual statement blank. The compensation information described under this subsection shall be maintained by the department as confidential and may not be disclosed to the public under IC 5-14-3.

IC 27-13-8-2
Additional information filed with commissioner
Sec. 2. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:
   (1) Audited financial statements of the health maintenance organization for the preceding calendar year prepared in conformity with statutory accounting practices prescribed or
otherwise permitted by the department.

(2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.

(3) A description of the grievance procedure of the health maintenance organization:
   (A) established under IC 27-13-10, including:
       (i) the total number of grievances handled through the procedure during the preceding calendar year;
       (ii) a compilation of the causes underlying those grievances; and
       (iii) a summary of the final disposition of those grievances;
   and
   (B) established under IC 27-13-10.1, including:
       (i) the total number of external grievances handled through the procedure during the preceding calendar year;
       (ii) a compilation of the causes underlying those grievances; and
       (iii) a summary of the final disposition of those grievances;
        for each independent review organization used by the health maintenance organization during the reporting year.

(4) The percentage of providers credentialed by the health maintenance organization according to the most current standards or guidelines, if any, developed by the National Committee on Quality Assurance or a successor organization.

(5) The RBC report required under IC 27-1-36-25.

(6) The health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data.

(b) The information required by subsection (a)(2) through (a)(5) must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be filed with the commissioner on or before June 1 of each year. The health maintenance organization's HEDIS data required by subsection (a)(6) must be filed with the commissioner on or before July 1 of each year. The commissioner shall:
   (1) make the information required to be filed under this section available to the public; and
   (2) prepare an annual compilation of the data required under subsections (a)(3), (a)(4), and (a)(6) that allows for comparative analysis.

(c) Upon a determination by a health maintenance organization's auditor that the health maintenance organization:
   (1) does not meet the requirements of IC 27-13-12-3; or
   (2) is in the condition described in IC 27-13-24-1(a)(5);
the health maintenance organization shall notify the commissioner within five (5) business days after the auditor's determination.

(d) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

IC 27-13-8-3
Annual statement convention blank; quarterly reports

Sec. 3. (a) This section applies to a domestic health maintenance organization that is authorized to transact business in Indiana.

(b) As used in this section, "NAIC" refers to the National Association of Insurance Commissioners.

(c) On or before March 1 of each year, a health maintenance organization shall file with the National Association of Insurance Commissioners and with the department a copy of the health maintenance organization's annual statement convention blank and additional filings prescribed by the commissioner for the preceding year. A health maintenance organization shall also file quarterly statements with the NAIC and with the department, on or before May 15, August 15, and November 15 of each year, in a form prescribed by the commissioner. The information filed with the NAIC under this subsection:

(1) must be:
   (A) in the same format; and
   (B) of the same scope;

   as is required by the commissioner under section 1 of this chapter;

(2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and

(3) must be filed electronically in accordance with NAIC electronic filing specifications.

The commissioner may, for good cause shown, grant an exemption from the requirement of this section to domestic health maintenance organizations that operate only in Indiana. If a health maintenance organization files any amendment or addendum to the health maintenance organization's annual statement convention blank or quarterly statement with the commissioner, the health maintenance organization shall also file a copy of the amendment or addendum with the NAIC. Annual and quarterly financial statements are considered filed with the NAIC when delivered to the address designated by the NAIC for the filings, regardless of whether the filing is accompanied by any applicable fee.

(d) The commissioner may, for good cause shown, grant a health maintenance organization an extension of time for the filing required by subsection (c).

(e) In the absence of actual malice:

(1) members of the NAIC;
(2) duly authorized committees, subcommittees, and task forces of members of the NAIC;
(3) delegates of members of the NAIC;
(4) employees of the NAIC; and
(5) other persons responsible for collecting, reviewing, analyzing, and disseminating information developed from the
filing of annual statement convention blanks under this section; shall be considered to be acting as agents of the commissioner under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of the collection, review, analysis, or dissemination of the data and information collected from the filings required by this section.

(f) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of a health maintenance organization that fails to file the health maintenance organization's annual statement convention blank or quarterly statements with the NAIC or with the department within the time allowed by subsection (c) or (d).


IC 27-13-8-4
Civil penalties

Sec. 4. (a) The commissioner may impose a civil penalty of five hundred dollars ($500), after notice and hearing under IC 4-21.5-3, on a health maintenance organization that fails to file an annual statement under this chapter.

(b) A domestic health maintenance organization that fails to file an audited annual financial statement under section 2(a)(1) of this chapter before June 1 of each year without obtaining an extension is subject to a civil penalty of fifty dollars ($50) per day until the report is received by the commissioner.

IC 27-13-9
Chapter 9. Information to Enrollees or Subscribers

IC 27-13-9-1
List of providers
Sec. 1. (a) Upon:
(1) the enrollment; and
(2) each reenrollment;
of a subscriber, a health maintenance organization must provide to
the subscriber in electronic or paper form a list of providers who
provide health care services through the health maintenance
organization. The health maintenance organization must also provide
the list of providers in electronic or paper form to a potential enrollee
upon request.
(b) A health maintenance organization shall:
(1) inform a subscriber or potential enrollee that the subscriber
or potential enrollee may request a list described in subsection
(a) in paper form; and
(2) provide the list in paper form upon the request of the
subscriber or potential enrollee.

IC 27-13-9-2
Notice of change in operation of health maintenance organization
Sec. 2. Not more than thirty (30) days after any material change
in the operation of a health maintenance organization that will
directly affect the subscribers or enrollees of the organization, the
health maintenance organization shall provide notice of the change
to the subscribers or enrollees affected by the change.

IC 27-13-9-3
Termination of provider
Sec. 3. (a) A health maintenance organization shall notify an
enrollee in writing of the termination of:
(1) the provider who currently provides primary health care
services to that enrollee;
(2) any other participating provider seen by the enrollee during
the previous year; and
(3) a hospital.
(b) After the termination of the provider who provided primary
health care services to an enrollee, the health maintenance
organization shall assist the enrollee in transferring to another
participating primary care provider.
(c) If a health maintenance organization notifies an enrollee of the
termination of a hospital, the notice must include the names of all
participating providers employed by the hospital.
IC 27-13-9-4
Information on services and filing grievances; telephone number

Sec. 4. A health maintenance organization shall provide to each enrollee and subscriber:

(1) information on:
   (A) how services can be obtained;
   (B) where additional information on access to services can be obtained;
   (C) how to file a grievance under IC 27-13-10 and IC 27-13-10.1;
   (D) the health maintenance organization's:
      (i) structure;
      (ii) health care benefits and exclusions; and
      (iii) criteria for denying coverage; and
   (E) costs for which the enrollee or subscriber is responsible; and

(2) a toll free telephone number through which the enrollee can contact the health maintenance organization at no cost to the enrollee to obtain information and to file grievances.

The information under this section must be provided to a potential enrollee of the health maintenance organization upon request.


IC 27-13-9-5
Prescription drug information card

Sec. 5. (a) This section applies to a health maintenance organization that provides coverage for prescription drugs or devices and issues a card or other technology for claims processing.

(b) The card or other technology issued by a health maintenance organization must contain uniform prescription drug information that complies with the requirements established under subsection (c).

(c) Prescription drug information cards or other technology must meet either of the following criteria:

(1) Be in a format and contain information fields approved by the National Council for Prescription Drug Programs (NCPDP) as contained in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect on the October 1 most immediately preceding the issuance of the card.

(2) Contain the following information:
   (A) The health benefit plan's name.
   (B) The enrollee's name, group number, and identification number.
   (C) A telephone number to inquire about pharmacy related issues.
   (D) The issuer's international identification number or ANSI BIN number, labeled as RxBIN.
   (E) The processor control number, labeled as RxPCN.
   (F) The insured's pharmacy benefits group number if
different than medical group number, labeled as RxGRP. Only those fields listed in clauses (A) through (F) that are required for proper adjudication of the claim must appear on the card. If the card is used to adjudicate non-pharmacy claims, then the designation "Rx" listed in clauses (D) through (F) is not required to be used by the issuer.

(d) A health maintenance organization may not be required to issue a prescription drug information card or other technology to a person more than one (1) time during a twelve (12) month period.

(e) The prescription drug information cards or other technology issued under this section may be used for health care service coverage other than the coverage to which this chapter applies.

IC 27-13-10
Chapter 10. Grievance Procedures

IC 27-13-10-1
Establishment of procedures
Sec. 1. A health maintenance organization or limited service health maintenance organization shall establish and maintain a grievance procedure for the resolution of grievances initiated by enrollees and subscribers of the organization. The grievance procedure of a health maintenance organization or limited service health maintenance organization must be approved by the commissioner.


IC 27-13-10-2
Examination by commissioner
Sec. 2. The commissioner may examine the grievance procedures of health maintenance organizations and limited service health maintenance organizations.


IC 27-13-10-3
Records of grievances
Sec. 3. A health maintenance organization or limited service health maintenance organization shall maintain records regarding all grievances of enrollees that the organization has received since the examination by the commissioner of the grievance procedure of the organization that immediately preceded the receipt of the grievances.


IC 27-13-10-4
Notice of grievance procedure
Sec. 4. (a) A health maintenance organization shall provide timely, adequate, and appropriate notice to each enrollee or subscriber of the grievance procedure under this chapter and IC 27-13-10.1.

(b) A health maintenance organization shall prominently display on all notices to enrollees and subscribers the telephone number and address at which a grievance may be filed.

(c) A written description of the enrollee's or subscriber's right to file a grievance must be posted by the provider in a conspicuous public location in each facility that offers services on behalf of a health maintenance organization.


IC 27-13-10-5
Filing; oral or written grievance; telephone number; date
Sec. 5. (a) An enrollee or a subscriber may file a grievance orally
or in writing.

(b) A health maintenance organization shall make available to enrollees and subscribers a toll free telephone number through which grievances may be filed. The toll free number must:
   (1) be staffed by a qualified representative of the health maintenance organization;
   (2) be available for at least forty (40) normal business hours per week; and
   (3) accept grievances in the languages of the major population groups served.

(c) A grievance is considered to be filed on the first date it is received, either by telephone or in writing.


IC 27-13-10-6
Filing; procedures; representative

Sec. 6. (a) A health maintenance organization shall establish procedures to assist enrollees and subscribers in filing grievances.

(b) An enrollee or subscriber may designate a representative to file a grievance for the enrollee or subscriber and to represent the enrollee or subscriber in a grievance under this chapter.


IC 27-13-10-7
Resolution of grievances

Sec. 7. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:

   (1) An acknowledgment of the grievance, orally or in writing, to the enrollee or subscriber within three (3) business days.
   (2) Documentation of the substance of the grievance and any actions taken.
   (3) An investigation of the substance of the grievance, including any aspects involving clinical care.
   (4) Notification to the enrollee or subscriber of the disposition of the grievance and the right to appeal.
   (5) Standards for timeliness in responding to complaints and providing notice to enrollees and subscribers of the disposition of the complaint and the right to appeal that accommodate the clinical urgency of the situation.

(b) The health maintenance organization shall appoint at least one (1) individual to resolve the complaint.

(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the grievance is filed.

If a health maintenance organization is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the health maintenance organization's control, the health maintenance organization shall:

   (1) notify the enrollee or subscriber in writing of the reason for
the delay before the twentieth business day; and
(2) issue a written decision regarding the complaint within an additional ten (10) business days.
(d) A health maintenance organization shall notify the enrollee or subscriber in writing of the resolution of the grievance within five (5) business days after completing the investigation. The grievance resolution notice must contain the following:
(1) The decision reached by the health maintenance organization.
(2) The reasons, policies, and procedures that are the basis of the decision.
(3) Notice of the enrollee's or subscriber's right to appeal the decision.
(4) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to appeal.


IC 27-13-10-8
Appeals of grievance decisions; filing of report for violation
Sec. 8. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:
(1) Acknowledgment of the appeal, orally or in writing, within three (3) business days after receipt of the appeal being filed.
(2) Documentation of the substance of the appeal and the actions taken.
(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.
(4) Notification to enrollees or subscribers of the disposition of the appeal and that the enrollee or subscriber may have the right to further remedies allowed by law.
(5) Standards for timeliness in responding to appeals and providing notice to enrollees or subscribers of the disposition of the appeal and the right to initiate an external appeals process that accommodate the clinical urgency of the situation.
(b) The health maintenance organization shall appoint a panel of qualified individuals to resolve an appeal. An individual may not be appointed to the panel who has been involved in the matter giving rise to the complaint or in the initial investigation of the complaint. Except for grievances that have previously been appealed under IC 27-8-17, in the case of an appeal from the proposal, refusal, or delivery of a health care procedure, treatment, or service, the health maintenance organization shall appoint one (1) or more individuals to the panel to resolve the appeal. The panel must include one (1) or more individuals who:
(1) have knowledge in the medical condition, procedure, or
treatment at issue;
(2) are in the same licensed profession as the provider who
proposed, refused, or delivered the health care procedure,
treatment, or service;
(3) are not involved in the matter giving rise to the appeal or the
previous grievance process; and
(4) do not have a direct business relationship with the enrollee
or the health care provider who previously recommended the
health care procedure, treatment, or service giving rise to the
grievance.

(c) An appeal of a grievance decision must be resolved as
expeditiously as possible and with regard to the clinical urgency of
the appeal. However, an appeal must be resolved not later than
forty-five (45) days after the appeal is filed. A health maintenance
organization that violates this subsection commits an unfair and
deceptive act or practice in the business of insurance under
IC 27-4-1-4.

(d) If a health maintenance organization violates subsection (c),
the health maintenance organization shall file a report with the
department during the quarter in which the violation occurred
concerning the insurer's compliance with subsection (c). The report
must include the following:
(1) The number of appealed grievance decisions that were not
resolved as required under subsection (c).
(2) The reason each appeal described in subdivision (1) was not
resolved.
(e) A health maintenance organization shall allow enrollees and
subscribers the opportunity to appear in person at the panel or to
communicate with the panel through appropriate other means if the
enrollee or subscriber is unable to appear in person.

(f) A health maintenance organization shall notify the enrollee or
subscriber in writing of the resolution of the appeal of a grievance
within five (5) business days after completing the investigation. The
grievance resolution notice must contain the following:
(1) The decision reached by the health maintenance
organization.
(2) The reasons, policies, or procedures that are the basis of the
decision.
(3) Notice of the enrollee's or subscriber's right to further
remedies allowed by law, including the right to review by an
independent review organization under IC 27-13-10.1.
(4) The department, address, and telephone number through
which an enrollee may contact a qualified representative to
obtain more information about the decision or the right to an
appeal.

As added by P.L.191-1997, SEC.10. Amended by P.L.133-1999,
SEC.6; P.L.178-2003, SEC.85.

IC 27-13-10-11
Action against provider representing enrollee or subscriber
Sec. 11. A health maintenance organization may not take action against a provider solely on the basis that the provider represents an enrollee or subscriber in a grievance filed under this chapter.

IC 27-13-10-12
Approval of grievance and appeals procedures
Sec. 12. (a) Notwithstanding IC 27-13, the department shall approve the grievance and appeals procedures of a health maintenance organization if:
(1) the health maintenance organization certifies in writing to the department of the health maintenance organization's compliance with grievance and appeals procedures established by the federal Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services; and
(2) the department certifies that the grievance and appeals procedures established by the federal Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services are substantially similar to the grievance and appeals process in IC 27-13.
(b) Subsection (a) does not:
(1) limit the authority of the department;
(2) limit the responsibility of a health maintenance organization;
(3) release a health maintenance organization from the prohibitions established under section 11 of this chapter; or
(4) require a health maintenance organization to use a grievance and appeals procedure established by the federal Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

IC 27-13-10-13
Adoption of rules
Sec. 13. The department may adopt rules under IC 4-22-2 to implement this chapter.
IC 27-13-10.1
Chapter 10.1. External Review of Grievances

IC 27-13-10.1-0.1
Application of chapter
Sec. 0.1. The addition of this chapter by P.L.133-1999 applies to grievances filed under IC 27-13-10-5 after January 1, 2000.
As added by P.L.220-2011, SEC.459.

