HOUSE BILL No. 1003

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8-7; IC 6-3.1-38; IC 27-1.

Synopsis: Health matters. Allows a credit against an employer's state tax liability if the employer has adopted a health reimbursement arrangement in lieu of a traditional employer provided health insurance plan. Provides that the amount of the credit depends on the number of employees employed by the employer. Provides that employers that claim and are allowed the credit must report certain information to the department of insurance. Provides that the amount of credits granted may not exceed $10,000,000 in a taxable year. Provides that the credit may be carried over for 10 years, but may not be carried back. Prohibits a health provider facility from entering into a health provider contract with a health carrier if the reimbursement under the provider contract would result in the health provider facility being reimbursed at greater than 10% for a service or item of any other health provider contract the health provider facility has entered into with another health carrier. Requires a health plan to provide a peer to peer conversation if the health plan makes an adverse determination concerning a health care provider's request for prior authorization of a health care service. Prohibits a health plan, after December 31, 2024, from requiring a health provider to obtain prior authorization for a particular type of health care service if the health provider meets specified requirements. Specifies requirements a health plan must meet in order to rescind a health provider's exemption from prior authorization. Requires the insurance commissioner to adopt rules concerning the prior authorization exemption and rescission.

Effective: July 1, 2023; January 1, 2024.

Snow, Lehman, Carbaugh

January 12, 2023, read first time and referred to Committee on Insurance.

Introduced

First Regular Session of the 123rd General Assembly (2023)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2022 Regular Session of the General Assembly.

HOUSE BILL No. 1003

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

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

SECTION 1. IC 5-10-8-7, AS AMENDED BY P.L.119-2022, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 7. (a) The state, excluding state educational institutions, may not purchase or maintain a policy of group insurance, except:

(1) life insurance for the state's employees;

(2) long term care insurance under a long term care insurance policy (as defined in IC 27-8-12-5), for the state's employees; or

(3) an insurance policy that provides coverage that supplements coverage provided under a United States military health care plan.

(b) With the consent of the governor, the state personnel department may establish self-insurance programs to provide group insurance other than life or long term care insurance for state employees and retired state employees. The state personnel department may contract with a private agency, business firm, limited liability company, or corporation for administrative services. A commission may not be paid for the placement of the contract. The department may require, as part of a

contract for administrative services, that the provider of the administrative services offer to an employee terminating state employment the option to purchase, without evidence of insurability, an individual policy of insurance.

(c) Notwithstanding subsection (a), with the consent of the governor, the state personnel department may contract for health services for state employees through one (1) or more prepaid health care delivery plans.

(d) The state personnel department shall adopt rules under IC 4-22-2 to establish long term and short term disability plans for state employees (except employees who hold elected offices (as defined by IC 3-5-2-17)). The plans adopted under this subsection may include any provisions the department considers necessary and proper and must:

(1) require participation in the plan by employees with six (6) months of continuous, full-time service;

(2) require an employee to make a contribution to the plan in the form of a payroll deduction;

(3) require that an employee's benefits under the short term disability plan be subject to a thirty (30) day elimination period and that benefits under the long term plan be subject to a six (6) month elimination period;

(4) prohibit the termination of an employee who is eligible for benefits under the plan;

(5) except as provided in section 25 of this chapter, provide, after a seven (7) day elimination period, eighty percent (80%) of base biweekly wages for an employee disabled by injuries resulting from tortious acts, as distinguished from passive negligence, that occur within the employee's scope of state employment;

(6) provide that an employee's benefits under the plan may be reduced, dollar for dollar, if the employee derives income from:

(A) Social Security;

(B) the public employees' retirement fund;

(C) the Indiana state teachers' retirement fund;

(D) pension disability;

(E) worker's compensation;

(F) benefits provided from another employer's group plan; or

(G) remuneration for employment entered into after the disability was incurred.

(The department of state revenue and the department of workforce development shall cooperate with the state personnel department to confirm that an employee has disclosed complete and accurate

information necessary to administer this subdivision.);

(7) provide that an employee will not receive benefits under the plan for a disability resulting from causes specified in the rules; and

(8) provide that, if an employee refuses to:

(A) accept work assignments appropriate to the employee's medical condition;

(B) submit information necessary for claim administration; or

(C) submit to examinations by designated physicians;

the employee forfeits benefits under the plan.

(e) This section does not affect insurance for retirees under IC 5-10.3 or IC 5-10.4.

