HOUSE BILL No. 1251

DIGEST OF INTRODUCED BILL

Citations Affected: IC 4-13-16.5-1; IC 5-10-8-17; IC 16-18-2-295.3; IC 16-21-2-17; IC 25-1-9; IC 27-8; IC 27-13.

Synopsis: Provider contracting. Specifies requirements for state employee plans, accident and sickness insurers, and health maintenance organizations related to use of contracted health care providers, referrals to and use of noncontracted health care providers, payment amounts, information provided to covered individuals, and independent review of determinations related to claims for services provided by contracted or noncontracted providers. Makes conforming amendments.

Effective: July 1, 2016.

Forestal

January 11, 2016, read first time and referred to Committee on Insurance.

Introduced

Second Regular Session of the 119th General Assembly (2016)

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 2015 Regular Session of the General Assembly.

HOUSE BILL No. 1251

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

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

SECTION 1. IC 4-13-16.5-1, AS AMENDED BY P.L.114-2010, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Commission" refers to the governor's commission on minority and women's business enterprises established under section 2 of this chapter.

(c) "Commissioner" refers to the deputy commissioner for minority and women's business enterprises of the department.

(d) "Contract" means any contract awarded by a state agency or, as set forth in section 2(f)(11) of this chapter, awarded by a recipient of state grant funds, for construction projects or the procurement of goods or services, including professional services. For purposes of this subsection, "goods or services" may not include the following when determining the total value of contracts for state agencies:

(1) Utilities.

(2) Health care services (as defined in ~~IC 27-8-11-1(c)).~~

IC 27-8-11-1(d)).

(3) Rent paid for real property or payments constituting the price of an interest in real property as a result of a real estate transaction.

(e) "Contractor" means a person or entity that:

(1) contracts with a state agency; or

(2) as set forth in section 2(f)(11) of this chapter:

(A) is a recipient of state grant funds; and

(B) enters into a contract:

(i) with a person or entity other than a state agency; and

(ii) that is paid for in whole or in part with the state grant funds.

(f) "Department" refers to the Indiana department of administration established by IC 4-13-1-2.

(g) "Minority business enterprise" or "minority business" means an individual, partnership, corporation, limited liability company, or joint venture of any kind that is owned and controlled by one (1) or more persons who are:

(1) United States citizens; and

(2) members of a minority group or a qualified minority nonprofit corporation.

(h) "Qualified minority or women's nonprofit corporation" means a corporation that:

(1) is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code;

(2) is headquartered in Indiana;

(3) has been in continuous existence for at least five (5) years;

(4) has a board of directors that has been in compliance with all other requirements of this chapter for at least five (5) years;

(5) is chartered for the benefit of the minority community or women; and

(6) provides a service that will not impede competition among minority business enterprises or women's business enterprises at the time a nonprofit applies for certification as a minority business enterprise or a women's business enterprise.

(i) "Owned and controlled" means:

(1) if the business is a qualified minority nonprofit corporation, a majority of the board of directors are minority;

(2) if the business is a qualified women's nonprofit corporation, a majority of the members of the board of directors are women; or

(3) if the business is a business other than a qualified minority or women's nonprofit corporation, having:

(A) ownership of at least fifty-one percent (51%) of the enterprise, including corporate stock of a corporation;

(B) control over the management and active in the day-to-day operations of the business; and

(C) an interest in the capital, assets, and profits and losses of the business proportionate to the percentage of ownership.

(j) "Minority group" means:

(1) Blacks;

(2) American Indians;

(3) Hispanics; and

(4) Asian Americans.

(k) "Separate body corporate and politic" refers to an entity established by the general assembly as a body corporate and politic.

(l) "State agency" refers to any authority, board, branch, commission, committee, department, division, or other instrumentality of the executive, including the administrative, department of state government.

SECTION 2. IC 5-10-8-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 17. (a) As used in this section, "care obtained in an emergency" means, with respect to a covered individual, health care services that are:**

(1) furnished by a health care provider within the scope of the health care 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, "covered individual" means an individual who is entitled to coverage under a state employee plan.