IC 27-13-10.1-1
External grievance procedure established
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).
   (B) An adverse determination of medical necessity.
   (C) A determination that a proposed service is experimental or investigational.
(2) The health maintenance organization's decision to rescind an individual contract or a group contract.

IC 27-13-10.1-2
Requirements of procedure
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 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 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 health maintenance organization.


IC 27-13-10.1-3
Cooperation with review organization; requirements of enrollee
Sec. 3. (a) An enrollee who files an appeal under this chapter shall:

1) not be subject to retaliation for exercising the enrollee's right to an appeal under this chapter;

2) be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the review process;

3) be permitted to submit additional information relating to the proposed service throughout the review process; and

4) cooperate with the independent review organization by:

(A) providing any requested medical information; or
(B) authorizing the release of necessary medical information.

(b) A health maintenance organization shall cooperate with an independent review organization selected under section 2 of this chapter by promptly providing any information requested by the independent review organization.


IC 27-13-10.1-4
Requirements of independent review organization
Sec. 4. (a) An independent review organization shall:
(1) for an expedited appeal filed under section 2(a)(2)(A) of this chapter, within seventy-two (72) hours after the appeal is filed; or
(2) for a standard appeal filed under section 2(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed;
make a determination to uphold or reverse the health maintenance organization's grievance resolution under IC 27-13-10-8 based on information gathered from the enrollee or the enrollee's designee, the health maintenance organization, and the treating physician, and any additional information that the independent review organization considers necessary and appropriate.
(b) When making the determination under this section, the independent review organization shall apply:
(1) standards of decision making that are based on objective clinical evidence; and
(2) the terms of the enrollee's benefit contract.
(c) The independent review organization shall notify the health maintenance organization and the enrollee of the determination made under this section:
(1) for an expedited appeal filed under section 2(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; or
(2) for a standard appeal filed under section 2(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.


IC 27-13-10.1-4.5
Information from independent review organization
Sec. 4.5. Upon the request of an enrollee who is notified under section 4(c) of this chapter that the independent review organization has made a determination, the independent review organization shall provide to the enrollee all information reasonably necessary to enable the enrollee to understand the:
(1) effect of the determination on the enrollee; and
(2) manner in which the health maintenance organization may be expected to respond to the determination.

As added by P.L.173-2007, SEC.43.
IC 27-13-10.1-5
Determination binding on health maintenance organization
Sec. 5. A determination made under section 4 of this chapter is binding on the health maintenance organization.
*As added by P.L.133-1999, SEC.7.*

IC 27-13-10.1-6
Reconsideration of resolution
Sec. 6. (a) If at any time during an external review performed under this chapter, the enrollee submits information to the health maintenance organization that is relevant to the health maintenance organization's resolution under IC 27-13-10-8 and was not considered by the health maintenance organization under IC 27-13-10:
   (1) the health maintenance organization shall reconsider the health maintenance organization's resolution under IC 27-13-10-8; and
   (2) the independent review organization shall cease the external review process until the reconsideration under subsection (b) is completed.
(b) A health maintenance organization to which information is submitted under subsection (a) shall reconsider the resolution under IC 27-13-10-8 based on the information and notify the enrollee of the health maintenance organization's decision:
   (1) within seventy-two (72) hours after the information is submitted for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:
      (A) life or health; or
      (B) ability to reach and maintain maximum function; or
   (2) within fifteen (15) days after the information is submitted for a reconsideration not described in subdivision (1).
(c) If the decision reached under subsection (b) is adverse to the enrollee, the enrollee may request that the independent review organization resume the external review under this chapter.
*As added by P.L.133-1999, SEC.7.*

IC 27-13-10.1-7
Terms of coverage unchanged
Sec. 7. This chapter does not add to or otherwise change the terms of coverage included in a contract under which an enrollee receives health care benefits under IC 27-13.
*As added by P.L.133-1999, SEC.7.*

IC 27-13-10.1-8
Certification of independent review organizations
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.
   (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.

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.

(c) 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.


IC 27-13-10.1-9
Confidentiality
Sec. 9. Except as provided in section 8(g) of this chapter, documents and other information created or received by the independent review organization or the medical review professional in connection with an external review under this chapter:

(1) are not public records;
(2) may not be disclosed under IC 5-14-3; and
(3) must be treated in accordance with confidentiality requirements of state and federal law.


IC 27-13-10.1-10
Immunity from civil liability
Sec. 10. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.

(b) The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy any party's burden of proof or persuasion concerning any material issue of fact or law.


IC 27-13-10.1-11
Medicare review
Sec. 11. If an enrollee has the right to an external review under Medicare (42 U.S.C. 1395 et seq.) the enrollee may not request an external review under this chapter.

Adoption of rules

Sec. 12. The department may adopt rules under IC 4-22-2 to implement this chapter.

IC 27-13-11  
Chapter 11. Investments

IC 27-13-11-1  
Permitted investments

  Sec. 1. Except for investments under IC 27-13-4-1(a)(1), the funds of a health maintenance organization or limited service health maintenance organization may be invested only as follows:

  (1) The funds of a health maintenance organization or limited service health maintenance organization that is domiciled in Indiana may be invested only in the types of securities and other investments in which investment is authorized under IC 27-1-13-3.

  (2) The funds of a foreign corporation (as defined in IC 27-1-2-3) that obtains a certificate of authority to operate a health maintenance organization under IC 27-13-2-3 or a limited service health maintenance organization under IC 27-13-34-9 may be invested only in the types of securities and other investments in which investment is authorized:

      (A) under the law of the state in which the foreign corporation is domiciled, if that law is acceptable to the commissioner; or
      (B) under IC 27-1-13-3, if the law of the state in which the foreign corporation is domiciled is silent or if the law of that state is not acceptable to the commissioner.

IC 27-13-12
Chapter 12. Protection Against Insolvency; Net Worth Requirements

IC 27-13-12-1
"Net worth" defined; computation
Sec. 1. (a) As used in this chapter, "net worth" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the commissioner.
(b) For the purposes of computing net worth, the total assets must be reduced by the value assigned to the following intangible assets:
   (1) Goodwill.
   (2) Going concern value.
   (3) Organizational expense.
   (4) Start-up costs.
   (5) Long term prepayments of deferred charges.
   (6) Nonreturnable deposits.
   (7) Obligations of officers, directors, owners, or affiliates, except short term obligations of affiliates for goods or services that:
       (A) arise in the normal course of business;
       (B) are payable on the same terms as equivalent transactions with nonaffiliates; and
       (C) are not past due.
(c) For purposes of computing net worth, the health maintenance organization may include in its assets the value assigned to the following:
   (1) Medical equipment that:
       (A) is owned by the health maintenance organization and is not subject to any lien, claim, or encumbrance;
       (B) is used in the treatment, diagnosis, or care of enrollees of the health maintenance organization;
       (C) has an initial cost of at least three thousand dollars ($3,000) for each piece of equipment; and
       (D) has a useful life of at least two (2) years.
   (2) Data processing equipment that is:
       (A) owned by the health maintenance organization and is not subject to any lien, claim, or encumbrance; and
       (B) used in the operation of the health maintenance organization.
(d) The value assigned to the assets described in subsection (c) must equal the lesser of:
   (1) the fair market value; or
   (2) the cost of the equipment, minus its accumulated depreciation, calculated in accordance with generally accepted accounting principles.
(e) The aggregate value of the medical equipment described in subsection (c)(1) may not exceed thirty percent (30%) of the total assets permitted to be included in the computation of net worth.
SEC. 6.

IC 27-13-12-2
Initial minimum net worth

Sec. 2. Before issuing a certificate of authority to a health maintenance organization, the commissioner shall require that the health maintenance organization:

1. have an initial net worth of at least one million five hundred thousand dollars ($1,500,000); and
2. maintain, after issuance of the certificate, at least the minimum net worth required under section 3 of this chapter.


IC 27-13-12-3
Maintenance of minimum net worth

Sec. 3. Except as provided in sections 4 and 5 of this chapter, a health maintenance organization shall maintain a minimum net worth equal to the greater of:

1. one million dollars ($1,000,000);
2. based on annual premium revenues as reported on the most recent annual financial statement filed with the commissioner, the total of two percent (2%) of annual premium revenues on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);
3. an amount equal to the sum of three (3) months of uncovered health care expenditures, as reported on the most recent financial statement of the health maintenance organization filed with the commissioner under IC 27-13-8-2(a)(1); or
4. an amount equal to the sum of:
   A. eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and
   B. four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.


IC 27-13-12-4
Net worth schedule

Sec. 4. A health maintenance organization licensed before July 1, 1994, must maintain a net worth equal to the following:

1. Twenty-five percent (25%) of the amount required under section 3 of this chapter by December 31, 1994.
2. Fifty percent (50%) of the amount required under section 3 of this chapter by December 31, 1995.
3. Seventy-five percent (75%) of the amount required under section 3 of this chapter by December 31, 1996.
(4) One hundred percent (100%) of the amount required under section 3 of this chapter by December 31, 1997.


IC 27-13-12-5
Consideration of debts
Sec. 5. (a) In determining net worth under this chapter, a debt may not be considered fully subordinated unless:

(1) the subordination clause is in a form acceptable to the commissioner; and

(2) any interest obligation relating to the repayment of the subordinated debt is subordinated under a clause that is in a form acceptable to the commissioner.

(b) The interest expense relating to the repayment of any fully subordinated debt is considered a covered expense.

(c) Any debt that:

(1) is incurred through a note that meets the requirements of this chapter; and

(2) is otherwise acceptable to the commissioner;

may not be considered liability and must be recorded as equity.


IC 27-13-12-6
Adoption of rules
Sec. 6. The commissioner may adopt rules to further define whether and to what extent the assets of a health maintenance organization may be considered admitted assets for purposes of complying with the requirements of this chapter.

IC 27-13-13
Chapter 13. Protection Against Insolvency; Deposit Requirements

IC 27-13-13-1
Items deposited; minimum value
Sec. 1. Except as provided in this chapter, a health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any bank or bank and trust company or other trustee acceptable to the commissioner through which a custodial or controlled account is used:
(1) cash;
(2) certificates of deposit;
(3) United States government obligations acceptable to the commissioner;
(4) any other securities acceptable to the commissioner; or
(5) a combination of items described in subdivisions (1) through (4);
which at all times must have a value of at least five hundred thousand dollars ($500,000).

IC 27-13-13-2
Deposit schedule
Sec. 2. A health maintenance organization that is in operation on July 1, 1994, shall make:
(1) a deposit with the commissioner equal to two hundred fifty thousand dollars ($250,000) on July 1, 1994; and
(2) an additional deposit with the commissioner equal to two hundred fifty thousand dollars ($250,000) by December 31, 1995.

IC 27-13-13-3
Deposits considered admitted asset
Sec. 3. Deposits made under this chapter shall be considered an admitted asset of the health maintenance organization in the determination of the net worth of the organization.

IC 27-13-13-4
Income from deposits; replacing deposits
Sec. 4. (a) All income from deposits made under this chapter is an asset of the organization that made the deposits.
(b) A health maintenance organization that has made a deposit under this chapter may replace the deposit or any part of the deposit with an equal amount and value of:
(1) cash;
(2) certificates of deposit;
(3) United States government obligations acceptable to the
commissioner;
(4) any other securities acceptable to the commissioner; or
(5) any combination of subdivisions (1) through (4).
(c) Any obligations of the United States government must be approved by the commissioner before being deposited or substituted under this chapter.

IC 27-13-13-5
Use of deposit
Sec. 5. (a) A deposit made by a health maintenance organization under this chapter must be used:
(1) to protect the interest of the enrollees of the health maintenance organization; and
(2) to ensure continuation of health care services to enrollees of the health maintenance organization, if the health maintenance organization is in supervision, rehabilitation, or liquidation.
(b) The commissioner may use the deposit for administrative costs that are attributable to a receivership of the health maintenance organization.
(c) If the health maintenance organization is placed in receivership, the deposit made by the organization must be treated as an asset of the organization subject to IC 27-9.

IC 27-13-13-6
Reduction or elimination of deposit requirements for foreign corporations
Sec. 6. The commissioner may reduce or eliminate the requirement of a deposit under this chapter for a health maintenance organization that is a foreign corporation as defined in IC 27-1-2-3 if:
(1) the organization makes a deposit that meets the requirements of section 1 of this chapter with the treasurer of state, insurance commissioner, or other official body of the state or jurisdiction in which the organization is domiciled for the protection of all subscribers and enrollees of the health maintenance organization; and
(2) the organization delivers to the commissioner a certificate, duly authenticated by the appropriate state official holding the deposit, that the requirements of this section have been met.

IC 27-13-13-7
Return of deposit
Sec. 7. If:
(1) a health maintenance organization ceases operation for reasons other than:
(A) insolvency; or
(B) receivership;
(2) the organization is not a debtor in any pending bankruptcy proceeding;
(3) the health maintenance organization submits a request in writing to the commissioner for the return of the deposit made by the organization; and
(4) the health maintenance organization has furnished the commissioner with written proof that all claims liabilities of the health maintenance organization have been paid;
the commissioner shall return all or a part of the deposit to the health maintenance organization not more than thirty (30) days after the commissioner receives written proof from the organization under subdivision (4).

IC 27-13-13-8
Additional financial requirements
Sec. 8. (a) In addition to meeting all other financial requirements imposed by IC 27-13-12 and this chapter, a health maintenance organization that offers a point of service product shall maintain either of the following:
(1) A reinsurance agreement, which must be satisfactory to the commissioner, that cedes one hundred percent (100%) of the liability for out-of-plan services.
(2) A ratio of the revenues of the health maintenance organization from the point of service product to the net worth of the organization of not more than three (3) to one (1).
(b) The reinsurance to which subsection (a)(1) refers may be used to:
(1) directly make payments for out-of-plan services; or
(2) reinsure coverage for out-of-plan services.
(c) To achieve the ratio referred to in subsection (a)(2), a health maintenance organization may use reinsurance to cede part or all of the liability for out-of-plan services.

IC 27-13-13-9
Deposit of cash or securities for noncovered health care expenditures
Sec. 9. (a) As used in this section, "noncovered health care expenditures" means the costs to a health maintenance organization for health care services:
(1) that are the obligation of the health maintenance organization;
(2) for which the enrollee may be liable in the event of the health maintenance organization's insolvency; and
(3) for which:
(A) no alternative arrangements have been made that are acceptable to the commissioner; or
(B) statutory deposits and net worth of the health maintenance organization are determined by the
commissioner to be inadequate.

(b) If noncovered health care expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall deposit cash or securities that are acceptable to the commissioner with:

(1) the commissioner; or

(2) an organization or trustee approved by the commissioner through which a custodial or controlled account is maintained.

(c) The deposit made under subsection (b) must have a fair market value:

(1) calculated on the first day of each month; and

(2) maintained for the remainder of the month;

of not less than one hundred twenty percent (120%) of the health maintenance organization's outstanding liability for noncovered health care expenditures for enrollees in Indiana, including incurred but not reported claims.

(d) The commissioner may require a health maintenance organization to file periodic reports, including reports on liability for noncovered health care expenditures and audit opinions, that the commissioner considers necessary to monitor compliance with this section.