(f) The state may pay part of the cost of self-insurance or prepaid health care delivery plans for its employees.

(g) A state agency may not provide any insurance benefits to its employees that are not generally available to other state employees, unless specifically authorized by law.

(h) The state may pay a part of the cost of group medical and life coverage for its employees.

(i) To carry out the purposes of this section, a trust fund may be established. The trust fund established under this subsection is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the trust fund established under this subsection by the state board of finance, the budget agency, or any other state agency. Money in a trust fund established under this subsection does not revert to the state general fund at the end of any state fiscal year. The trust fund established under this subsection consists of appropriations, revenues, or transfers to the trust fund under IC 4-12-1. Contributions to the trust fund are irrevocable. The trust fund must be limited to providing prefunding of annual required contributions and to cover OPEB liability for covered individuals. Funds may be used only for these purposes and not to increase benefits or reduce premiums. The trust fund shall be established to comply with and be administered in a manner that satisfies the Internal Revenue Code requirements concerning a trust fund for prefunding annual required contributions and for covering OPEB liability for covered individuals. All assets in the trust fund established under this subsection:

(1) are dedicated exclusively to providing benefits to covered individuals and their beneficiaries according to the terms of the health plan; and

(2) are exempt from levy, sale, garnishment, attachment, or other

legal process.

The trust fund established under this subsection shall be administered by the state personnel department. The expenses of administering the trust fund shall be paid from money in the trust fund. Notwithstanding IC 5-13, the treasurer of state shall invest the money in the trust fund not currently needed to meet the obligations of the trust fund in the same manner as money may be invested by the public employees' retirement fund under IC 5-10.3-5. However, the trustee may not invest the money in the trust in equity securities. The trustee shall also comply with the prudent investor rule set forth in IC 30-4-3.5. The trustee may contract with investment management professionals, investment advisors, and legal counsel to assist in the investment of the trust and may pay the state expenses incurred under those contracts from the trust. Interest that accrues from these investments shall be deposited in the trust fund.

(j) Nothing in this section prohibits the state personnel department from directly contracting with health care providers for health care services for state employees.

(k) The state personnel department shall ensure that the private entity it contracts with under subsection (b) for administration of the self-insurance programs for state employees and retired state employees complies with IC 27-1-37.6 concerning exemptions from requesting prior authorization for health care services.

SECTION 2. IC 6-3.1-38 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2024]:

Chapter 38. Health Reimbursement Arrangement Credit

Sec. 1. This chapter applies only to taxable years beginning after December 31, 2023.

Sec. 2. As used in this chapter, "qualified taxpayer" means an employer that is a corporation, a limited liability company, a partnership, or another entity that:

(1) has any state tax liability; and

(2) has adopted a health reimbursement arrangement in lieu of a traditional employer provided health insurance plan.

Sec. 3. As used in this chapter, "state tax liability" means a qualified taxpayer's total tax liability that is incurred under:

(1) IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax);

(2) IC 6-5.5 (the financial institutions tax); and

(3) IC 27-1-18-2 (the insurance premiums tax) or IC 6-8-15 (the nonprofit agricultural organization health coverage tax);

as computed after the application of the credits that, under

IC 6-3.1-1-2, are to be applied before the credit provided by this chapter.

Sec. 4. A qualified taxpayer is entitled to a credit against the qualified taxpayer's state tax liability for a qualified contribution as follows:

(1) For a qualified taxpayer with less than fifty (50) employees, up to two hundred dollars ($200) in the first year per covered life if the amount provided toward the health reimbursement arrangement is equal to or greater than either the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered life toward the employer provided health insurance plan during the previous benefit year. The credit under this subdivision decreases to one hundred dollars ($100) per covered life in the second year.

(2) For a qualified taxpayer with at least fifty (50) and less than two hundred fifty (250) employees, up to one hundred fifty dollars ($150) in the first year per covered life if the amount provided toward the health reimbursement arrangement is equal to or greater than either the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered life toward the employer provided health insurance plan during the previous benefit year. The credit under this subdivision decreases to seventy-five dollars ($75) per covered life in the second year.

(3) For a qualified taxpayer with at least two hundred fifty (250) employees, up to one hundred dollars ($100) in the first year per covered life if the amount provided toward the health reimbursement arrangement is equal to or greater than either the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered life toward the employer provided health insurance plan during the previous benefit year. The credit under this subdivision decreases to fifty dollars ($50) per covered life in the second year.