(c) As used in this section, "nonparticipating provider" means a health care provider that has not entered into a contract with a state employee plan to serve as a participating provider.

(d) As used in this section, "participating provider" means a health care provider that has entered into a contract with a state employee plan concerning terms and conditions of reimbursement, other than copayments or deductibles, by the state employee plan for health care services provided to covered individuals.

(e) As used in this section, "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to ensure, 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.

(f) As used in this section, "state employee plan" means one (1) of the following:

(1) A self-insurance program established under section 7(b) of this chapter to provide group health coverage.

(2) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

The term includes a person that pays or administers claims on behalf of a state employee plan described in subdivision (1) or (2).

(g) The following apply to a state employee plan that contracts with participating providers:

(1) The state employee plan shall provide the following to a covered individual:

(A) On an annual basis and in electronic or paper form, a directory of participating providers that includes the name, address, telephone number, and specialty of each participating provider.

(B) On the state employee plan's Internet web site, and in writing, annually updated information that will allow the covered individual to estimate out-of-pocket costs for health care services received:

(i) from a nonparticipating provider; and

(ii) in a particular geographic area;

based on the difference between what the state employee plan will pay for the health care services and the usual and customary cost of the health care services in the geographic area.

(C) Upon receiving notice that a particular health care provider is scheduled to render health care services to the covered individual, whether the health care provider is a participating provider and, if not, the approximate dollar amount that the state employee plan will pay for health care services rendered by the nonparticipating provider.

An approximate dollar amount provided under this clause is not binding on the state employee plan.

(2) The state employee plan shall:

(A) inform a covered individual that the covered individual may request the directory described in subdivision (1) in paper form; and

(B) provide the directory in paper form upon the request of the covered individual.

(3) When:

(A) a participating provider determines that a covered individual needs a particular health care service; and

(B) the state employee plan determines that the type of health care service needed by the covered individual to treat a specific condition is:

(i) covered by the state employee plan; and

(ii) not available from a participating provider;

the participating provider and the state employee plan shall refer the covered individual to an appropriate nonparticipating provider within a reasonable amount of time and within a reasonable geographic proximity of the covered individual.

(4) When a covered individual receives health care services from a nonparticipating provider to whom the covered individual was referred under subdivision (3), the following apply:

(A) The covered individual is liable only for the deductible, copayment, coinsurance, or other out-of-pocket expense, if any, that would apply if the health care services were provided by a participating provider.

(B) The state employee plan shall pay the nonparticipating provider the lesser of the following:

(i) An amount equal to the usual, customary, and reasonable charge payable in the geographic area for the health care services.

(ii) An amount agreed to between the state employee plan and the nonparticipating provider.

(C) The state employee plan or nonparticipating provider may not bill the covered individual for any difference between the nonparticipating provider's charge and the amount paid to the nonparticipating provider under this subdivision.

(5) A participating provider's contract with the state

employee plan may not provide for a financial or other penalty to the participating provider for making a determination described in subdivision (3).

(6) As described in subdivision (7), the state employee plan shall provide coverage for care obtained in an emergency by a covered individual without:

(A) prior authorization; or

(B) regard to the whether the health care provider that provided health care services to the covered individual in an emergency is a participating provider;

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

(7) The state employee plan shall provide coverage for care obtained in an emergency rendered by a nonparticipating provider at a rate equal to the lesser of the following:

(A) The usual, customary, and reasonable charge in the state employee plan's service area for health care services provided during the emergency.

(B) An amount agreed to between the state employee plan and the nonparticipating provider.

A nonparticipating provider that rendered care obtained in an emergency to a covered individual under this subdivision may not charge the covered individual except for an applicable copayment or deductible. Care and treatment provided to a covered individual once the covered individual is stabilized is not care obtained in an emergency.

(h) If a state employee plan does not use an independent review organization for reviews of grievances as described for accident and sickness insurers under IC 27-8-29 and health maintenance organizations under IC 27-13-10.1, the state personnel department shall, in cooperation with the department of insurance created by IC 27-1-1-1, adopt rules under IC 4-22-2 establishing a procedure for independent review of grievances for state employee plans that is substantially similar to the procedure established for accident and sickness insurers under IC 27-8-29.