IC 27-13-14  
Chapter 14. Protection Against Insolvency; Liabilities

IC 27-13-14-1  
Determination of liabilities

Sec. 1. When determining its liabilities, a health maintenance organization shall include an amount estimated in the aggregate to provide:

(1) for any unearned premium;
(2) for the payment of all claims for health care expenditures, whether reported or unreported:
   (A) that have been incurred;
   (B) that are unpaid; and
   (C) for which the organization is or may be liable; and
(3) for the expense of adjustment or settlement of claims described in subdivision (2).


IC 27-13-14-2  
Computation of liabilities

Sec. 2. The liabilities of a health maintenance organization must be computed:

(1) in accordance with rules adopted by the commissioner; and
(2) upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

IC 27-13-15
Chapter 15. Participating Providers; Contracts and Legal Actions

IC 27-13-15-0.1
Application of certain amendments to chapter
Sec. 0.1. The addition of section 4 of this chapter by P.L.74-2007 applies to a contract between a health maintenance organization and a participating provider that is entered into, amended, or renewed on or after April 26, 2007.
As added by P.L.220-2011, SEC.460.

IC 27-13-15-1
Contract requirements; enrollee coverage; payment of provider; application
Sec. 1. (a) A contract between a health maintenance organization and a participating provider of health care services:
   (1) must be in writing;
   (2) may not prohibit the participating provider from disclosing:
       (A) the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider; or
       (B) all treatment options available to an insured, including those not covered by the insured's policy;
   (3) may not provide for a financial or other penalty to a provider for making a disclosure permitted under subdivision (2); and
   (4) must provide that in the event the health maintenance organization fails to pay for health care services as specified by the contract, the subscriber or enrollee is not liable to the participating provider for any sums owed by the health maintenance organization.

   (b) An enrollee is not entitled to coverage of a health care service under a group or an individual contract unless that health care service is included in the enrollee's contract.

   (c) A provider is not entitled to payment under a contract for health care services provided to an enrollee unless the provider has a contract or an agreement with the carrier.

   (d) This section applies to a contract entered, renewed, or modified after June 30, 1996.

IC 27-13-15-2
Contract requirements not met; collection of money owed by health maintenance organization prohibited
Sec. 2. If:
   (1) the contract between a health maintenance organization and a participating provider has not been reduced to writing as required by this chapter; or
   (2) the contract fails to contain the provision required by section
1(a)(4) of this chapter;
the participating provider may not collect or attempt to collect from
the subscriber or enrollee any sums that are owed by the health
maintenance organization.

SEC.25.

IC 27-13-15-3
Actions against subscribers; costs and attorney's fees

Sec. 3. (a) A:
(1) participating provider; or
(2) trustee, an agent, a representative, or an assignee of a
participating provider;
may not bring or maintain any legal action against a subscriber or an
enrollee of a health maintenance organization to collect sums owed
by the health maintenance organization.

(b) Except as provided in subsection (c), if a participating provider
of a health maintenance organization brings or maintains a legal
action against a subscriber or enrollee for an amount owed to the
participating provider by the health maintenance organization, the
participating provider is liable to the subscriber or enrollee for costs
and attorney's fees incurred by the subscriber or enrollee in defending
the legal action.

(c) A participating provider shall not be liable to the subscriber or
enrollee for costs and attorney's fees described in subsection (b) if the
participating provider can demonstrate a reasonable basis for
believing at the time the legal action was brought and while the legal
action was maintained that the health maintenance organization did
not owe the sums the participating provider sought to collect from the
subscriber or enrollee.

SEC.26.

IC 27-13-15-4
Participating provider agreement prohibitions

Sec. 4. (a) As used in this section, "health maintenance
organization" includes the following:
(1) A limited service health maintenance organization.
(2) A person that pays or administers claims on behalf of a
health maintenance organization or a limited service health
maintenance organization.

(b) An agreement between a health maintenance organization and
a participating provider under this chapter may not contain a
provision that:
(1) prohibits, or grants the health maintenance organization an
option to prohibit, the participating provider from contracting
with another health maintenance organization to accept lower
payment for health care services than the payment specified in
the agreement;
(2) requires, or grants the health maintenance organization an
option to require, the participating provider to accept a lower payment from the health maintenance organization if the participating provider agrees with another health maintenance organization to accept lower payment for health care services; (3) requires, or grants the health maintenance organization an option of, termination or renegotiation of the agreement if the participating provider agrees with another health maintenance organization to accept lower payment for health care services; or (4) requires the participating provider to disclose the participating provider's reimbursement rates under contracts with other health maintenance organizations.

(c) A contract provision that violates this section is void.

As added by P.L.74-2007, SEC.2.

IC 27-13-15-5
Coverage for dialysis treatment

Sec. 5. (a) Notwithstanding IC 27-13-1-12, as used in this section, "enrollee" refers only to an enrollee who requires dialysis treatment.

(b) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) An agent of a health maintenance organization or a limited service health maintenance organization.

(c) A health maintenance organization shall not require an enrollee, as a condition of coverage or reimbursement, to:

(1) if the nearest dialysis facility is located within thirty (30) miles of the enrollee's home, travel more than thirty (30) miles from the enrollee's home to obtain dialysis treatment; or

(2) if the nearest dialysis facility is located more than thirty (30) miles from the enrollee's home, travel a greater distance than the distance to the nearest dialysis facility to obtain dialysis treatment;

regardless of whether the enrollee chooses to receive dialysis treatment at a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

IC 27-13-16
Chapter 16. Protection Against Receivership; Continuation of Benefits

IC 27-13-16-1
Plan for receivership
Sec. 1. The commissioner shall require a health maintenance organization to have a plan for handling receivership that allows for the continuation of benefits after the date of receivership:
   (1) for the duration of the contract period for which premiums have been paid; or
   (2) if an enrollee is hospitalized on the date of receivership for the longer of:
       (A) the period ending when the enrollee is discharged from hospitalization; or
       (B) the duration of the contract period for which premiums have been paid.

IC 27-13-16-2
Requirements of commissioner to ensure continuation of benefits
Sec. 2. (a) In considering the plan prepared by a health maintenance organization under section 1 of this chapter, the commissioner may require one (1) or more of the following:
   (1) Insurance to cover the expenses to be paid for continued benefits after receivership.
   (2) Receivership reserves.
   (3) Any other arrangements to ensure that benefits are continued as required by section 1 of this chapter.
   (b) However, the commissioner may not require provisions in contracts between the health maintenance organization and participating providers that obligate a provider to provide services after the organization enters receivership.

IC 27-13-16-3
Termination of continuation of benefits
Sec. 3. The continuation of benefits required under section 1 of this chapter shall terminate on the date that an enrollee obtains coverage under IC 27-13-18.

IC 27-13-16-4
Eligibility for Indiana comprehensive health insurance policy
Sec. 4. If an enrollee is hospitalized continuously from the date of receivership through the last date of the enrollee's continuation of benefits under section 1 of this chapter, the enrollee shall be eligible for an Indiana comprehensive health insurance policy under IC 27-8-10. Notwithstanding any provision of IC 27-8-10, the policy may not contain preexisting condition exclusions with respect to the
condition for which the enrollee was hospitalized. The enrollee shall become eligible for coverage effective on the first day after the enrollee's continuation of benefits ends.


IC 27-13-16-5
Rules for governing plan
Sec. 5. The commissioner may adopt rules governing a health maintenance organization's plan for covering all outstanding claims during the first sixty (60) days that the health maintenance organization enters receivership. These rules may govern at least the following:

(1) Letters of guarantee from a parent company.
(2) Conversion policies.
(3) Insolvency insurance policies.
(4) Additional deposits.

IC 27-13-17
Chapter 17. Protection Against Insolvency; Notice of Termination

IC 27-13-17-1
Notice requirements before termination of agreement by provider
Sec. 1. An agreement between a provider and a health maintenance organization under which the provider agrees to provide health care services must require the provider to give the organization at least sixty (60) days advance notice before terminating the agreement unless the provider or the group of providers provide thirty percent (30%) or more of the health maintenance organization services, in which case the provider must give at least one hundred twenty (120) days advance notice.
IC 27-13-18
Chapter 18. Enrollment Period in Event of Receivership

IC 27-13-18-1
Offer of coverage required; allocation of contracts

Sec. 1. (a) In the event of receivership of a health maintenance organization, the commissioner may order all other carriers that participated in the enrollment process of the group covered by the organization in receivership at the last regular enrollment period of the group to offer the enrollees of the organization in receivership an enrollment period of thirty (30) days beginning on the date of receivership.

(b) Each carrier referred to in subsection (a) shall offer the enrollees of the health maintenance organization in receivership:

(1) the same coverage;
(2) under the same terms; and
(3) at the same rates;
as the carrier had offered at the last regular enrollment period of the group. The coverage required under this chapter shall begin on the date of receivership and end on the date the contract period would have ended had the health maintenance organization not gone into receivership.

(c) If there is no carrier referred to in subsection (a), or the commissioner determines that there is no carrier referred to in subsection (a) that has adequate or accessible resources, the commissioner shall equitably allocate the:

(1) group contracts of the health maintenance organization in receivership; and
(2) individual contracts of the health maintenance organization in receivership belonging to enrollees who are unable to obtain other coverage;
among all health maintenance organizations operating within a portion of the service area of the health maintenance organization in receivership. The commissioner shall not allocate individual contracts to a health maintenance organization that does not offer direct individual enrollment.

(d) A health maintenance organization to which the commissioner allocates a group contract under subsection (c)(1) shall offer to the group existing coverage that is most similar to the group's coverage with the health maintenance organization in receivership, at rates consistent with the successor health maintenance organization's existing rating methodology.

(e) A health maintenance organization to which the commissioner allocates individual contracts under subsection (c)(2) shall offer to the enrollee existing individual or conversion coverage that is most similar to the enrollee's coverage with the health maintenance organization in receivership, at rates consistent with the successor health maintenance organization's existing rating methodology.

IC 27-13-18-2
Failing to provide for continuation of benefits; assessments of health maintenance organizations; tax credits or premium adjustments

Sec. 2. (a) If for any reason the plan of the health maintenance organization under IC 27-13-16 does not provide for continuation of benefits as required by IC 27-13-16-1, the liquidator shall assess, or cause to be assessed, each licensed health maintenance organization doing business in Indiana. The amount that each licensed health maintenance organization is assessed must be based on the ratio of the amount of all subscriber premiums received by the health maintenance organization for contracts issued in Indiana for the previous calendar year to the amount of the total subscriber premiums received by all licensed health maintenance organizations for contracts issued in Indiana for the previous calendar year.

(b) The total assessments of health maintenance organizations under subsection (a) must equal an amount sufficient to provide for continuation of benefits as required by IC 27-13-16-1 to enrollees covered under contracts issued by the health maintenance organization to subscribers located in Indiana, and to pay administrative expenses.

(c) The total amount of all assessments to be paid by a health maintenance organization in any one (1) calendar year may not exceed one percent (1%) of the premiums received by the health maintenance organization from business in Indiana during the calendar year preceding the assessment.

(d) If the total amount of all assessments in any one (1) calendar year does not provide an amount sufficient to meet the requirements of subsection (a), additional funds must be assessed in succeeding calendar years.

(e) Health maintenance organizations that, during any preceding calendar year, have paid one (1) or more assessments levied under this section may either:

(1) take as a credit against adjusted gross income taxes or similar taxes upon revenue or income of health maintenance organizations that may be imposed by Indiana up to twenty percent (20%) of any assessment described in this section for each calendar year following the year in which those assessments were paid until the aggregate of those assessments have been offset; or

(2) include in the premiums charged for coverage to which this article applies amounts sufficient to recoup a sum equal to the amounts paid in assessments as long as the premiums are not excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the health maintenance organization.

IC 27-13-19
Chapter 19. Replacement Coverage in Event of Receivership

IC 27-13-19-1
"Discontinuance" defined
Sec. 1. As used in this chapter, "discontinuance" means the termination of the contract between a group contract holder and a health maintenance organization due to the receivership of the health maintenance organization. The term does not refer to the termination of an individual contract.

IC 27-13-19-2
Replacement coverage; challenge of enrollee
Sec. 2. (a) A carrier that provides replacement coverage with respect to group health care services after the discontinuance of the prior health maintenance organization contract or policy providing health care services must, immediately upon beginning to provide the replacement coverage, cover all enrollees who were covered under the previous health maintenance organization contract or policy on the date of discontinuance.
(b) A carrier that provides replacement coverage under this section may challenge whether an individual designated as an enrollee under the previous health maintenance organization contract qualified as an enrollee under the previous health maintenance organization contract. As added by P.L.26-1994, SEC.25.

IC 27-13-19-3
Provisions reducing or excluding benefits
Sec. 3. (a) Except as provided in subsection (b), a provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to the benefits preexisted the effective date of the succeeding carrier's contract may not be applied with respect to those enrollees who were covered under the prior carrier's contract or policy on the date of discontinuance.
(b) A provision in a succeeding carrier's contract of replacement coverage may operate to reduce or exclude benefits on the basis of a preexisting condition to the extent that the prior carrier's contract or policy would have required that benefits for the condition be reduced or excluded.
IC 27-13-20  
Chapter 20. Filing Requirements

IC 27-13-20-1  
Rates; approval

Sec. 1. The rates to be used by a health maintenance organization, including the actuarial assumptions underlying those rates, must be filed with the commissioner for approval and:

(1) must be established in accordance with actuarial principles for various categories of enrollees and, in the case of a group contract, shall not be individually determined based on the status of an enrollee's health;
(2) must be developed by an actuary or other qualified person acceptable to the commissioner; and
(3) may not be excessive, inadequate, or unfairly discriminatory.

IC 27-13-20-2  
Approval of documents by commissioner

Sec. 2. (a) Except as provided in subsection (b), a document submitted to the commissioner under this chapter is deemed approved when one (1) of the following conditions is met:

(1) The health maintenance organization receives a written communication of approval from the commissioner.
(2) Thirty (30) days pass after the commissioner receives the document.

(b) A document is not deemed approved under subsection (a)(2) if, within thirty (30) days after the commissioner receives the document, or within any period of extension granted by the commissioner, the commissioner deposits in the United States mail addressed to the health maintenance organization a written communication to the contrary. Not more than thirty (30) days after receiving the written communication from the commissioner, the health maintenance organization may request a hearing. If, not more than thirty (30) days after receiving the communication from the commissioner, the health maintenance organization requests a hearing, the commissioner shall hold a hearing upon not less than ten (10) days notice to the health maintenance organization.
Chapter 21. Insurance Producers of Health Maintenance
Organizations and Limited Service Health Maintenance
Organizations

IC 27-13-21-1
Licensing of insurance producer

Sec. 1. To qualify to represent a health maintenance organization
or a limited service health maintenance organization, an insurance
producer shall be licensed with an accident and health or sickness
qualification under IC 27-1-15.6-7.

SEC.18; P.L.178-2003, SEC.86.
IC 27-13-22
Chapter 22. Powers of Insurers and Hospital Corporations

IC 27-13-22-1
Operation of health maintenance organization by insurer or hospital
Sec. 1. (a) A licensed insurer or a hospital authorized to conduct business in Indiana may, through a subsidiary or an affiliate, organize and operate a health maintenance organization under this article.
(b) This section does not apply to a health maintenance organization granted a certificate of authority under this article before July 1, 2001.

IC 27-13-22-2
Joint organization or operation as health maintenance organization
Sec. 2. Notwithstanding any other law:
1. insurers;
2. hospitals; or
3. subsidiaries or affiliates of entities referred to in subdivisions (1) and (2);
may jointly organize and operate a health maintenance organization.

IC 27-13-22-3
Business of insurance including health care maintenance organizations
Sec. 3. For the purposes of IC 27-1-2-2, the business of insurance includes the providing of health care services by a health care maintenance organization owned or operated by an insurer or a subsidiary of an insurer.