Sec. 5. Qualified taxpayers that claim the credit under this chapter are required to report to the department of insurance every three (3) years following the allowance of a credit under this

chapter in a manner prescribed by the department of insurance. The report must state whether or not the qualified taxpayer continued to offer the health reimbursement arrangement or reverted to a traditional employer sponsored plan. If the qualified taxpayer continued to offer the health reimbursement arrangement, the report must include information regarding the amount of the benefit.

Sec. 6. To receive the credit provided by this chapter, a qualified taxpayer must claim the credit on the qualified taxpayer's state tax return or returns in the manner prescribed by the department.

Sec. 7. The amount of tax credits granted under this chapter may not exceed ten million dollars ($10,000,000) in any taxable year.

Sec. 8. (a) The amount of the credit provided by this chapter that a qualified taxpayer uses during a particular taxable year may not exceed the state tax liability of the qualified taxpayer.

(b) If the amount of a credit determined under this chapter for a particular qualified taxpayer and a particular taxable year exceeds the qualified taxpayer's state tax liability for that taxable year, then the qualified taxpayer may carry the excess over to the immediately succeeding taxable years. The credit carryover may not be used for any taxable year that begins more than ten (10) years after the date on which the donation from which the credit results is made. The amount of the credit carryover from a taxable year shall be reduced to the extent that the carryover is used by the qualified taxpayer to obtain a credit under this chapter for any subsequent taxable year.

(c) A qualified taxpayer is not entitled to a carryback or refund of any unused credit.

Sec. 9. The department shall adopt rules under IC 4-22-2 to implement this chapter.

SECTION 3. IC 27-1-3-36 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 36. Before July 1, 2024, the insurance commissioner shall adopt rules under IC 4-22-2 to administer IC 27-1-37.6, including rules concerning:**

(1) the duties of a health plan:

(A) to determine during an evaluation period whether health care providers are entitled to an exemption from requesting prior authorization;

(B) to continue a health care provider's exemption for consecutive exemption periods unless the exemption is

rescinded; and

(C) to provide information to a health care provider concerning the health care provider's entitlement to an exemption;

(2) the rescission of a health care provider's exemption; and

(3) the review of the rescission of an exemption, including:

(A) the qualifications of the members of an independent review panel;

(B) the procedure for:

(i) initiating; and

(ii) conducting;

a review of a health care provider's exemption from prior authorization; and

(C) the compensation of the members of an independent review panel for conducting a review.

SECTION 4. IC 27-1-37-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 9. Beginning January 1, 2024, a health provider facility may not enter into, amend, or renew a health provider contract with a health carrier that, when implemented, would result in reimbursement to the health provider facility for any one (1) service or item that is greater than ten percent (10%) for that service or item of any other health provider contract the health provider has entered into with another health carrier.**

SECTION 5. IC 27-1-37.5-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 17. (a) As used in this section, "adverse determination" means:**

(1) a denial of a preauthorization for a covered benefit;

(2) a denial of a request for benefits for an individual on the ground that the treatment or covered benefit:

(A) is not medically necessary, appropriate, effective, or efficient; or

(B) would not be provided in or at the appropriate health care setting or level of care; or

(3) a denial of a request for benefits on the ground that the treatment or service is experimental or investigational.

(b) As used in this section, "clinical peer" means a practitioner or other health care provider who holds a nonrestricted license in a state of the United States and in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review.

(c) If an adverse determination is made by a health plan in response to a health care provider's request for prior authorization, the health plan must provide the health care provider with the opportunity to request a peer to peer conversation with a clinical peer regarding the adverse determination.

(d) A request made by a health care provider under subsection (c) may be made in writing or electronically.

(e) A peer to peer conversation under this section must take place not more than seven (7) business days after a request under subsection (c) is received by the health plan.

(f) The peer to peer conversation must be conducted between the health care provider and a clinical peer.

SECTION 6. IC 27-1-37.6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 37.6. Exemption From Health Care Service Prior Authorization

Sec. 1. This chapter applies after December 31, 2024.

Sec. 2. As used in this chapter, "evaluation period" refers to:

(1) the period of six (6) calendar months beginning January 1; or

(2) the period of six (6) calendar months beginning July 1;

during which a health care provider may qualify under section 9(c) of this chapter for an exemption from the requirement to obtain prior authorization from a particular health plan for a particular type of health care service.