SECTION 3. IC 16-18-2-295.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 295.3. "Provider contract" means**

an agreement with a health care provider relating to terms and conditions of reimbursement for health care services rendered by the health care provider to an individual who is covered under any of the following health benefit plans:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19).

(3) A self-insurance program established under IC 5-10-8-7(b), including a person that pays or administers claims on behalf of the self-insurance program.

(4) A prepaid health care delivery plan entered into under IC 5-10-8-7(c).

SECTION 4. IC 16-21-2-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 17. (a) As used in this section, "provider facility" refers to a hospital, an ambulatory outpatient surgery center, an abortion clinic, or a birthing center that is licensed under this chapter.**

(b) Before providing nonemergency health care services, a provider facility shall inform the patient of any provider contracts entered into by the provider facility (including the name and contact information of the health benefit plan with which the provider facility has entered into each provider contract).

(c) If a patient seeks health care services at a provider facility and the provider facility has not entered into a provider contract with the health benefit plan under which the patient is entitled to coverage for health care services, the provider facility shall, before rendering nonemergency health care services, inform the patient that the estimated charge for the health care services:

(1) is available upon request; and

(2) may increase if unanticipated complications occur.

(d) A physician who admits a patient to a provider facility shall inform the patient of:

(1) the name, contact information, and specialty of any other health professional who is scheduled to provide a health care service to the patient while the patient is in the provider facility; and

(2) a list of health benefit plans for which a health professional described in subdivision (1) has entered into a provider contract.

(e) A provider facility shall post in the public area of the

provider facility and on the provider facility's Internet web site, and make available in paper form upon request, the following:

(1) A list of health benefit plans for which the provider facility has entered into a provider contract.

(2) A warning that charges for physicians who render health care services in the provider facility are not part of the provider facility's charges.

(3) A warning that physicians who render health care services in the provider facility may not have entered into a provider contract for the same health benefit plans as the health benefit plans for which the provider facility has entered into a provider contract.

(4) The names and specialties of physicians who provide health care services in the provider facility and the manner in which each physician may be contacted to determine the health benefit plans for which the physician has entered into a provider contract.

SECTION 5. IC 25-1-9-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 2. **(a) Except as provided in subsection (b),** as used in this chapter, "practitioner" means an individual who holds:

(1) an unlimited license, certificate, or registration;

(2) a limited or probationary license, certificate, or registration;

(3) a temporary license, certificate, registration, or permit;

(4) an intern permit; or

(5) a provisional license;

issued by the board regulating the profession in question, including a certificate of registration issued under IC 25-20.

(b) As used in section 4.5 of this chapter, the term does not include an individual who holds a license, certification, registration, or permit issued under IC 25-19 or IC 25-38.1.

SECTION 6. IC 25-1-9-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 4.5. (a) As used in this section, "contracted provider" means a practitioner or facility that enters into a contract relating to terms and conditions of reimbursement for health care services rendered by the practitioner or facility to an individual who is covered under a health benefit plan.**

(b) As used in this chapter, "health benefit plan" means one (1) of the following:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19).

(3) A self-insurance program established under IC 5-10-8-7(b), including a person that pays or administers claims on behalf of the self-insurance program.

(4) A prepaid health care delivery plan entered into under IC 5-10-8-7(c).

(c) A practitioner who is a contracted provider shall do the following:

(1) Before providing nonemergency health care services, inform the patient of any health benefit plan (including the name and contact information of the health benefit plan) for which the practitioner is a contracted provider.

(2) If a patient seeks health care services and the practitioner is not a contracted provider for the health benefit plan under which the patient is entitled to coverage for health care services, the practitioner shall, before rendering nonemergency health care services, inform the patient that the estimated charge for the health care services:

(A) is available upon request; and

(B) may increase if unanticipated complications occur.