IC 27-13-22-4
Contracting with health maintenance organizations to provide insurance coverage
Sec. 4. An insurer or a hospital may contract with a health maintenance organization to provide to the health maintenance organization:
1. insurance coverage or similar protection against the cost of health care services provided through the health maintenance organization; or
2. insurance coverage in the event of the failure of the health maintenance organization to meet its obligations to enrollees or providers.

IC 27-13-22-5
Benefit payments to health maintenance organization; contract
provisions

Sec. 5. Under a contract between an insurer or a hospital and a health maintenance organization under section 4 of this chapter, the insurer or hospital may make benefit payments to the health maintenance organization for health care services for which the health maintenance organization is liable.

IC 27-13-23
Chapter 23. Examinations

IC 27-13-23-1
Health maintenance organization examination
Sec. 1. The commissioner may make an examination of a health maintenance organization whenever necessary for the protection of the interests of the citizens of Indiana. However, an examination of a health maintenance organization domiciled in Indiana must be conducted at least once every three (3) years.

IC 27-13-23-2
Quality management program examination
Sec. 2. The commissioner may make an examination concerning the quality management program of a health maintenance organization whenever necessary for the protection of the citizens of Indiana. However, an examination of the quality management program of a health maintenance organization domiciled in Indiana must be conducted at least once every three (3) years.

IC 27-13-23-3
Availability of books and records
Sec. 3. Each health maintenance organization that is subject to an examination under this chapter shall make its books and records, and the books and records in its custody or control, available for examination and otherwise facilitate the completion of the examination.

IC 27-13-23-4
Officers and agents; oaths and examination by commissioner
Sec. 4. When conducting an examination of a health maintenance organization, the commissioner:
(1) may administer oaths to; and
(2) examine;
the officers and agents of the health maintenance organization concerning the business of the organization.

IC 27-13-23-5
Expenses of examination
Sec. 5. The expenses incurred by the commissioner in conducting an examination under this chapter must be paid by the health maintenance organization being examined.

IC 27-13-23-6
Health maintenance organizations outside Indiana; reports of other
insurance commissioners
Sec. 6. Instead of conducting an examination of a health maintenance organization that is not domiciled in Indiana, the commissioner may accept the report of an examination made by the insurance commissioner of another state if the other state is accredited by the National Association of Insurance Commissioners. 

IC 27-13-23-7
Annual review of HEDIS data
Sec. 7. (a) Beginning July 1, 1999, the commissioner shall review each health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data on an annual basis.
(b) The commissioner may contract with an appropriate entity to conduct the reviews required under this section.

IC 27-13-23-8
Filing examination reports of other states
Sec. 8. A health maintenance organization shall file a copy of any examination report filed by the insurance commissioner of another state during the preceding calendar year with the annual statement required under IC 27-13-8-1.
IC 27-13-24
Chapter 24. Suspension, Revocation, or Denial of Certificate of Authority

IC 27-13-24-1
Grounds for suspension or revocation

Sec. 1. (a) The commissioner may suspend or revoke a certificate of authority issued under this article or deny an application submitted under this article if the commissioner finds that any of the following conditions exists:

1. The health maintenance organization is operating:
   (A) significantly in contravention of its basic organizational document; or
   (B) in a manner contrary to that described in any other information submitted under IC 27-13-2; unless amendments to the basic organizational document or other submissions that are consistent with the operations of the organization have been filed with and approved by the commissioner.

2. The health maintenance organization:
   (A) issues an evidence of coverage;
   (B) enters into a contract with a participating provider; or
   (C) uses a schedule of charges for health care services; that does not comply with the requirements of IC 27-13-7, IC 27-13-15, and IC 27-13-20.

3. The health maintenance organization does not provide or arrange for basic health care services.

4. The commissioner determines that the health maintenance organization is unable to fulfill its obligations to furnish health care coverage.

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

6. The health maintenance organization has failed to correct, within the time prescribed by section 2 of this chapter, any deficiency occurring due to the impairment of the prescribed minimum net worth of the health maintenance organization.

7. The health maintenance organization has failed to implement the grievance procedures required by IC 27-13-10 in a reasonable manner to resolve valid complaints.

8. The health maintenance organization or any person acting on behalf of the organization has intentionally advertised or merchandised the services of the organization in an untrue, a misrepresentative, a misleading, a deceptive, or an unfair manner.

9. The continued operation of the health maintenance organization would be hazardous to the enrollees of the organization.

10. The health maintenance organization fails to comply with the requirements provided under IC 27-13-36 through
IC 27-13-40.
(11) The health maintenance organization has otherwise failed substantially to comply with this article.

(b) The commissioner, in a proceeding under IC 4-21.5-3-8, may impose a civil penalty of not more than twenty-five thousand dollars ($25,000) against a health maintenance organization for each cause listed in subsection (a). The civil penalties may not exceed one hundred thousand dollars ($100,000) for any one (1) health maintenance organization in one (1) calendar year. The penalty may be imposed in addition to or instead of a suspension or revocation of the certificate of authority of the health maintenance organization.


IC 27-13-24-2
Deficient net worth

Sec. 2. (a) If the commissioner finds that the net worth maintained by a health maintenance organization subject to this article is less than the minimum net worth required by IC 27-13-12, the commissioner shall:

(1) give written notice to the health maintenance organization of the amount of the deficiency; and

(2) require the health maintenance organization to:
   (A) file with the commissioner a plan for correction of the deficiency that is acceptable to the commissioner; and
   (B) correct the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed an additional sixty (60) days, is granted by the commissioner.

(b) A deficiency described in subsection (a) is an impairment, and the failure of a health maintenance organization to correct the impairment in the time prescribed by the commissioner under subsection (a) is grounds for:

(1) the suspension or revocation of the certificate of authority of the organization; or

(2) placing the health maintenance organization in rehabilitation or liquidation.


IC 27-13-24-3
Procedures; written order; revised application; hearing

Sec. 3. (a) The commissioner may:

(1) suspend or revoke a certificate of authority;
(2) deny an application for a certificate of authority; or
(3) impose an administrative penalty;

under this article only after complying with this section.

(b) The commissioner may:

(1) suspend or revoke a certificate of authority;
(2) deny an application for a certificate of authority; or
(3) impose an administrative penalty;
under this section by written order that shall be sent to the health
maintenance organization or applicant by certified or registered mail.
In the case of an application for a certificate of authority, the written
order must be sent within one hundred twenty (120) days after the
submission of a completed application. Failure by the commissioner
to issue an order within the one hundred twenty (120) day period
constitutes approval of the application for a certificate of authority.
The written order must state the grounds, charges, or conduct on
which the suspension, revocation, denial, or administrative penalty
is based. The health maintenance organization or applicant may in
writing request a hearing within thirty (30) days after the date of the
mailing of the order. If a written request is not made, the order is final
upon expiration of the thirty (30) days.

(c) If an order is issued under subsection (b) denying an
application for a certificate of authority, the applicant may initiate the
following procedure:

1) The applicant may submit to the commissioner a revised
application or any other information or material addressing the
reasons the commissioner denied the application. A revised
application and other information submitted to the
commissioner under this subdivision must be submitted within
thirty (30) days after receiving the order, unless the applicant
requests an extension of time from the commissioner, who may
not unreasonably deny the request.

2) Upon receiving an applicant's revised application or other
information or materials as described in subdivision (1), the
commissioner shall promptly review the materials regardless of
whether the applicant has requested a hearing under subsection
(b).

3) An applicant's submission of a revised application or other
information or materials is considered to correct and resolve the
reasons for denying the original application for a certificate of
authority. The application or revised application is considered
to be approved unless the commissioner notifies the applicant in
writing by certified or registered mail, within fifteen (15)
business days after the date the submission under subdivision
(1) is made, that the application or revised application is not
approved. A written notification under this subdivision must
state in detail the reasons for continuing to deny the application
or the revised application.

(d) If the health maintenance organization or applicant requests a
hearing under this chapter, the commissioner shall issue a written
notice of hearing and send the notice to the health maintenance
organization or applicant by certified or registered mail. The notice
must contain a specific date and time for the hearing, which may not
be less than twenty (20) days or more than sixty (60) days after the
mailing of the notice of hearing.

SEC.8.
IC 27-13-24-4  
Action by commissioner after hearing  
Sec. 4. (a) After a hearing, or upon failure of the health maintenance organization or applicant to appear at the hearing, the commissioner shall:  
(1) take whatever action the commissioner finds necessary and appropriate based on written findings; and  
(2) mail the decision to the health maintenance organization or applicant.  
(b) The action of the commissioner under this chapter is subject to review under IC 4-21.5.  

IC 27-13-24-5  
Application of IC 4-21.5  
Sec. 5. IC 4-21.5 applies to proceedings under this chapter to the extent IC 4-21.5 does not conflict with any section of this chapter.  

IC 27-13-24-6  
Prohibited activity during suspension  
Sec. 6. A health maintenance organization whose certificate of authority is suspended may not, during the period of suspension:  
(1) enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees; or  
(2) engage in any advertising or solicitation.  

IC 27-13-24-7  
Conclusion of affairs following revocation of certificate of authority  
Sec. 7. (a) A health maintenance organization whose certificate of authority is revoked:  
(1) shall proceed, immediately following the effective date of the order of revocation, to wind up the affairs of the organization; and  
(2) may not conduct further business, except as essential to the orderly conclusion of the affairs of the organization.  
(b) After the certificate of authority of a health maintenance organization is revoked, the health maintenance organization may not engage in further advertising or solicitation.  
(c) Notwithstanding subsection (a), the commissioner may, by written order, permit further operation of a health maintenance organization after the certificate of authority of the organization is revoked if the commissioner finds the further operation of the organization to be in the best interest of enrollees.  

IC 27-13-24-8  
Prohibited activities before hearing  
Sec. 8. If the commissioner issues an order under section 3(b)(1)
of this chapter and the health maintenance organization requests a hearing under section 3(d) of this chapter within the time period specified, the health maintenance organization may not:

(1) enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees; or

(2) engage in any advertising or solicitation;

until the commissioner takes action under section 4 of this chapter. 
IC 27-13-25
Chapter 25. Rehabilitation or Liquidation of Health Maintenance Organizations

IC 27-13-25-1
Rehabilitation or liquidation as an insurance company; applicability of IC 27-9
Sec. 1. The rehabilitation or liquidation of a health maintenance organization:
(1) shall be considered to be the rehabilitation or liquidation of an insurance company; and
(2) shall be conducted under IC 27-9.

IC 27-13-25-2
Appointment of commissioner as rehabilitator or liquidator; grounds
Sec. 2. The commissioner may apply for an order appointing the commissioner as rehabilitator or liquidator to rehabilitate or liquidate a health maintenance organization:
(1) upon at least one (1) of the grounds set forth in IC 27-9-3-1 or IC 27-9-3-6; or
(2) when, in the commissioner's opinion, the continued operation of the health maintenance organization would be hazardous to the enrollees of the organization or the people of Indiana.

IC 27-13-25-3
Claims against health maintenance organization
Sec. 3. (a) In the liquidation of a health maintenance organization, the claims against the health maintenance organization by enrollees, beneficiaries, and providers qualify as class 3 claims under IC 27-9-3-40(3).
(b) If an enrollee is liable to a provider for services provided under and covered by a health maintenance organization, that liability has the status of an enrollee claim in the liquidation of a health maintenance organization. If the health maintenance organization in liquidation pays the provider the amount of a claim under this subsection, then the claim of the enrollee is extinguished.
IC 27-13-26
Chapter 26. Summary of Orders and Supervision

IC 27-13-26-1
Hazardous financial condition; corrective action ordered by commissioner

Sec. 1. (a) If the commissioner determines that:
(1) the financial condition of a health maintenance organization
is such that the continued operation of the organization might be
hazardous to:
(A) the subscribers, enrollees, or creditors of the
organization; or
(B) the general public; or
(2) the organization has violated any provision of this article;
the commissioner may, after notice and hearing, order the health
maintenance organization to take action reasonably necessary to
rectify the condition or violation.

(b) An order of the commissioner under subsection (a) may
require a health maintenance organization to do one (1) or more of
the following:
(1) Reduce the total amount of present and potential liability for
benefits by reinsurance or another method acceptable to the
commissioner.
(2) Reduce the volume of new business being accepted.
(3) Reduce expenses by specified methods.
(4) Suspend or limit the writing of new business for a period of
time.
(5) Increase the capital and surplus of the health maintenance
organization by contribution.
(6) Take other steps the commissioner considers appropriate
under the circumstances.

(c) The commissioner’s order under this section may require items
in addition to those set forth in subsection (b).

IC 27-13-26-2
Violation of article

Sec. 2. For purposes of section 1(a)(2) of this chapter, the
violation by a health maintenance organization of any Indiana law to
which the health maintenance organization is subject is considered a
violation of this article.

IC 27-13-26-3
Adoption of rules; uniform standards set by commissioner

Sec. 3. (a) The commissioner may adopt rules under IC 4-22-2 to
do the following:
(1) Set uniform standards and criteria to produce an early
warning that the continued operation of a health maintenance
organization might be hazardous to the subscribers, enrollees, or
creditors of the organization or to the general public.
(2) Set standards for evaluating the financial condition of a
health maintenance organization.
(b) The standards set under subsection (a)(2) must be consistent
with the purposes expressed in section 1 of this chapter.

IC 27-13-26-4
Remedies and measures
Sec. 4. The remedies and measures available to the commissioner
under this chapter are in addition to and not in place of the remedies
and measures available to the commissioner under IC 27-9.
IC 27-13-27
Chapter 27. Fees

IC 27-13-27-1
Filing fees

Sec. 1. Each health maintenance organization subject to this article shall pay to the commissioner for deposit into the department of insurance fund established by IC 27-1-3-28 the following fees:

(1) Three hundred fifty dollars ($350) for filing:
   (A) an application for a certificate of authority; or
   (B) an application for an amendment to a certificate of authority.

(2) Fifty dollars ($50) for filing each annual report.


IC 27-13-27-2
Fees required by IC 27-1-3-15

Sec. 2. In addition to the fees required by section 1 of this chapter, a health maintenance organization subject to this article must pay the fees required by IC 27-1-3-15. For purposes of IC 27-1-3-15, a contract between a health maintenance organization and a subscriber or enrollee and an evidence of coverage shall constitute a single policy.

IC 27-13-28
Chapter 28. Penalties and Enforcement

IC 27-13-28-1
Augmentation of penalty; damages suffered by enrollees or other members of the public
Sec. 1. The commissioner may augment a penalty imposed under IC 27-13-24-1(b) by an amount equal to the sum that the commissioner calculates to be the damages suffered by enrollees or other members of the public. The commissioner may direct that any penalty imposed under this section be paid to the enrollees or other members of the public damaged by the health maintenance organization.

IC 27-13-28-2
Conference to determine violations
Sec. 2. If the commissioner has cause to believe that a violation of this article by a health maintenance organization has occurred or is threatened, the commissioner may give notice to:
(1) the health maintenance organization; and
(2) the other persons who appear to be involved in the suspected violation;
to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to determine the facts relating to the suspected violation and, if a violation has occurred or is threatened, to determine an adequate and effective means of correcting or preventing the violation.

IC 27-13-28-3
Procedural requirements
Sec. 3. Proceedings under section 2 of this chapter are not governed by any formal procedural requirements and may be conducted in a manner the commissioner considers appropriate under the circumstances. However, a conference under section 2 of this chapter may not result in a rule or an order until the requirements of section 2 of this chapter are satisfied, unless the health maintenance organization consents to the rule or order.

