SENATE BILL No. 249

DIGEST OF INTRODUCED BILL

Citations Affected: IC 25-1-9.8-20; IC 27-1; IC 27-2-28; IC 27-8; IC 27-13-15.

Synopsis: Health insurance transparency. Requires the commissioner of the department of insurance to provide an order directing the discontinuance of an illegal, unauthorized, or unsafe practice of an insurance company. Amends the deadlines by which a health plan must respond to a prior authorization request. Provides that a health plan may not require a participating provider to seek prior authorization for a particular health service if the health plan approved at least 90% of the prior authorization requests for the particular health service in the previous six month period. Requires a health plan to post notice of a technical issue with its claims submission system on the health plan's Internet web site. Requires a health plan to post on its Internet web site not later than February 1 of each year: (1) the 30 most frequently submitted CPT codes in the previous calendar year; and (2) the percentage of the 30 most frequently submitted CPT codes that were approved in the previous calendar year. Requires a health plan to provide annual and quarterly financial statements to the department of insurance. Establishes an approval process for a health plan's proposed premium rate increase of 5% or greater as compared to the previous calendar year. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule: (1) every two years; and (2) when three or more CPT code rates change in a 12 month period. Requires an insurer and a health maintenance organization to provide a contracted provider with notice of a proposed material change to the agreement between the insurer or health maintenance organization and the contracted provider at least 90 days prior to the proposed effective date.

(Continued next page)

Effective: July 1, 2022.

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January 10, 2022, read first time and referred to Committee on Health and Provider Services.

Digest Continued

Establishes requirements for the contents of a notice of a proposed material change. Requires an insurer or health maintenance organization to provide a contracted provider with notice at least 15 days prior to a change to an existing prior authorization, precertification, notification, referral program, edit program, or specific edits.

Introduced

Second Regular Session of the 122nd General Assembly (2022)

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 2021 Regular Session of the General Assembly.

SENATE BILL No. 249

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 25-1-9.8-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 20. A practitioner may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 2. IC 27-1-3-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 19. (a) Whenever the commissioner determines that any insurance company to which this article is applicable:

(1) is conducting its business contrary to law or in an unsafe or unauthorized manner;

(2) has had its capital or surplus fund impaired or reduced below the amount required by law; or

(3) has failed, neglected, or refused to observe and comply with

any **law,** order, or rule of the department or commissioner;

then the commissioner ~~may,~~ **shall,** by an order in writing addressed to the board of directors, board of trustees, attorney in fact, partners, or owners of or in any such insurance company, to direct the discontinuance of any such illegal, unauthorized, or unsafe practice, the restoration of an impairment to the capital or the surplus fund, or the compliance with any such law, order, or rule of the department or commissioner. The order shall be mailed to the last known principal office of the insurance company by certified or registered mail or delivered to an officer of the company and shall be considered to be received by the insurance company three (3) days after mailing or on the date of delivery.

(b) If the insurance company fails, neglects, or refuses to comply with the terms of that order within thirty (30) days after its receipt by the insurance company, or within a shorter period set out in the order if the commissioner determines that an emergency exists, the commissioner may, in addition to any other remedy conferred upon the department or the commissioner by law, bring an action against any such insurance company, its officers, and agents to compel that compliance.

(c) The action shall be brought by the commissioner in the Marion County circuit court. The action shall be commenced and prosecuted in accordance with the Indiana Rules of Trial Procedure, and relief for noncompliance of the order includes any remedy appropriate under the facts, including injunction, preliminary injunction, and temporary restraining order. In that action, a change of venue from the judge, but no change of venue from the county, is permitted.

SECTION 3. IC 27-1-37.5-10, AS ADDED BY P.L.208-2018, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 10. (a) This section applies to a request for prior authorization delivered to a health plan after December 31, 2019.

(b) A health plan shall accept a request for prior authorization delivered to the health plan by a covered individual's health care provider through a secure electronic transmission. A health care provider shall submit a request for prior authorization through a secure electronic transmission. A health plan shall provide for:

(1) a secure electronic transmission; and

(2) acknowledgment of receipt, by use of a transaction number or another reference code;

of a request for prior authorization and any supporting information.

(c) Subsection (b) does not apply and a health plan that requires prior authorization shall accept a request for prior authorization that is

not submitted through a secure electronic transmission if a covered individual's health care provider and the health plan have entered into an agreement under which the health plan agrees to process prior authorization requests that are not submitted through a secure electronic transmission because:

(1) secure electronic transmission of prior authorization requests would cause financial hardship for the health care provider;

(2) the area in which the health care provider is located lacks sufficient Internet access; or

(3) the health care provider has an insufficient number of covered individuals as patients or customers, as determined by the commissioner, to warrant the financial expense that compliance with subsection (b) would require.

(d) If a covered individual's health care provider is described in subsection (c), the health plan shall accept from the health care provider a request for prior authorization as follows:

(1) The prior authorization request must be made on the standardized prior authorization form established by the department under section 16 of this chapter.