(3) Post in the public area of the practitioner's office and on the practitioner's Internet web site, and make available in paper form upon request, all the following:

(A) A list of health benefit plans for which the practitioner is a contracted provider.

(B) A warning that charges for health care services rendered by the practitioner in a facility may not be part of the facility's charges.

(C) A warning that a facility in which the practitioner provides health care services may not be a contracted provider for the same health benefit plans as the health benefit plans for which the practitioner is a contracted provider.

(D) The names of facilities in which the practitioner renders health care services and the manner in which each facility may be contacted to determine the health benefit plans for which the facility is a contracted provider.

(4) Upon the practitioner's admission of a patient to a facility, inform the patient of:

(A) the name, contact information, and specialty of any other practitioner who is scheduled to provide a health

care service to the patient while the patient is in the facility; and

(B) a list of health benefit plans for which a practitioner described in clause (A) is a contracted provider.

SECTION 7. IC 27-8-11-1, AS AMENDED BY P.L.26-2005, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Contracted provider" means a provider that has entered into an agreement with an insurer under section 3 of this chapter.

~~(b)~~ **(c)** "Credentialing" means a process through which an insurer makes a determination:

(1) based on criteria established by the insurer; and

(2) concerning whether a provider is eligible to:

(A) provide health care services to an insured; and

(B) receive reimbursement for the health care services;

under an agreement entered into between the provider and the insurer under section 3 of this chapter.

~~(c)~~ **(d)** "Health care services":

(1) means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization; and

(2) includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

~~(d)~~ **(e)** "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.

~~(e)~~ **(f)** "Insurer" means an insurance company authorized in this state to issue policies that provide reimbursement for expenses of health care services.

(g) "Noncontracted provider" means a provider that has not entered into an agreement with an insurer under section 3 of this chapter.

~~(f)~~ **(h)** "Person" means an individual, an agency, a political subdivision, a partnership, a corporation, an association, or any other entity.

~~(g)~~ **(i)** "Preferred provider plan" means an undertaking to enter into agreements with providers relating to terms and conditions of reimbursements for the health care services of insureds, members, or enrollees relating to the amounts to be charged to insureds, members, or enrollees for health care services.

~~(h)~~ **(j)** "Provider" means an individual or entity duly licensed or

legally authorized to provide health care services.

SECTION 8. IC 27-8-11-8, AS ADDED BY P.L.125-2005, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 8. **(a) As used in this section, "insurer" includes the following:**

(1) An administrator licensed under IC 27-1-25.

(2) A person that pays or administers claims on behalf of an insurer.

~~(a)~~ **(b)** An insurer ~~may~~ **shall** provide to an insured **the following:**

(1) On an annual basis and in electronic or paper form, a directory of **contracted** providers ~~with which the insurer has entered into an agreement under section 3 of this chapter.~~ **that includes the name, address, telephone number, and specialty of each contracted provider.**

(2) On the insurer's Internet web site and in writing, annually updated information that will allow the insured to estimate out-of-pocket costs for health care services received:

(A) from a noncontracted provider; and

(B) in a particular geographic area;

based on the difference between what the insurer will pay for the health care services and the usual and customary cost of the health care services in the geographic area.

(3) Upon receiving notice that a particular provider is scheduled to render health care services to the insured, whether the provider is a contracted provider and, if not, the approximate dollar amount that the insurer will pay for health care services rendered by the noncontracted provider. An approximate dollar amount provided under this subdivision is not binding on the insurer.

~~(b)~~ **(c)** An insurer ~~that provides a directory described in subsection (a)~~ shall:

(1) inform ~~the~~ **an** insured that the insured may request the directory **described in subsection (b)** in paper form; and

(2) provide the directory in paper form upon the request of the insured.

SECTION 9. IC 27-8-11-11, AS ADDED BY P.L.144-2009, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 11. ~~(a) As used in this section, "noncontracted provider" means a provider that has not entered into an agreement with an insurer under section 3 of this chapter.~~

~~(b)~~ After September 30, 2009, if an insurer makes a payment to an insured for a health care service rendered by a noncontracted provider,

the insurer shall include with the payment instrument written notice to the insured 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 insurer for each claim.