IC 27-13-28-4
Cease and desist orders
Sec. 4. (a) The commissioner may issue an order directing:
(1) a health maintenance organization; or
(2) a representative of a health maintenance organization;
to cease and desist from engaging in any act or practice that violates this article.
(b) Within ten (10) days after a cease and desist order is served under subsection (a), the health maintenance organization or its
representative may request a hearing on the question of whether acts or practices in violation of this article have occurred. The hearing must be conducted under IC 4-21.5.

IC 27-13-28-5
Injunctive or other relief
Sec. 5. In the case of a violation of this article, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued under section 4 of this chapter, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in the Marion County circuit court.

IC 27-13-28-6
Failure to comply with net worth requirements; continued operation
Sec. 6. Notwithstanding any other provision of this article, if a health maintenance organization fails to comply with the net worth requirement of this article, the commissioner may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to the enrollees of the organization.

IC 27-13-28-7
Investigations on behalf of enrollees or providers not precluded
Sec. 7. This article does not preclude the department from investigating complaints, grievances, or appeals on behalf of enrollees or providers.
IC 27-13-29
Chapter 29. Statutory Construction and Relationship to Other Laws

IC 27-13-29-1
Applicability of provisions
Sec. 1. (a) Except as provided in subsection (b) or as otherwise provided in this article or IC 27:
(1) IC 27; and
(2) the provisions of IC 16 regulating hospitals;
do not apply to any health maintenance organization or limited service health maintenance organization (as defined in IC 27-13-34-4) that is granted a certificate of authority under this article. However, this section does not apply to an insurer or a hospital that is licensed under Indiana law, except with respect to the health maintenance organization activities of the hospital or insurer that are authorized and regulated under this article.
(b) Every:
(1) health maintenance organization; and
(2) limited service health maintenance organization (as defined in IC 27-13-34-4);
authorized to do business in Indiana is subject to IC 27-4-1 relating to unfair methods of competition and unfair or deceptive acts or practices to the extent that IC 27-4-1 does not conflict with this article. If a provision in IC 27-4-1 conflicts with this article, this article governs and controls.

IC 27-13-29-2
Solicitation of enrollees
Sec. 2. Provided that the solicitation otherwise complies with IC 27-13-21, the solicitation of enrollees by:
(1) a health maintenance organization or limited service health maintenance organization that is granted a certificate of authority; or
(2) a representative of an organization described in subdivision (1);
may not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

IC 27-13-29-3
Repealed
(Repealed by P.L.227-1995, SEC.2.)

IC 27-13-29-4
Risk based capital requirements
Sec. 4. A:
(1) health maintenance organization; or
(2) limited service health maintenance organization; that is domiciled in Indiana is subject to the risk based capital requirements of IC 27-1-36, unless exempted by the commissioner under IC 27-1-36-1.

IC 27-13-30
Chapter 30. Filings and Reports as Public Documents

IC 27-13-30-1
Public records; exemptions; annual financial statement

Sec. 1. (a) All applications, filings, and reports required under this article shall be treated as public records under IC 5-14-3, except those that are:

(1) trade secrets; or
(2) privileged or confidential:
    (A) quality management information; or
    (B) commercial or financial information.

(b) An annual financial statement required under IC 27-13-8 is not exempt from treatment as a public document under subsection (a)(2)(B).

IC 27-13-31  
Chapter 31. Confidentiality of Medical Information and Limitation of Liability

IC 27-13-31-1  
Information treated as confidential; exceptions; privilege against disclosure

Sec. 1. (a) Notwithstanding IC 27-13-30, any information:
(1) that pertains to the diagnosis, treatment, or health of any enrollee of a health maintenance organization or limited service health maintenance organization; and
(2) that is obtained from:
   (A) the enrollee; or
   (B) any provider;
by any health maintenance organization or limited service health maintenance organization;
is confidential and may not be disclosed to any person, except under the circumstances set forth in subsection (b).

(b) Information described in subsection (a) may be disclosed:
   (1) to the extent necessary to carry out this article;
   (2) upon the express consent of the enrollee;
   (3) under a statute or court order for the production of evidence or the discovery of evidence; or
   (4) in the event of a claim or litigation between:
      (A) the enrollee; and
      (B) the health maintenance organization or limited service health maintenance organization;
in which the data or information is pertinent.

(c) A health maintenance organization or limited service health maintenance organization is entitled to claim any statutory privilege against the disclosure of information described in subsection (a) that the provider who furnished the information to the health maintenance organization or limited service health maintenance organization is entitled to claim.


IC 27-13-31-2  
Liability limitations

Sec. 2. (a) As used in this section, "in good faith and without malice" when used to describe an action taken or a decision or recommendation made means that:
   (1) a reasonable effort has been taken to obtain the facts of the matter;
   (2) a reasonable belief exists that the action, decision, or recommendation is warranted by the facts known; and
   (3) if the action is described in IC 34-30-15-7, the action is made in compliance with IC 34-30-15-7.

(b) As used in this section, "health care review committee" means a peer review committee under IC 34-6-2-99 (or IC 34-4-12.6-1(c) before its repeal).
(c) In all actions to which this section applies, good faith shall be presumed and malice shall be required to be proven by the person aggrieved.

(d) A person who, in good faith and without malice:

(1) takes any action or makes a decision or recommendation as a member, an agent, or an employee of a health care review committee; or

(2) furnishes any record, information, or assistance to a health care review committee;

is not subject to liability for damages in any legal action in consequence of that action.

(e) Neither:

(1) the health maintenance organization or limited service health maintenance organization that established the health care review committee; or

(2) the officers, directors, employees, or agents of the health maintenance organization or limited service health maintenance organization;

are liable for damages in any civil action for the activities of a person who, in good faith and without malice, takes any action or makes a decision or recommendation as a member, an agent, or an employee of a health care review committee, or furnishes any record, information, or assistance to a health care review committee.

(f) This section does not relieve any person of liability arising from treatment of a patient or an enrollee, or from a determination of the reimbursement to be provided under the terms of an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for health care costs based on the appropriateness of health care services delivered to an enrollee.

(g) A health care review committee shall comply with IC 34-6-2-99.


IC 27-13-31-3

Information and records subject to subpoena or discovery

Sec. 3. (a) Notwithstanding IC 27-13-30, the information considered by a health care review committee and the record of the actions and proceedings of the committee are confidential for purposes of IC 5-14-3-4 and not subject to subpoena or order to produce, except:

(1) in proceedings before the appropriate state licensing or certifying agency; and

(2) in an appeal, if permitted, from the finding or recommendation of the health care review committee.

(b) If information considered by a health care review committee or records of the actions and proceedings of a health care review committee are used under subsection (a) by a state licensing or certifying agency or in an appeal, the information or records:
(1) shall be kept confidential; and
(2) are subject to the same provisions concerning discovery and
use in legal actions as are the original information and records
in the possession and control of a health care review committee.


IC 27-13-31-4
Quality management program; access to records
Sec. 4. To fulfill its obligations under IC 27-13-6 concerning the
quality management program of the organization, a health
maintenance organization is entitled to access to treatment records
and other information pertaining to the diagnosis, treatment, and
health status of any enrollee during the period of time the enrollee is
covered by the health maintenance organization.

IC 27-13-32
Chapter 32. Transfers of Ownership

IC 27-13-32-1
Acquisition of control of health maintenance organization or limited service health maintenance organization

Sec. 1. (a) This section does not apply to a health maintenance organization or a limited service health maintenance organization that is a foreign corporation.

(b) As used in this section, "foreign corporation" means a corporation organized or reorganized under the law of a state or jurisdiction other than Indiana.

(c) A person may not acquire control, as that term is defined in IC 27-1-23-1, of a health maintenance organization or a limited service health maintenance organization unless:

(1) that person complies with the requirements of IC 27-1-23-2; and

(2) the acquisition is approved by the commissioner under the procedure set forth in IC 27-1-23-2.

IC 27-13-32.5
Chapter 32.5. Voluntary Dissolution

IC 27-13-32.5-1
Notice; filing articles of dissolution
Sec. 1. Upon authorization of voluntary dissolution by the board of directors and any shareholders entitled to vote in respect of the voluntary dissolution, the board of directors shall:

(1) cause a notice that the health maintenance organization is about to be dissolved to be published at least once in a newspaper of general circulation, printed and published in the English language, in the county in which the principal office of the health maintenance organization is located, and at least once in a newspaper of general circulation, printed and published in the English language in the city of Indianapolis, Marion County, Indiana;
(2) cause a copy of the publication under subdivision (1) to be mailed to each subscriber;
(3) file a copy of the publication under subdivision (1) with the department;
(4) file a certified copy of the articles of dissolution with the department; and
(5) present to the department the certificate of authority issued or renewed under IC 27-13-3-1 for cancellation.

The department shall file the certified copy of the articles of dissolution, cancel the certificate of authority, endorse the cancellation on the certificate, and return the canceled certificate of authority to the health maintenance organization or its representatives.


IC 27-13-32.5-2
Effect on rights of enrollees
Sec. 2. The dissolution of a health maintenance organization under this chapter does not alter the rights of an enrollee under IC 27-13-7-13.

IC 27-13-33
Chapter 33. Coordination of Benefits

IC 27-13-33-1
Coordination of benefits provision; purpose
Sec. 1. Health maintenance organizations may adopt a coordination of benefits provision to:
   (1) avoid overinsurance; and
   (2) provide for the orderly payment of a claim when a person is covered by two (2) or more group health insurance or health care plans.

IC 27-13-33-2
Provision consistent with 760 IAC 1-38.1
Sec. 2. If a health maintenance organization adopts a coordination of benefits provision, the provision must be consistent with the coordination of benefits provisions of 760 IAC 1-38.1 as it may be amended or replaced from time to time.
IC 27-13-34
Chapter 34. Limited Service Health Maintenance Organizations

IC 27-13-34-0.1
Application of certain amendments to chapter
Sec. 0.1. The amendments made to section 12 of this chapter by P.L.69-1998 apply to contracts that are entered into, renewed, or modified after June 30, 1998.
As added by P.L.220-2011, SEC.461.

IC 27-13-34-1
"Enrollee" defined
Sec. 1. (a) As used in this chapter, "enrollee" means an individual who is entitled to limited health services under a contract with an entity authorized to provide or arrange for limited health services under this chapter.
(b) The term includes the dependent of an individual described in subsection (a).

IC 27-13-34-2
"Evidence of coverage" defined
Sec. 2. As used in this chapter, "evidence of coverage" means the certificate, agreement, or contract issued under section 13 of this chapter setting forth the coverage to which an enrollee is entitled.

IC 27-13-34-3
"Limited health services" defined
Sec. 3. (a) As used in this chapter, "limited health services" refers to:
   (1) dental care services;
   (2) vision care services;
   (3) mental health services;
   (4) substance abuse services;
   (5) pharmaceutical services;
   (6) podiatric care services; and
   (7) other services that the commissioner determines to be limited health services.
(b) The term does not include hospital or emergency services, except as those services are provided incident to a limited health service.

IC 27-13-34-4
"Limited service health maintenance organization" defined
Sec. 4. (a) As used in this chapter, "limited service health maintenance organization" means a corporation, partnership, limited liability company, or other entity that undertakes to provide or
arrange a limited health service on a prepayment basis or other basis.

(b) The term does not include a provider or an entity when providing or arranging for the provision of limited health services under a contract with a limited service health maintenance organization.


IC 27-13-34-5
"Provider" defined

Sec. 5. As used in this chapter, "provider" means a physician, a dentist, an optometrist, a health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health service.


IC 27-13-34-6
"Subscriber" defined

Sec. 6. As used in this chapter, "subscriber" means a person whose employment status or other status, except for family dependency, is the basis for eligibility for limited health services under a contract with an entity authorized to provide or arrange for limited health services under this chapter.


IC 27-13-34-7
Certificate of authority required; foreign entities

Sec. 7. (a) After December 31, 1994, a person, corporation, partnership, limited liability company, or other entity may not operate a limited service health maintenance organization in Indiana without obtaining and maintaining a certificate of authority from the commissioner under this chapter.

(b) A for-profit or nonprofit corporation organized under the laws of another state, other than a foreign corporation defined under IC 27-1-2-3, may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation is authorized to do business in Indiana under IC 23-1-49 or IC 23-17-26 and complies with this chapter.

(c) A foreign corporation (as defined in IC 27-1-2-3) may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation complies with this chapter.

(d) A foreign or alien limited service health maintenance organization granted a certificate of authority under this chapter has the same but not greater rights and privileges than a domestic limited service health maintenance organization.


IC 27-13-34-8
Application for certificate of authority; requirements
Sec. 8. (a) An application for a certificate of authority to operate a limited service health maintenance organization must be filed with the commissioner on a form prescribed by the commissioner. An application must be verified by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

1. A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, articles of organization, or other applicable documents, and all amendments to those documents.
2. A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.
3. A list of the names, addresses, official positions, and biographical information of the individuals who are to be responsible for conducting the affairs and daily operations of the applicant, including the following:
   (A) All members of the board of directors, board of trustees, executive committee, or other governing board or committee.
   (B) The principal officers.
   (C) Any person or entity owning or having the right to acquire at least ten percent (10%) of the voting securities of the applicant.
   (D) In the case of a partnership or an association, the partners or members of the partnership or association.
   (E) In the case of a limited liability company, the managers or members of the limited liability company.
4. A statement generally describing the applicant, the facilities and personnel of the applicant, and the limited health service or services that the applicant will offer.
5. A copy of the form of any contract that has been made or is to be made between the applicant and any providers regarding the provision of limited health services to enrollees.
6. A copy of the form of any contract that has been made or is to be made between the applicant and any person referred to in subdivision (3).
7. A copy of the form of any contract that has been made or is to be made between the applicant and any person, corporation, partnership, or other entity for the performance of any functions on behalf of the applicant, including the following:
   (A) Marketing.
   (B) Administration.
   (C) Enrollment.
   (D) Investment management.
   (E) Subcontracting for the provision of limited health services to enrollees.
8. A copy of the form of any contract that is to be issued to employers, unions, trustees, or other organizations or individuals, and a copy of any form of evidence of coverage to
be issued to subscribers.
(9) Subject to subsection (b), a copy of the most recent financial statements of the applicant, audited by an independent certified public accountant.
(10) A copy of the financial plan of the applicant, including:
   (A) a projection of anticipated operating results for at least three (3) years; and
   (B) a statement of the sources of working capital and any other sources of funding and provisions for contingencies.
(11) A description of the proposed method of marketing.
(12) A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in Indiana is valid if served in accordance with the Indiana Rules of Trial Procedure.
(13) A description of the complaint procedures to be established and maintained under IC 27-13-10.
(14) A description of the quality assessment and utilization review procedures to be used by the applicant.
(15) A description of how the applicant will comply with sections 16 and 17 of this chapter.
(16) The fee for the issuance of a certificate of authority required by section 23 of this chapter.
(17) A written waiver of the applicant's rights under federal bankruptcy laws.
(18) Other information that the commissioner reasonably requires to make the determinations required by this chapter.
(19) If the applicant is not domiciled in Indiana, an executed power of attorney appointing the commissioner, the commissioner's successors in office, and authorized deputies of the commissioner as the true and lawful attorney of the applicant in and for Indiana upon whom all lawful process in any legal action or proceeding against the limited service health maintenance organization on a cause of action arising in Indiana may be served.

(b) If the financial affairs of the parent company of the applicant are audited by independent certified public accountants but those of the applicant are not, an applicant may satisfy the requirement set forth in subsection (a) by including with the application the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, unless the commissioner determines that additional or more recent financial information is required for the proper administration of this chapter.


IC 27-13-34-9
Issuance of certificate of authority; application deficiencies; denial of application
Sec. 9. (a) After receiving an application filed under section 8 of
this chapter, the commissioner shall review the application and notify
the applicant of any deficiencies in the application.