Sec. 3. As used in this chapter, "exemption period" refers to the period of six (6) calendar months during which a health care provider, under section 9(c) or 9(d) of this chapter, is exempt from the requirement to request prior authorization from a particular health plan for a particular type of health care service.

Sec. 4. As used in this chapter, "health care provider" means an individual or entity that:

(1) is licensed, certified, registered, or regulated by an entity described in IC 25-0.5-11; and

(2) is authorized to provide health care services.

Sec. 5. (a) As used in this chapter, "health care provider fraud" means knowingly or intentionally taking any of the following actions:

(1) Submitting a false claim or causing a false claim to be submitted.

(2) Making a misrepresentation of fact to obtain a payment to which the health care provider would not otherwise be entitled.

(3) Soliciting, receiving, offering, or paying remuneration to induce or reward a referral for health care service.

(b) The term includes the following:

(1) Knowingly billing for services at a level of complexity higher than the complexity of the services that are actually provided or documented in the medical records.

(2) Knowingly billing for a health care service not furnished or provided, including falsifying records to show delivery of the health care service.

(3) Knowingly ordering a medically unnecessary health care service for a patient.

(4) Billing for an appointment that the patient did not keep.

Sec. 6. (a) As used in this chapter, "health care service" means a health care related service or product rendered or sold by a health care provider within the scope of the health care provider's license or legal authorization, including hospital, medical, surgical, mental health, and substance abuse services and products.

(b) The term does not include the following:

(1) Dental services.

(2) Vision services.

(3) Long term rehabilitation treatment.

(4) Pharmaceutical services or products.

Sec. 7. (a) As used in this chapter, "health plan" means any of the following:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(3) A self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.

(b) The term includes the following:

(1) The insurer that issues a policy of accident and sickness insurance described in subsection (a)(1).

(2) The health maintenance organization referred to in subsection (a)(2).

(3) The entity with which the state contracts for the administration of the self-insurance program established

under IC 5-10-8-7(b) to provide health care coverage.

Sec. 8. As used in this chapter, "prior authorization" means a health plan's approval of a health care service which, according to a requirement established by the health plan, must be obtained from the health plan before the health care service is provided in order for the health care service to be covered by the health plan.

Sec. 9. (a) The first evaluation period during which a health plan is required to determine whether health care providers are entitled to an exemption from requesting prior authorization begins on January 1, 2024. Each succeeding evaluation period begins immediately upon the expiration of the previous evaluation period.

(b) During each evaluation period, a health plan shall determine whether the health care providers requesting prior authorization for health care services during the evaluation period are entitled to an exemption under subsection (c). A health plan shall make this determination with respect to every health care provider that requests prior authorization from the health plan for a health care service during the evaluation period. A health care provider is not required to request or apply in any way for a determination as to the health care provider's entitlement to an exemption under subsection (c).

(c) If a health plan, during an evaluation period, approves at least ninety percent (90%) of a health care provider's requests for prior authorization for a particular type of health care service under the health plan's medical necessity criteria, the health plan may not require the health care provider to request prior authorization for that type of health care service for the entire duration of an exemption period of six (6) calendar months immediately following the evaluation period.

(d) After an exemption period during which a health care provider is entitled to an exemption under subsection (c) with respect to a particular type of health care service, the health care provider shall continue to be exempt from requesting prior approval from the health plan for that type of health care service for consecutive exemption periods unless the health plan rescinds the health care provider's exemption from prior authorization under section 11 of this chapter.

(e) A health care provider entitled under subsection (d) to a continuing exemption from the requirement to request prior authorization for a type of health care service shall be granted the continuing exemption without the need to request or apply in any way for the continuing exemption.

Sec. 10. (a) Not more than ten (10) business days after a health care provider qualifies under section 9(c) of this chapter for an exemption from requesting prior authorization, the health plan shall provide to the health care provider a notice that includes:

(1) a statement that the health care provider is entitled to the exemption;

(2) a list of each type of health care service and each health plan to which the exemption applies; and

(3) a statement concerning:

(A) the duration of the initial exemption period; and

(B) the continuance of the exemption for consecutive exemption periods under section 9(d) of this chapter.

(b) If a health plan determines that a health care provider that requested prior authorization for a particular type of health care service during an evaluation period is not entitled under section 9(c) of this chapter to an exemption from requesting prior authorization for that type of health care service, the health plan shall provide to the health care provider:

(1) actual statistics and data for the evaluation period; and

(2) other detailed information;

sufficient to demonstrate that the health care provider is not entitled to the exemption under section 9(c) of this chapter.