(4) Any amount of a claim that is the insured's responsibility.

(5) A statement in at least 24 point bold type that:

(A) instructs the insured to use the payment to pay the noncontracted provider if the insured has not paid the noncontracted provider in full;

(B) specifies that paying the noncontracted provider is the insured's responsibility; and

(C) states that the failure to make the payment violates the law and may result in collection proceedings or criminal penalties.

SECTION 10. IC 27-8-11-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 12. (a) As used in this section, "insurer" includes the following:**

(1) An administrator licensed under IC 27-1-25.

(2) A person that pays or administers claims on behalf of an insurer.

(b) When:

(1) a contracted provider determines that an insured needs a particular health care service; and

(2) the insurer determines that the type of health care service needed by the insured to treat a specific condition is:

(A) covered by the insurer; and

(B) not available from a contracted provider;

the contracted provider and the insurer shall refer the insured to an appropriate noncontracted provider within a reasonable amount of time and within a reasonable geographic proximity of the insured.

(c) When an insured receives health care services from a noncontracted provider to whom the insured was referred under subsection (b), the following apply:

(1) The insured is liable only for the deductible, copayment, coinsurance, or other out-of-pocket expense, if any, that would apply if the health care services were provided by a contracted provider.

(2) The insurer shall pay the noncontracted provider the lesser of the following:

(A) An amount equal to the usual, customary, and reasonable charge payable in the geographic area for the health care services.

(B) An amount agreed to between the insurer and the noncontracted provider.

(3) The insurer or noncontracted provider may not bill the insured for any difference between the noncontracted provider's charge and the amount paid to the noncontracted provider under this subsection.

(d) An agreement entered into by a provider and an insurer under section 3 of this chapter may not provide for a financial or other penalty to the contracted provider for making a determination described in subsection (b).

SECTION 11. IC 27-8-11-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 13. (a) As used in this section, "care obtained in an emergency" means, with respect to an insured, health care 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 ensure, 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), an insurer shall provide coverage for care obtained in an emergency by an insured without:

(1) prior authorization; or

(2) regard to the whether the provider who provided health care services to the insured in an emergency is a contracted

provider;

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

(d) An insurer shall provide coverage for care obtained in an emergency rendered by a noncontracted provider at a rate equal to the lesser of the following:

(1) The usual, customary, and reasonable charge in the insurer's service area for health care services provided during the emergency.

(2) An amount agreed to between the insurer and the noncontracted provider.

A noncontracted provider that rendered care obtained in an emergency to an insured under this subsection may not charge the insured except for an applicable copayment or deductible. Care and treatment provided to an insured once the insured is stabilized is not care obtained in an emergency.

SECTION 12. IC 27-8-29-12, AS AMENDED BY P.L.160-2011, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding the following:

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

(A) An adverse determination of appropriateness.

(B) An adverse determination of medical necessity.

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

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

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

(3) A determination made by the insurer or an agent of the insurer in connection with payment of a claim based on whether the service was provided by a contracted provider (as defined in IC 27-8-11-1) or a noncontracted provider (as defined in IC 27-8-11-1).

SECTION 13. IC 27-13-1-22.5 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 22.5. "Nonparticipating provider" means a provider that has not entered into a contract with a health maintenance organization to serve as a participating provider.**

SECTION 14. IC 27-13-9-1, AS AMENDED BY P.L.125-2005, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: 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.

(c) Upon receiving notice that a particular provider is scheduled to render health care services to an enrollee, a health maintenance organization shall inform the enrollee concerning whether the provider is a participating provider and, if not, the approximate dollar amount that the health maintenance organization will pay for health care services rendered by the nonparticipating provider. An approximate dollar amount provided under this subsection is not binding on the health maintenance organization.

SECTION 15. IC 27-13-10.1-1, AS AMENDED BY P.L.160-2011, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: 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.

(3) A determination made by the health maintenance organization or an agent of the health maintenance organization in connection with payment of a claim based on whether the service was provided by a participating provider or a nonparticipating provider.