(b) The commissioner shall issue a certificate of authority to an
applicant if the following conditions are met:

(1) The requirements of section 8 of this chapter have been
fulfilled.

(2) The individuals responsible for conducting the affairs of the
applicant are competent, trustworthy, possess good reputations,
and have had appropriate experience, training, or education.

(3) The applicant is financially responsible and may reasonably
be expected to meet its obligations to enrollees and to
prospective enrollees. In making this determination, the
commissioner may consider:

(A) the financial soundness of the arrangements of the
applicant for limited health services;

(B) the adequacy of the applicant's working capital, other
sources of funding, and provisions for contingencies;

(C) any agreement for paying the cost of the limited health
services or for alternative coverage in the event of
insolvency of the limited service health maintenance
organization; and

(D) the manner in which the requirements of sections 16 and
17 of this chapter have been fulfilled.

(4) The agreements with providers for the provision of limited
health services contain the provisions required by section 15 of
this chapter.

(5) Any deficiencies identified by the commissioner have been
corrected.

(c) If an application for a certificate of authority is denied, the
commissioner shall notify the applicant and shall specify in the notice
the reasons for the denial of the application. Within thirty (30) days
after receiving the notice, the applicant may request a hearing before
the commissioner under IC 4-21.5.


IC 27-13-34-10
Powers of limited service health maintenance organization

Sec. 10. (a) Subject to subsection (b), the powers of a limited
service health maintenance organization include the following:

(1) The purchase, lease, construction, renovation, operation, or
maintenance of:

(A) medical facilities that will provide limited health
services;

(B) equipment for medical facilities providing limited health
services; and

(C) other property reasonably required for the principal
office of the limited service health maintenance organization
or for purposes necessary in the transaction of the business
of the organization.

(2) Engaging in transactions between affiliated entities,
including loans and the transfer of responsibility under any or all contracts:
(A) between affiliates; or
(B) between the limited service health maintenance organization and the parent organization of the limited service health maintenance organization.

3) The furnishing of limited health services through the following:
(A) Providers.
(B) Provider associations.
(C) Agents for providers who are under contract with or are employed by the limited service health maintenance organization. The contracts with providers, provider associations, or agents for providers may include fee for service, cost plus, capitation, or other payment or risk-sharing agreements.

4) Contracting with any person for the performance on behalf of the limited service health maintenance organization of certain functions, including:
(A) marketing;
(B) enrollment; and
(C) administration.

5) Contracting with:
(A) an insurance company licensed in Indiana; or
(B) an authorized reinsurer for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the limited service health maintenance organization.

6) The offering of point-of-service products for the limited health services for which the limited service health maintenance organization is licensed so long as the limited service health maintenance organization complies with the reinsurance or ratio requirements of IC 27-13-13-8.

7) The joint marketing of products with:
(A) an insurance company that is licensed in Indiana; or
(B) a health maintenance organization that is authorized to conduct business in Indiana;
if the company that is offering each product is clearly identified.

8) Providing limited health services at the expense of a self-funded plan.

(b) Nothing in this section qualifies an asset of a prepaid limited health service organization as an admitted asset.


IC 27-13-34-11
Modification of documents; filing; disapproval
Sec. 11. (a) Before making any material modification of any matter or document furnished under section 8 of this chapter, a limited service health maintenance organization shall file with the commissioner:
(1) a notice of the modification; and
(2) supporting documents that are necessary to fully explain the modification.

(b) If a limited service health maintenance organization desires to add one (1) or more limited health services, it must:

(1) file a notice with the commissioner;
(2) submit the information required by section 8 of this chapter concerning each limited health service to be added, if that information is different from the information filed with the application of the limited service health maintenance organization; and
(3) demonstrate compliance with sections 16, 17, 18, and 23 of this chapter with respect to each limited health service to be added by the organization.

(c) If the commissioner does not disapprove a filing under subsection (a) or (b) within thirty (30) days after the commissioner receives the filing, or within any period of extension granted by the commissioner, the filing shall be deemed approved.

(d) If a filing under subsection (a) or (b) is disapproved, the commissioner shall:

(1) notify the limited service health maintenance organization of the disapproval of the filing in writing deposited in the United States mail addressed to the limited service health maintenance organization; and
(2) specify the reasons for disapproval of the filing in the notice.

(e) Within thirty (30) days after it receives a notice of disapproval under subsection (d), the limited service health maintenance organization may request a hearing before the commissioner under IC 4-21.5 concerning the disapproval of the filing. If, not more than thirty (30) days after receiving the notice from the commissioner, the limited service health maintenance organization requests a hearing, the commissioner shall hold a hearing upon not less than ten (10) days notice to the limited service health maintenance organization. 


IC 27-13-34-12
Applicable statutes
Sec. 12. A limited service health maintenance organization operated under this chapter is subject to the following:

(1) IC 27-1-36 concerning risk based capital, unless exempted by the commissioner under IC 27-1-36-1.
(2) IC 27-13-2-10, concerning physical presence in Indiana.
(3) IC 27-13-8, except for IC 27-13-8-2(a)(6) concerning reports.
(4) IC 27-13-9-3 concerning termination of providers.
(5) IC 27-13-10-1 through IC 27-13-10-3 concerning grievance procedures.
(6) IC 27-13-11 concerning investments.
(8) IC 27-13-21 concerning producers.
(9) IC 27-13-29 concerning statutory construction and relationship to other laws.
(10) IC 27-13-30 concerning public records.
(11) IC 27-13-31 concerning confidentiality of medical information and limitation of liability.
(12) IC 27-13-36-5 and IC 27-13-36-6 concerning referrals to out of network providers and continuation of care.
(13) IC 27-13-40 concerning comparison sheets of services provided by the limited service health maintenance organization.


IC 27-13-34-13
Evidence of coverage; required information
Sec. 13. (a) Every subscriber of a limited service health maintenance organization shall be issued an evidence of coverage in electronic or paper form, which must contain a clear and complete statement of the following:
   (1) The limited health services to which each enrollee is entitled.
   (2) Any limitation of the services, kinds of services, or benefits to be provided.
   (3) Any exclusions, including any copayment or other charges.
   (4) Where and in what manner information is available as to where and how services may be obtained.
   (5) The method for resolving complaints.
   (b) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document in electronic or paper form.
   (c) A limited service health maintenance organization shall issue the evidence of coverage described in subsection (a) and an amendment described in subsection (b) in paper form upon the request of the subscriber.
   (d) A limited service health maintenance organization shall include in the limited service health maintenance organization's enrollment materials information concerning the manner in which a subscriber may:
      (1) obtain an evidence of coverage; and
      (2) request the evidence of coverage in paper form.


IC 27-13-34-14
Examinations by commissioner
Sec. 14. (a) The commissioner may examine a limited service health maintenance organization as often as is reasonably necessary to protect the interests of Indiana citizens. However, an examination of a limited service health maintenance organization domiciled in Indiana must be conducted at least one (1) time every three (3) years.
(b) A limited service health maintenance organization:
(1) shall make its relevant books and records, and the books and records in its custody and control, available for examination under this section; and
(2) in every way cooperate with the commissioner to facilitate the examination.
(c) The expenses of an examination under this section shall be paid by the organization being examined.
(d) Instead of conducting an examination of a limited service health maintenance organization that is not domiciled in Indiana, the commissioner may accept the report of an examination made by the chief administrative officer who regulates insurance in another state, if the other state is accredited by the National Association of Insurance Commissioners.


IC 27-13-34-15
Required contract terms and conditions; exemptions
Sec. 15. All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment basis or other basis must contain, or shall be construed to contain, the following terms and conditions:
(1) If the limited service health maintenance organization fails to pay for limited health services for any reason whatsoever, including insolvency or breach of this contract, the enrollees shall not be liable to the provider for any sums owed to the provider under this contract.
(2) No provider or agent, trustee, representative, or assignee of a provider may maintain an action at law or attempt to collect from the enrollee sums that the limited service health maintenance organization owes to the provider.
(3) These provisions do not prohibit the collection of:
   (A) uncovered charges consented to by enrollees; or
   (B) copayments;
   from enrollees.
(4) The contract may not provide for a financial or other penalty to a primary care provider for making a referral permitted under IC 27-13-36-5(a), but may provide for reasonable cost sharing between the primary care provider and the limited service health maintenance organization for the additional costs incurred as a result of services provided by an out of network provider.
(5) These provisions survive the termination of this contract, regardless of the reason for the termination.
(6) For not more than ninety (90) days after the termination of this contract, the provider must complete procedures in progress on an enrollee receiving treatment for a specific condition, at the same schedule of copayment or other applicable charge that is in effect on the effective date of termination of the contract.
(7) An amendment to the provisions of this contract set forth in subdivisions (1) through (6) must be:
"Net worth" and "uncovered expense" defined; computation of net worth; minimum net worth

Sec. 16. (a) As used in this section, "net worth" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the commissioner.

(b) For the purposes of computing net worth, the total assets must be reduced by the value assigned to the following intangible assets:

1. Goodwill.
2. Going concern value.
3. Organizational expense.
4. Start-up costs.
5. Long term prepayments of deferred charges.
7. Obligations of officers, directors, owners, or affiliates, except short term obligations of affiliates for goods or services that:
   - (A) arise in the normal course of business;
   - (B) are payable on the same terms as equivalent transactions with nonaffiliates; and
   - (C) are not past due.

(c) As used in this section, "uncovered expense" means the cost of health care services:

1. that are the obligation of a limited service health maintenance organization;
2. for which an enrollee may be liable in the event of the insolvency of the organization; and
3. for which alternative arrangements acceptable to the commissioner have not been made to cover the costs.

(d) For purposes of the definition of "uncovered expense" set forth in subsection (c), costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered a covered expense.

(e) Each limited service health maintenance organization must, at all times, have and maintain net worth equal to the greater of:

1. fifty thousand dollars ($50,000); or
2. two and one-half percent (2.5%) of the annual gross subscription income of the organization, up to a maximum of two hundred fifty thousand dollars ($250,000).

(f) A limited service health maintenance organization shall maintain as a claim or loss reserve, in cash or obligations of the United States government, assets sufficient to discharge all liabilities on all uncovered expenses arising under policies issued.

(g) The commissioner may adopt rules under IC 4-22-2 to further
define whether and to what extent the assets of a limited service health maintenance organization may be considered to be admitted assets for the purposes of complying with the requirements of this chapter.


IC 27-13-34-17

Required deposit

Sec. 17. (a) Each limited service health maintenance organization shall deposit in a joint-name account with:

(1) the commissioner; or
(2) any bank or bank and trust company or other financial institution acceptable to the commissioner through which a custodial or controlled account is used;
cash, securities acceptable to the commissioner, or any combination of these, in an amount equal to fifty thousand dollars ($50,000).

(b) For the purposes of section 16 of this chapter:

(1) a deposit made by an organization under this section shall be treated as an admitted asset of the organization in the determination of net worth; and
(2) all income from deposits of an organization under this section shall be an asset of the organization.

(c) An organization may withdraw:

(1) a deposit made under this section; or
(2) any part of the deposit;
after making a substitute deposit of equal amount and value.

(d) Any obligations of the United States government deposited with the commissioner under this section must be approved by the commissioner before being substituted under subsection (c).

(e) The deposit made by a limited service health maintenance organization under this section shall be used to protect the interest of the enrollees of the organization and to assure continuation of limited health care services to enrollees of a limited service health maintenance organization that is in rehabilitation or conservation.

(f) If a limited service health maintenance organization is placed in rehabilitation or liquidation, the deposit made by the organization under this section shall be an asset subject to IC 27-9.

(g) The commissioner is not required to but may reduce or eliminate the deposit requirement of this section for a limited service health maintenance organization if the organization:

(1) has made an acceptable deposit with the state or jurisdiction in which the organization is domiciled for the protection of all enrollees, wherever located; and
(2) delivers to the commissioner a certificate to that effect, authenticated by the appropriate state official holding the deposit.


IC 27-13-34-18

Fidelity bonds; deposit in place of bond
Sec. 18. (a) Except as provided in subsection (c), a limited service health maintenance organization shall maintain in force a fidelity bond in its own name on its officers and employees:
   (1) in an amount not less than fifty thousand dollars ($50,000); or
   (2) in any other amount prescribed by the commissioner.
(b) The fidelity bond required by this section must be issued by an insurance company not affiliated in any way with the limited service health maintenance organization, that is licensed to do business in Indiana. However, if a fidelity bond is not available from an insurance company that holds a certificate of authority in Indiana, a limited service health maintenance organization may satisfy the requirement of this section by maintaining a fidelity bond procured by a surplus lines insurance producer not affiliated in any way with the limited service health maintenance organization who holds a license issued under IC 27-1-15.8.
(c) Instead of maintaining a fidelity bond under subsection (a), a limited service health maintenance organization may deposit with the commissioner:
   (1) cash;
   (2) certificates of deposit;
   (3) United States government obligations acceptable to the commissioner;
   (4) any other securities acceptable to the commissioner of the types referred to in IC 27-13-11-1; or
   (5) a combination of the items described in subdivisions (1) through (4).
A deposit made under this subsection is in addition to any other required deposit, and must also be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a fidelity bond under this section.


IC 27-13-34-19
Annual reports; additional reports
Sec. 19. (a) On or before March 1 of each year, a limited service health maintenance organization shall file with the commissioner a report that covers the preceding calendar year. The report must be:
   (1) made on forms prescribed by the commissioner; and
   (2) verified by at least two principal officers of the limited service health maintenance organization.
(b) In addition to the report required by subsection (a), a limited service health maintenance organization shall file with the commissioner on or before June 1 of each year an audited financial statement of the limited service health maintenance organization for the preceding calendar year.
(c) The commissioner may require any additional reports necessary to enable the commissioner to carry out the duties of the commissioner under this chapter.
IC 27-13-34-20
Suspension or revocation of certificate of authority

Sec. 20. (a) The commissioner may suspend or revoke the certificate of authority issued to a limited service health maintenance organization under this chapter or deny an application submitted under this chapter upon determining that any of the following conditions exist:

(1) The limited service health maintenance organization is operating:
   (A) significantly in contravention of the basic organizational document of the organization; or
   (B) in a manner contrary to that described in and reasonably inferred from any other information submitted under section 8 of this chapter; unless amendments to the organization's submissions have been filed and authorized under section 11 of this chapter.
(2) The limited service health maintenance organization issues an evidence of coverage that does not comply with the requirements of section 13 of this chapter.
(3) The limited service health maintenance organization is unable to fulfill its obligations to furnish limited health services.
(4) The limited service health maintenance organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
(5) The net worth of the limited service health maintenance organization is less than that required by section 16 of this chapter, or the limited service health maintenance organization has failed to correct any deficiency in its net worth as required by the commissioner.
(6) The limited service health maintenance organization has failed to implement in a reasonable manner the grievance system required by IC 27-13-10.
(7) The continued operation of the limited service health maintenance organization would be hazardous to the enrollees of the organization.
(8) The limited service health maintenance organization has otherwise failed to comply with this chapter.

(b) The commissioner may suspend or revoke a certificate of authority or deny an application for a certificate of authority by written order sent to the limited service health maintenance organization by certified mail or registered mail. The written order shall state the grounds for the suspension, revocation, or denial. A limited service health maintenance organization may request in writing a hearing within thirty (30) days after mailing of the order. If the limited service health maintenance organization requests a hearing within the time specified, the commissioner shall hold a hearing, which may not be less than twenty (20) days or more than
sixty (60) days after the date of the notice for a hearing on the matter under IC 4-21.5.