(c) If a health care provider submits a request for prior authorization for a health care service although the health care provider is exempt under section 9(c) or 9(d) of this chapter from requesting prior authorization for the health care service, the health plan must promptly provide a notice to the health care provider that includes:

(1) the information described in subsection (a)(1) through (a)(3); and

(2) a notification of any additional steps the health care provider must take to receive payment from the health plan for the health care service.

Sec. 11. (a) Except as provided in subsection (b), a health plan may rescind a health care provider's exemption from prior authorization only if the following conditions are met:

(1) The health plan may rescind the exemption:

(A) only in January or July; and

(B) only on the basis of health care services provided by the health care provider during one (1) exemption period.

(2) A determination must be made, based on a retrospective review of a random sample of at least five (5) and not more

than twenty (20) health care services of the type to which the exemption relates that were provided by the health care provider during the exemption period, that less than ninety percent (90%) of the health care services met the medical necessity criteria used by the health plan in determining eligibility for an exemption under section 9(c) of this chapter.

(3) The determination under subdivision (2):

(A) must be made by a physician licensed under IC 25-22.5; and

(B) if the exempt health care provider is a physician, must be made by a physician licensed under IC 25-22.5 who is qualified to practice:

(i) in the same medical specialty as the exempt health care provider; or

(ii) in a medical specialty similar to the medical specialty in which the exempt health care provider practices.

(4) The health plan must:

(A) notify the health care provider in writing of the rescission; and

(B) include with the notice provided under clause (A):

(i) a description of the sample information used to make the determination under subdivision (2); and

(ii) a plain language explanation of how the health care provider may initiate a review of the determination by an independent review panel under section 12 of this chapter.

The rescission of a health care provider's exemption under this subsection takes effect thirty (30) business days after the day on which the health care provider receives notification of the rescission under subdivision (4), except as provided in subsection (c).

(b) A health plan may rescind a health care provider's exemption from prior authorization without meeting the conditions set forth in subsection (a) if the health plan determines that:

(1) the health care provider has committed health care provider fraud in connection with one (1) or more health care services for which the health plan provided coverage; or

(2) the health care provider's license or legal authorization to provide health care services is suspended or has been revoked.

The rescission of a health care provider's exemption under this subsection takes effect when the health plan notifies the health care provider that the health care provider's exemption has been

rescinded under this subsection.

(c) If a health care provider's exemption is rescinded under subsection (a) and the health care provider initiates a review of the rescission under section 12 of this chapter less than thirty (30) business days after the day on which the health care provider receives notification of the rescission, the rescission of the health care provider's exemption is stayed pending the outcome of the review. If a health care provider's exemption is rescinded under subsection (b) and the health care provider initiates a review of the rescission, the rescission of the health care provider's exemption is not stayed pending the outcome of the review.

Sec. 12. (a) A health care provider whose exemption from requesting prior approval is rescinded under section 11(a) or 11(b) of this chapter may initiate a review of the rescission according to the rules adopted under IC 27-1-3-36.

(b) The review of the rescission of a health care provider's exemption shall be conducted by an independent review panel recognized by the insurance commissioner as meeting the qualifications established by the rules adopted under IC 27-1-3-36. The independent review panel shall review the rescission of the exemption according to:

(1) section 13 or 14 of this chapter; and

(2) the rules adopted under IC 27-1-3-36.

(c) A health plan may not require a health care provider to satisfy any prerequisite involving a process internal to the health plan before initiating a review of the rescission by an independent review panel.

(d) An independent review panel shall complete its review of the rescission of a health care provider's exemption not more than thirty (30) business days after the day on which the health care provider initiates the review of the rescission.

Sec. 13. (a) If a health care provider whose exemption from requesting prior approval is rescinded under section 11(a) of this chapter initiates a review of the rescission, the independent review panel shall review the rescission according to one (1) of the following:

(1) Except as provided in subdivision (2), the independent review panel shall determine whether at least ninety percent (90%) of the random sample of health care services reviewed under section 11(a)(2) of this chapter met the medical necessity criteria used by the health plan in determining eligibility for an exemption under section 9(c) of this chapter.