(c) Immediately after the certificate of authority of a limited service health maintenance organization is revoked, the organization shall proceed to wind up its affairs. An organization whose certificate is revoked:

(1) shall not conduct further business except as may be essential to the orderly conclusion of the affairs of the organization; and

(2) shall not engage in further advertising or solicitation.

However, the commissioner may, by written order, permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.


IC 27-13-34-21
Chapter violations; fines and penalties

Sec. 21. (a) In place of any other penalty specified in this chapter, or when no penalty is specifically provided, whenever any limited service health maintenance organization or other person, corporation, partnership, limited liability company, or entity subject to this chapter has been found to have violated any provision of this chapter, the commissioner may:

(1) issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person, or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) impose a monetary penalty of not more than two thousand five hundred dollars ($2,500) for each violation, but not to exceed an aggregate penalty of twenty-five thousand dollars ($25,000).

(b) A limited service health maintenance organization may appeal any action taken by the commissioner under this section within thirty (30) days after receiving notice of the action by requesting a hearing before the commissioner under IC 4-21.5.


IC 27-13-34-22
Supervision, rehabilitation, or liquidation; remedies and measures

Sec. 22. (a) Any supervision, rehabilitation, or liquidation of a limited service health maintenance organization shall be considered to be the supervision, rehabilitation, or liquidation of an insurance company and shall be conducted under IC 27-9.

(b) A limited service health maintenance organization is not subject to IC 27-6-8 or IC 27-8-8.

(c) The remedies and measures available to the commissioner under this chapter are in addition to and not in the place of the remedies and measures available to the commissioner under IC 27-9.
IC 27-13-34-23  
Fees  
Sec. 23. (a) A limited service health maintenance organization subject to this chapter shall pay to the commissioner for deposit into the department of insurance fund established by IC 27-1-3-28 the following fees:  
   (1) For filing an application for a certificate of authority or an amendment to an application, three hundred fifty dollars ($350).  
   (2) For filing each annual report, fifty dollars ($50).  
(b) In addition to the fees required by subsection (a), a limited service health maintenance organization subject to this chapter must pay the fees required by IC 27-1-3-15.  

IC 27-13-34-24  
Dental care services and director; review of adverse decisions; complaints  
Sec. 24. (a) A limited service health maintenance organization that provides dental care services shall appoint a dental director who has an unlimited license to practice dentistry under IC 25-14 or an equivalent license issued by another state.  
(b) The dental director appointed under subsection (a) is responsible for oversight of treatment policies, protocols, quality assurance activities, credentialing of participating providers, and utilization management decisions of the limited service health maintenance organization.  
(c) A limited service health maintenance organization that provides dental care services shall contract with or employ at least one (1) individual who holds an unlimited license to practice dentistry under IC 25-14 or an equivalent license issued by another state to do the following:  
   (1) Develop, in consultation with a group of appropriate providers, the limited service health maintenance organization's treatment policies, protocols, and quality assurance activities.  
   (2) Respond when a treating provider requests in writing that a dentist reconsider an adverse utilization review decision.  
(d) A limited service health maintenance organization that provides dental care services that receives a written request for reconsideration of an adverse utilization review decision from a treating provider shall:  
   (1) review the decision as expeditiously as possible; and  
   (2) provide a response to the treating provider not more than ten (10) business days after receiving the request.  
(e) A limited service health maintenance organization that provides dental care services shall provide participating providers with an opportunity to comment on the following:  
   (1) Treatment policies.
IC 27-13-34-26
Complaints; records
Sec. 26. (a) The department shall maintain records concerning complaints filed against a limited service health maintenance organization that provides dental care services.
(b) The department shall classify complaints described in subsection (a) in categories according to the National Association of Insurance Commissioners standardized complaint report procedures.
(c) The department shall classify the disposition of complaints in each category by:
   (1) number of complaints for which corrective action is considered necessary by the department; and
   (2) number of complaints classified by National Association of Insurance Commissioners disposition codes.
(d) The department shall make information specified in this section available to the public in a form that does not identify any specific individual.
(e) A limited service health maintenance organization that provides dental care services may not take any retaliatory action, including cancellation or refusal to renew a participating provider contract, individual contract, or group contract, solely because a participating provider, enrollee, or individual or group contract holder files a complaint against the limited service health maintenance organization.
As added by P.L.91-2000, SEC.2.
IC 27-13-35
   Chapter 35. General Rulemaking Authority

IC 27-13-35-1
Adoption of rules to carry out article
   Sec. 1. The commissioner may adopt reasonable rules under IC 4-22-2 that are necessary or proper to carry out this article.
IC 27-13-36
Chapter 36. Patient Protection; Clinical Decision Making; Access to Personnel and Facilities

IC 27-13-36-1
Medical director; individual to develop treatment policies and consult with treating providers

Sec. 1. (a) Each health maintenance organization shall appoint a medical director who has an unlimited license to practice medicine under IC 25-22.5 or an equivalent license issued by another state.

(b) The medical director is responsible for oversight of treatment policies, protocols, quality assurance activities, and utilization management decisions of the health maintenance organization.

(c) A health maintenance organization shall contract with or employ at least one (1) individual who holds an unlimited license to practice medicine under IC 25-22.5 to do the following:

(1) Develop, in consultation with a group of appropriate providers, the health maintenance organization's treatment policies, protocols, and quality assurance activities.

(2) Consult with the treating provider before an adverse utilization review decision is made.

(d) Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.


IC 27-13-36-2
Sufficient number and type of primary care providers

Sec. 2. Beginning July 1, 1999, each health maintenance organization shall include a sufficient number and type of primary care providers and other appropriate providers throughout the health maintenance organization's service area to:

(1) meet the needs of; and

(2) provide a choice of primary care providers and other appropriate providers to enrollees and subscribers of the health maintenance organization.

Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.


IC 27-13-36-2.5
Discrimination on basis of provider's license or certification prohibited

Sec. 2.5. (a) A health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certification with respect to:

(1) participation;

(2) reimbursement;
(3) indemnification; or
(4) scope of care;
solely on the basis of the provider's license or certification.
(b) This section does not require a health maintenance
organization to enter into a contract with a provider that would allow
the provider to enter the health maintenance organization network.

IC 27-13-36-3
Adequate number of services and providers within reasonable
proximity of subscribers
Sec. 3. (a) The provisions of this section do not apply until July 1,
1999.
(b) Each health maintenance organization shall demonstrate to the
department that the health maintenance organization offers an
adequate number of:
   (1) acute care hospital services;
   (2) primary care providers; and
   (3) other appropriate providers;
that are located within a reasonable proximity of subscribers of the
health maintenance organization. Compliance with the most current
standards or guidelines developed by the National Committee on
Quality Assurance or a successor organization is sufficient to meet
the requirements of this subsection.
(c) If a health maintenance organization provides coverage for:
   (1) specialty medical services, including physical therapy,
       occupational therapy, and rehabilitation services;
   (2) mental and behavioral care services; or
   (3) pharmacy services;
the health maintenance organization shall demonstrate to the
department that the offered services are located within a reasonable
proximity of subscribers of the health maintenance organization. Compliance with the most current standards or guidelines developed
by the National Committee on Quality Assurance or a successor
organization is sufficient to meet the requirements of this subsection.

IC 27-13-36-4
Specialty areas of primary care providers
Sec. 4. Beginning July 1, 1999, primary care providers shall
include licensed physicians who practice in one (1) or more of the
following areas:
   (1) Family practice.
   (2) General practice.
   (3) Internal medicine.
   (4) As a woman's health care provider, in compliance with
       IC 27-8-24.7.
   (5) Pediatrics.
IC 27-13-36-5
Referrals to out of network providers

Sec. 5. (a) The provisions of the section do not apply until July 1, 1999.

(b) When an enrollee's primary care provider determines that the enrollee needs a particular health care service and the health maintenance organization determines that the type of health care service needed by the enrollee to treat a specific condition:
   (1) is a covered service; and
   (2) is not available from the health maintenance organization's network of participating providers;
the primary care provider and the health maintenance organization shall refer the enrollee to an appropriate provider who is not a participating provider within a reasonable amount of time and within a reasonable proximity of the enrollee.

(c) When an enrollee receives health care services from a provider to whom the enrollee was referred as described in subsection (b), the health maintenance organization shall pay the out of network provider the lesser of the following:
   (1) The usual, customary, and reasonable charge in the health maintenance organization's service area for the health care services provided by the out of network provider.
   (2) An amount agreed to between the health maintenance organization and the out of network provider.
The enrollee's treating provider may collect from the enrollee only the deductible or copayment, if any, that the enrollee would be responsible to pay if the health care services had been provided by a participating provider. The enrollee may not be billed by the health maintenance organization or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the health maintenance organization to the out of network provider as provided in this subsection.

(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a determination allowed under subsection (b).


IC 27-13-36-6
Continuation of care provisions

Sec. 6. (a) A health maintenance organization shall include provisions in the health maintenance organization's contracts with providers to provide for continuation of care in the event that a provider's contract with the health maintenance organization is terminated, provided that the termination is not due to a quality of care issue.

(b) The contract provisions under subsection (a) shall require that the provider, upon the request of the enrollee, continue to treat the enrollee for up to sixty (60) days following the termination of the provider's contract with the health maintenance organization or, in the
case of a pregnant enrollee in the third trimester of pregnancy, throughout the term of the enrollee's pregnancy. If the provider is a hospital, the contract shall provide for continuation of treatment until the earlier of the following:

(1) Sixty (60) days following the termination of the provider's contract with the health maintenance organization.

(2) The enrollee is released from inpatient status at the hospital.

(c) During a continuation period under this section, the provider:

(1) shall agree to continue accepting the contract terms and conditions, together with applicable deductibles and copayments, as payment in full; and

(2) is prohibited from billing the enrollee for any amounts in excess of the enrollee's applicable deductible or copayment.


IC 27-13-36-7
Telephone access for authorization of care
Sec. 7. Each health maintenance organization shall provide the following:

(1) Telephone access to the health maintenance organization during business hours to ensure enrollee access for routine care.

(2) Twenty-four (24) hour telephone access to either:

(A) a representative of the health maintenance organization;

or

(B) a participating provider;

for authorization for care.


IC 27-13-36-8
Guidelines for establishing reasonable periods for appointments
Sec. 8. (a) Each health maintenance organization shall establish guidelines for establishing reasonable periods of time within which an enrollee must be given an appointment with a participating provider, except as provided in section 9 of this chapter regarding emergency services.

(b) The guidelines described in subsection (a) must include appointment scheduling guidelines based on the type of health care services most often requested, including the following:

(1) Prenatal care appointments.

(2) Well-child visits and immunizations.

(3) Routine physicals.

(4) Adult preventive services.

(5) Urgent visits.


IC 27-13-36-9
Coverage and reimbursement for expenses for care obtained in an emergency
Sec. 9. (a) As used in this section, "care obtained in an emergency" means, with respect to an enrollee, covered services that
are:

(1) furnished by a provider within the scope of the provider's license and as otherwise authorized under law; and
(2) needed to evaluate or stabilize an individual in an emergency.

(b) As used in this section, "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(1) The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual.
(2) The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility.
(3) The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient setting.

(c) As described in subsection (d), each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency by an enrollee without:

(1) prior authorization; or
(2) regard to the contractual relationship between:
   (A) the provider who provided health care services to the enrollee in an emergency; and
   (B) the health maintenance organization;

in a situation where a prudent lay person could reasonably believe that the enrollee's condition required immediate medical attention. The emergency care obtained by an enrollee under this section includes care for the alleviation of severe pain, which is a symptom of an emergency as provided in IC 27-13-1-11.7.

(d) Each health maintenance organization shall cover and reimburse expenses for emergency services at a rate equal to the lesser of the following:

(1) The usual, customary, and reasonable charge in the health maintenance organization's service area for health care services provided during the emergency.
(2) An amount agreed to between the health maintenance organization and the out of network provider.

A provider that provides emergency services to an enrollee under this section may not charge the enrollee except for an applicable copayment or deductible. Care and treatment provided to an enrollee once the enrollee is stabilized is not care obtained in an emergency.


IC 27-13-36-10
Access plan to meet needs of vulnerable, underserved, and non-English speaking enrollees
Sec. 10. Each health maintenance organization shall demonstrate to the commissioner that the health maintenance organization has developed an access plan to meet the needs of the health maintenance organization's enrollees, including vulnerable and underserved enrollees and enrollees from major population groups who speak a primary language other than English.


IC 27-13-36-11
Standards for continuity of care

Sec. 11. The health maintenance organization shall develop standards for continuity of care following enrollment, including sufficient information on how to access care within the health maintenance organization.


IC 27-13-36-12
Payment to enrollee for service rendered by nonparticipating provider; requirements

Sec. 12. (a) As used in this section, "nonparticipating provider" means a provider that has not entered into an agreement with a health maintenance organization to serve as a participating provider.

(b) After September 30, 2009, if a health maintenance organization makes a payment to an enrollee for a health care service rendered by a nonparticipating provider, the health maintenance organization shall include with the payment instrument written notice to the enrollee that includes the following:

1. A statement specifying the claims covered by the payment instrument.
2. The name and address of the provider submitting each claim.
3. The amount paid by the health maintenance organization for each claim.
4. Any amount of a claim that is the enrollee's responsibility.
5. A statement in at least 24 point bold type that:
   A) instructs the enrollee to use the payment to pay the nonparticipating provider if the enrollee has not paid the nonparticipating provider in full;
   B) specifies that paying the nonparticipating provider is the enrollee's responsibility; and
   C) states that the failure to make the payment violates the law and may result in collection proceedings or criminal penalties.

As added by P.L.144-2009, SEC.3.
IC 27-13-36.2
Chapter 36.2. Provider Payment

IC 27-13-36.2-1
"Clean claim" defined
Sec. 1. As used in this chapter, "clean claim" means a claim submitted by a provider for payment for health care services provided to an enrollee that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

IC 27-13-36.2-2
"Health maintenance organization" defined
Sec. 2. As used in this chapter, "health maintenance organization" includes:
(1) an insurance administrator that:
   (A) collects charges or premiums; and
   (B) adjusts or settles claims;
in connection with coverage under a contract with a health maintenance organization; and
(2) a limited service health maintenance organization.

IC 27-13-36.2-3
Notice of deficiencies in claims
Sec. 3. (a) A health maintenance organization shall pay or deny each clean claim in accordance with section 4 of this chapter.
(b) A health maintenance organization shall notify a provider of any deficiencies in a submitted claim not more than:
   (1) thirty (30) days for a claim that is filed electronically; or
   (2) forty-five (45) days for a claim that is filed on paper;
and describe any remedy necessary to establish a clean claim.
(c) Failure of a health maintenance organization to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

IC 27-13-36.2-4
Payment or denial of claims; interest
Sec. 4. (a) A health maintenance organization shall pay or deny each clean claim as follows:
   (1) If the claim is filed electronically, not more than thirty (30) days after the date the claim is received by the health maintenance organization.
   (2) If the claim is filed on paper, not more than forty-five (45) days after the date the claim is received by the health maintenance organization.
(b) If:
   (1) a health maintenance organization fails to pay or deny a
clean claim in the time required under subsection (a); and
(2) the health maintenance organization subsequently pays the
claim;
the health maintenance organization shall pay the provider that
submitted the claim interest on the lesser of the usual, customary, and
reasonable charge for the health care services provided to the enrollee
or an amount agreed to between the health maintenance organization
and the provider paid under this section.
(c) Interest paid under subsection (b):
(1) accrues beginning:
   (A) thirty-one (31) days after the date the claim is filed under
   subsection (a)(1); or
   (B) forty-six (46) days after the date the claim is filed under
   subsection (a)(2); and
(2) stops accruing on the date the claim is paid.
(d) In paying interest under subsection (b), a health maintenance
organization shall use the same interest rate as provided in
IC 12-15-21-3(7)(A).
SEC.4.
IC 27-13-36.2-5
Permitted forms
Sec. 5. A provider shall submit only the following forms for
payment by a health maintenance organization:
   (1) HCFA-1500.
   (2) HCFA-1450 (UB-92).
   (3) American Dental Association (ADA) claim form.
IC 27-13-36.2-6
Civil penalties
Sec. 6. (a) If the commissioner finds that a health maintenance
organization has failed during any calendar year to process and pay
clean claims in compliance with this chapter, the commissioner may
assess an aggregate civil penalty against the health maintenance
organization according to the following schedule:
(1) If the health maintenance organization has paid at least
eighty-five percent (85%) but less than ninety-five percent
(95%) of all clean claims received from all providers during the
calendar year in compliance with this chapter, a civil penalty of
up to ten thousand dollars ($10,000).
(2) If the health maintenance organization has paid at least sixty
percent (60%) but less than eighty-five percent (85%) of all
clean claims received from all providers during the calendar
year in compliance with this chapter, a civil penalty of at least
ten thousand dollars ($10,000) but not more than one hundred
thousand dollars ($100,000).
(3) If the health maintenance organization has paid less than
sixty percent (60%) of all clean claims received from all
providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

(b) In determining the amount of a civil penalty under this section, the commissioner shall consider whether the health maintenance organization's failure to achieve the standards established by this chapter is due to circumstances beyond the health maintenance organization's control.

(c) A health maintenance organization may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the health maintenance organization receives notice of the assessment of the fine.

(d) If the commissioner imposes a civil penalty under this section, the commissioner may not impose a penalty against the health maintenance organization under IC 27-4-1 for the same activity.

(e) Civil penalties collected under this section shall be deposited in the state general fund.


IC 27-13-36.2-7
Repealed
(Repealed by P.L.1-2007, SEC.248.)

IC 27-13-36.2-8
Claim payment errors
Sec. 8. (a) A health maintenance organization may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the health maintenance organization:

1. request that the provider repay the overpayment; or  
2. adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.

(b) A health maintenance organization may not be required to correct a payment error to a provider more than two (2) years after the date on which a payment on a provider claim was made to the provider by the health maintenance organization.

(c) This section does not apply in cases of fraud by the provider, the enrollee, or the health maintenance organization with respect to the claim on which the overpayment or underpayment was made.

As added by P.L.55-2006, SEC.3.

IC 27-13-36.2-9
Claim overpayment adjustment
Sec. 9. Every subsequent claim that is adjusted by a health maintenance organization for reimbursement on an overpayment of a previous provider claim made to the provider must be accompanied by an explanation of the reason for the adjustment, including:
(1) an identification of:
   (A) the claim on which the overpayment was made; and
   (B) if ascertainable, the party financially responsible for the amount overpaid; and

(2) the amount of the overpayment that is being reimbursed to the health maintenance organization through the adjusted subsequent claim.

As added by P.L.55-2006, SEC.4.
IC 27-13-37
Chapter 37. Patient Protection; Choice of Health Care Professional

IC 27-13-37-1
Enrollees allowed to choose primary care provider from list
Sec. 1. (a) A health maintenance organization shall allow each enrollee of the health maintenance organization to choose the enrollee's own primary care provider from a list of participating primary care providers within the health maintenance organization.
(b) The list described in subsection (a) shall be updated semiannually and must include a sufficient number of primary care providers that accept new enrollees. The list must be:
   (1) provided to each enrollee annually; and
   (2) sent to an enrollee at the enrollee's request.

IC 27-13-37-2
Use of participating provider other than primary care provider
Sec. 2. (a) Each health maintenance organization shall develop a system to allow an enrollee to use an appropriate participating provider to manage the enrollee's medical condition when the enrollee's primary care provider determines that the use of another appropriate participating provider is warranted by the enrollee's medical condition.
(b) A primary care provider who makes the required determination under subsection (a) shall refer the enrollee to a participating provider whom the primary care provider determines is appropriate.
(c) A health maintenance organization shall provide coverage under this section for treatment received by an enrollee from an appropriate participating provider when the enrollee is referred to the participating provider as provided in this section for as long as the treatment is appropriate for the medical condition, subject to the terms and conditions of the enrollee's contract with the health maintenance organization.
(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a referral allowed under this section.

IC 27-13-37-3
Continuity of care and referrals when specialty care warranted
Sec. 3. Beginning July 1, 1999, each health maintenance organization shall provide continuity of care and referral to appropriate participating providers when specialty care is warranted, including the following:
   (1) Enrollees have access to appropriate participating providers on a timely basis.
   (2) Enrollees have a choice of appropriate participating
providers when a referral is made.  
*As added by P.L.69-1998, SEC.15.*

**IC 27-13-37-4**  
**Point-of-service products; dental care services**  
Sec. 4. (a) Each health maintenance organization shall offer to each purchaser of a group contract or individual contract a point-of-service product to the extent permitted by IC 27-13-13-8.  
(b) Beginning July 1, 2001, a limited service health maintenance organization that provides dental care services shall offer to each purchaser of a group contract or individual contract:  
(1) a point-of-service product to the extent permitted by IC 27-13-34-10(a)(6);  
(2) a preferred provider plan (as defined in IC 27-8-11-1); or  
(3) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);  
that provides dental care services.  

**IC 27-13-37-5**  
**Second medical opinions**  
Sec. 5. Each health maintenance organization shall allow an enrollee who has received a medical opinion from a participating provider to obtain a second medical opinion from an appropriate participating provider concerning the enrollee's medical condition at the enrollee's request.  
*As added by P.L.69-1998, SEC.15.*
IC 27-13-37.5
Chapter 37.5. Mail Order and Internet Pharmacy Designation

IC 27-13-37.5-0.1
Application of chapter
Sec. 0.1. This chapter applies to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2003.
As added by P.L.220-2011, SEC.462.

IC 27-13-37.5-1
"Mail order or Internet based pharmacy"
Sec. 1. As used in this chapter, "mail order or Internet based pharmacy" has the meaning set forth in IC 25-26-18-1.
As added by P.L.251-2003, SEC.5.

IC 27-13-37.5-2
Designation of mail order or Internet based pharmacy
Sec. 2. (a) A health maintenance organization may designate, under an individual contract or a group contract that provides coverage for prescription drugs, a mail order or an Internet based pharmacy to provide prescription drugs to an enrollee.
(b) A health maintenance organization may not require an enrollee to obtain a prescription drug from a pharmacy designated under subsection (a) as a condition of coverage.
As added by P.L.251-2003, SEC.5.
IC 27-13-38
Chapter 38. Patient Protection; Drugs and Devices; Drug Utilization Review Program

IC 27-13-38-1
Drugs and devices formularies
Sec. 1. (a) A health maintenance organization may apply a formulary to the prescription drug and devices benefits provided by the health maintenance organization if the formulary is developed, reviewed, and updated:
(1) in consultation with; and
(2) with the approval of;
a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.
(b) If a health maintenance organization maintains one (1) or more drug and devices formularies, the health maintenance organization shall do the following:
(1) Disseminate to participating providers and pharmacists the complete drug and devices formulary or formularies maintained by the health maintenance organization, including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.
(2) Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost sharing beyond that provided for in the enrollee's covered benefits with the health maintenance organization, coverage for a specific, medically necessary and appropriate nonformulary drug or device without prior approval from the health maintenance organization.
(c) A health maintenance organization may not:
(1) void a contract; or
(2) refuse to renew a contract;
between the health maintenance organization and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary drug or device as provided in subsection (b)(2).

IC 27-13-38-2
Substitution of brand name drugs
Sec. 2. Subject to IC 16-42-22:
(1) a pharmacist shall not substitute; and
(2) a health maintenance organization shall not require the substitution of;
a different single source brand name drug for a single source brand name drug written on a prescription form or electronically transmitted to a pharmacy unless the substitution is approved by the prescribing provider.
IC 27-13-38-3
Drug utilization review programs; contents
Sec. 3. Each health maintenance organization that has a prescription drug benefit shall establish and operate, or cause to be established and operated, a drug utilization review program that includes the following:

(1) Retrospective review of prescription drugs furnished to enrollees.
(2) Education of physicians, enrollees, and pharmacists regarding the appropriate use of prescription drugs.
(3) Ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees.
(4) Clinically relevant criteria and standards for drug therapy.
(5) Nonproprietary criteria and standards, developed and revised through an open, professional consensus process.
(6) Interventions that focus on improving therapeutic outcomes, including prospective drug utilization review programs that monitor for possible prescription drug problems or complications, including drug to disease interactions, drug to drug interactions, or therapeutic duplication.


IC 27-13-38-4
Drug utilization review programs; primary emphasis
Sec. 4. The primary emphasis of the drug utilization review program established under section 3 of this chapter is to enhance quality of care for enrollees by assuring appropriate drug therapy.


IC 27-13-38-5
Drug utilization review programs; confidentiality of enrollees
Sec. 5. The name of an enrollee that is discovered in the course of the drug utilization review program shall remain confidential.


IC 27-13-38-6
Adoption of rules
Sec. 6. The commissioner, with input and assistance from the state health commissioner, may adopt rules under IC 4-22-2 to implement this chapter.

IC 27-13-39
Chapter 39. Patient Protection; Experimental Treatments

IC 27-13-39-1
Procedures regarding experimental treatments

Sec. 1. (a) A health maintenance organization shall develop and implement a procedure to evaluate whether to provide coverage for new medical technologies and new applications of existing medical technologies, including medical treatments, procedures, drugs, and devices.

(b) A health maintenance organization shall maintain the procedure required under subsection (a) in writing. The written procedure shall describe the process used to determine whether the health maintenance organization will provide coverage for new medical technologies and new uses of existing medical technologies.

(c) The procedure required under this section shall include a review of information from appropriate governmental regulatory bodies and published scientific literature about new medical technologies and new uses of existing medical technologies.

(d) A health maintenance organization shall include appropriate professionals in the decision making process to determine whether new medical technologies and new uses of existing medical technologies qualify for coverage.


IC 27-13-39-2
Disclosure of coverage limitations

Sec. 2. (a) A health maintenance organization that limits coverage for experimental treatments, procedures, drugs, or devices must clearly state the limitations in any contract, policy, agreement, or certificate of coverage.

(b) The disclosure required under subsection (a) must include the following:

(1) A description of the process used to make the determination regarding a limitation under subsection (a).

(2) A description of the criteria the health maintenance organization uses to determine whether a treatment, procedure, drug, or device is experimental, as provided in section 1 of this chapter.


IC 27-13-39-3
Written explanation of denial of coverage of experimental treatment; review

Sec. 3. (a) If a health maintenance organization denies coverage for a treatment, procedure, drug, or device on the grounds that the treatment, procedure, drug, or device is experimental, the health maintenance organization shall provide the enrollee with a written explanation that includes the following:

(1) The basis for the denial.
(2) The enrollee's right to appeal the health maintenance organization's decision as provided in IC 27-8-16-8, IC 27-8-17-12, and IC 27-13-10.

(3) The telephone number of:
   (A) an individual employed by the health maintenance organization whom; or
   (B) a department of the health maintenance organization that; the enrollee may contact for assistance in initiating an appeal of the health maintenance organization's decision.

(b) An enrollee is entitled to a review that takes not more than seventy-two (72) hours if the enrollee's health situation is life threatening or is an emergency.

*As added by P.L.69-1998, SEC.17.*
IC 27-13-40
Chapter 40. Patient Protection; Health Maintenance Organization Comparison Sheets

IC 27-13-40-1
Availability of comparison sheets
Sec. 1. Beginning January 1, 2000, each health maintenance organization shall make available a health maintenance organization comparison sheet for each policy or contract that either covers or is marketed to an Indiana resident or the resident's employer.

IC 27-13-40-2
Requirements for comparison sheets
Sec. 2. (a) The comparison sheet required under section 1 of this chapter must include information of general interest to:
(1) purchasers of group contracts and individual contracts; and
(2) individuals covered by each group contract or individual contract.
(b) The comparison sheet must be designed to facilitate comparison of different health maintenance organizations.

IC 27-13-40-3
Persons to be provided comparison sheets
Sec. 3. A health maintenance organization shall provide a completed health maintenance organization comparison sheet to the following:
(1) Upon request, to an enrollee or subscriber or to the enrollee's or subscriber's employer.
(2) As part of the health maintenance organization's marketing materials, to a person or an employer that may be interested in purchasing or obtaining coverage under a group contract or individual contract offered by the health maintenance organization.
IC 27-13-41
Chapter 41. Claims

IC 27-13-41-1
Use of diagnostic or procedure codes
Sec. 1. Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this section:
(1) a health maintenance organization and a limited service health maintenance organization shall begin using the most current version of the:
(A) current procedural terminology (CPT);
(B) international classification of diseases (ICD);
(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
(D) current dental terminology (CDT);
(E) Healthcare common procedure coding system (HCPCS); and
(F) third party administrator (TPA);
codes under which the health maintenance organization and limited service health maintenance organization pay claims for health care services covered under an individual contract or a group contract; and
(2) a provider shall begin using the most current version of the:
(A) current procedural terminology (CPT);
(B) international classification of diseases (ICD);
(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
(D) current dental terminology (CDT);
(E) Healthcare common procedure coding system (HCPCS); and
(F) third party administrator (TPA);
codes under which the provider submits claims for payment for health care services covered under an individual contract or a group contract.


IC 27-13-41-2
Reimbursement
Sec. 2. If a provider provides health care services that are covered under an individual contract or a group contract:
(1) after the effective date of the most current version of a diagnostic or procedure code described in section 1 of this chapter; and
(2) before the health maintenance organization or limited service health maintenance organization begins using the most current version of the diagnostic or procedure code;
the health maintenance organization or limited service health maintenance organization shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the
date that the health care services were provided. 

*As added by P.L.161-2001, SEC. 5.*
IC 27-13-42
Chapter 42. Specific Reporting Requirements

IC 27-13-42-1
Allowing a health maintenance organization to report the number of children enrollees who are prescribed stimulant medication for the treatment of certain disorders

Sec. 1. A health maintenance organization that enters into an individual contract or a group contract that provides a prescription drug benefit may report to the drug utilization review board established by IC 12-15-35-19, not later than October 1 of each calendar year, the number of enrollees who are:
(1) less than eighteen (18) years of age; and
(2) prescribed a stimulant medication approved by the federal Food and Drug Administration for the treatment of attention deficit disorder or attention deficit hyperactivity disorder.

IC 27-13-43
Chapter 43. Credentialing

IC 27-13-43-1
Application of chapter

Sec. 1. (a) Except as provided in subsection (b), this chapter applies to a health maintenance organization that provides basic health care services.

(b) This chapter does not apply to the credentialing of a provider by a health maintenance organization if the provider's application for credentialing is only for purposes of providing health care services to the following:

1. A Medicaid recipient under a Medicaid risk based managed care program described in IC 12-15-12.
2. An individual who is covered under the children's health insurance program established under IC 12-17.6-2.


IC 27-13-43-2
Provider credentialing

Sec. 2. (a) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by:

1. a provider who applies for credentialing by a health maintenance organization; and
2. a health maintenance organization that performs credentialing activities.

(b) A health maintenance organization shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than thirty (30) business days after the health maintenance organization receives the completed credentialing application form.

(c) A health maintenance organization shall notify a provider concerning the status of the provider's completed credentialing application not later than:

1. sixty (60) days after the health maintenance organization receives the completed credentialing application form; and
2. every thirty (30) days after the notice is provided under subdivision (1), until the health maintenance organization makes a final credentialing determination concerning the provider.