(2) The health care provider may request that the independent review panel consider a new random sample of not less than five (5) and not more than twenty (20) cases in which the health care provider provided health care services of the type to which the health care provider's exemption relates during the exemption period that was the subject of the review under section 11(a)(2) of this chapter. If the health care provider makes a request under this subdivision, the independent review panel shall base its determination on whether at least ninety percent (90%) of the health care services in the random sample reviewed under this subdivision met the medical necessity criteria used by the health plan in determining eligibility for an exemption under section 9(c) of this chapter.

(b) If the independent review panel determines under subsection (a)(1) or (a)(2) that at least ninety percent (90%) of the health care services reviewed met the medical necessity criteria used by the health plan in determining eligibility for an exemption under section 9(c) of this chapter, the health plan is bound by the determination under this subsection and shall restore the health care provider's exemption.

(c) If the independent review panel determines under subsection (a)(1) or (a)(2) that less than ninety percent (90%) of the health care services reviewed met the medical necessity criteria used by the health plan in determining eligibility for an exemption under section 9(c) of this chapter, the rescission of the health care provider's exemption takes effect five (5) business days after the day on which the independent review panel makes its determination under this section.

Sec. 14. (a) If a health care provider whose exemption from requesting prior approval is rescinded under section 11(b) of this chapter initiates a review of the rescission, the independent review panel's review of the rescission is limited to a determination of:

(1) whether the health care provider committed health care provider fraud in connection with one (1) or more health care services for which the health plan provided coverage; or

(2) whether the health care provider's license or legal authorization to provide health care services is suspended or has been revoked;

whichever applies.

(b) If the independent review panel determines that the health care provider did not commit health care provider fraud or that

the health care provider's license or legal authorization is not suspended or has not been revoked, the health plan is bound by the determination under this subsection and shall restore the health care provider's exemption.

(c) If the independent review panel determines that the health care provider committed health care provider fraud or that the health care provider's license or legal authorization is suspended or has been revoked, the health care provider's exemption remains rescinded.

Sec. 15. A health plan:

(1) shall promptly provide copies of all medical records and other documents requested by:

(A) the health care provider; or

(B) the independent review panel;

for the purposes of; and

(2) shall pay all costs of;

a review conducted by an independent review panel under sections 12 through 14 of this chapter.

Sec. 16. (a) This section applies under any of the following circumstances:

(1) A health plan rescinds a health care provider's exemption from prior authorization under section 11(a) of this chapter and the health care provider does not initiate a review of the rescission within the period allowed by section 11(c) of this chapter.

(2) A health plan rescinds a health care provider's exemption from prior authorization under section 11(a) of this chapter, the health care provider initiates a review of the rescission, and the determination of the independent review panel, as described in section 13(c) of this chapter, is not in favor of the health care provider.

(3) A health plan rescinds a health care provider's exemption from prior authorization under section 11(b) of this chapter and the health care provider does not initiate a review of the rescission within the period allowed by section 11(c) of this chapter.

(4) A health plan rescinds a health care provider's exemption from prior authorization under section 11(b) of this chapter, the health care provider initiates a review of the rescission, and the determination of the independent review panel, as described in section 14(c) of this chapter, is not in favor of the health care provider.

(b) Under the circumstances set forth in subsection (a)(1), the first evaluation period during which the health plan is again required to determine under section 9(c) of this chapter whether the health care provider is entitled to an exemption from requesting prior authorization is the first evaluation period beginning at least two (2) years after the health plan's rescission of the health care provider's exemption from prior authorization takes effect under section 11(a) of this chapter.

(c) Under the circumstances set forth in subsection (a)(2), the first evaluation period during which the health plan is again required to determine under section 9(c) of this chapter whether the health care provider is entitled to an exemption from requesting prior authorization is the first evaluation period beginning at least two (2) years after the health plan's rescission of the health care provider's exemption from prior authorization takes effect under section 13(c) of this chapter.

(d) Under the circumstances set forth in subsection (a)(3), the first evaluation period during which the health plan is again required to determine under section 9(c) of this chapter whether the health care provider is entitled to an exemption from requesting prior authorization is the first evaluation period beginning at least two (2) years after the health plan's rescission of the health care provider's exemption from prior authorization takes effect under section 11(b) of this chapter.

(e) Under the circumstances set forth in subsection (a)(4), the first evaluation period during which the health plan is again required to determine under section 11(c) of this chapter whether the health care provider is entitled to an exemption from requesting prior authorization is the first evaluation period beginning at least two (2) years after the health plan's rescission of the health care provider's exemption from prior authorization takes effect under section 11(b) of this chapter.