(2) The health plan shall provide for secure electronic transmission and ~~acknowledgement~~ **acknowledgment** of receipt of the standardized prior authorization form and any supporting information for the prior authorization by use of a transaction number or another reference code.

(e) A health plan that utilizes a third party to review requests for prior authorization:

(1) may not require a covered individual's health care provider to submit a request for prior authorization to the third party; and

(2) must transmit a request for prior authorization provided by a covered individual's health care provider through secure electronic transmission to the third party.

SECTION 4. IC 27-1-37.5-11, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 11. (a) This section applies to a prior authorization request delivered to a health plan after December 31, 2019.

(b) A health plan shall respond to a request delivered under section 10 of this chapter as follows:

(1) If the request is delivered under section 10(b) of this chapter, the health plan shall immediately send to the requesting health care provider an electronic receipt for the request.

(2) If the request is for an urgent care situation, the health plan

shall respond with a prior authorization determination not more than ~~seventy-two (72)~~ **twenty-four (24)** hours after receiving the request.

(3) If the request is for a nonurgent care situation, the health plan shall respond with a prior authorization determination not more than ~~seven (7)~~ **two (2)** business days after receiving the request.

(c) If a request delivered under section 10 of this chapter is incomplete:

(1) the health plan shall respond within the period required by subsection (b) and indicate the specific additional information required to process the request;

(2) if the request was delivered under section 10(b) of this chapter, upon receiving the response under subdivision (1), the health care provider shall immediately send to the health plan an electronic receipt for the response made under subdivision (1); and

(3) if the request is for an urgent care situation, the health care provider shall respond to the request for additional information not more than ~~seventy-two (72)~~ **twenty-four (24)** hours after the health care provider receives the response under subdivision (1).

(d) If a request delivered under section 10 of this chapter is denied, the health plan shall respond within the period required by subsection (b) and indicate the specific reason for the denial **in clear and easy to understand language.**

SECTION 5. IC 27-1-37.5-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 13.5. (a) A health plan may not require a participating provider to obtain prior authorization for a particular health care service if, in the most recent six (6) month period, the health plan has approved at least ninety percent (90%) of the prior authorization requests submitted by the participating provider for the particular health care service.**

(b) A health plan must update a participating provider not later than January 1 and July 1 of each calendar year of the particular health care services that do not require prior authorization for the following six (6) month period under subsection (a).

(c) A health plan may rescind a participating provider's exemption from obtaining prior authorization for a particular health care service under subsection (a) if the health plan makes a determination, on the basis of a retrospective review of a random sample of not less than five (5) and not more than twenty (20) claims submitted by the participating provider during the most

recent six (6) month period, that less than ninety percent (90%) of the claims for the particular health care service met the medical necessity criteria that would have been used by the health plan when conducting prior authorization review for the particular health care service during the relevant six (6) month period. Nothing in this subsection prohibits a participating provider from qualifying for an exemption from obtaining prior authorization for a particular health care service in a future six (6) month period as provided for in subsection (a), even if an exemption was previously rescinded.

(d) A rescission by a health plan under subsection (c) must:

(1) be provided to the participating provider in writing not less than thirty (30) calendar days prior to the effective date of the rescission;

(2) include documentation of the random sample of claims; and

(3) include information on how the participating provider may appeal the rescission.

(e) If an exemption from obtaining prior authorization for a particular health care service granted under subsection (a) is rescinded by a health plan following review under subsection (c), a participating provider may appeal the rescission. After reviewing any supporting documentation submitted by the participating provider with the appeal, a health plan must make a decision on the appeal and provide the decision to the participating provider in writing not later than fourteen (14) calendar days after the health plan receives notice of the appeal.

SECTION 6. IC 27-1-46-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 18. A provider facility may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 7. IC 27-1-48 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]:

Chapter 48. Health Plan Transparency

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 2. As used in this chapter, "CPT code" refers to the medical billing code that applies to a specific health care service, as published in the Current Procedural Terminology code set

maintained by the American Medical Association.

Sec. 3. (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 or 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. 4. (a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:

(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) The Medicaid risk based managed care program under IC 12-15.

(b) The term includes a person that administers any of the following:

(1) A policy described in subsection (a)(1).

(2) A contract described in subsection (a)(2).

(3) Medicaid risk based managed care.

Sec. 5. As used in this chapter, "participating provider" refers to the following:

(1) A health care provider that has entered into an agreement with an insurer under IC 27-8-11-3.

(2) A participating provider (as defined in IC 27-13-1-24).

Sec. 6. As used in this chapter, "prior authorization" means a practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.

Sec. 7. (a) Within twenty-four (24) hours of the identification of a technical issue with a health plan's claims submission system that would require a participating provider to submit a second claim for the same health care service, the health plan must post notice

of the technical issue on the health plan's Internet web site.

(b) When a technical issue that was posted under subsection (a) is resolved, the health plan must post an update on the resolution of the technical issue on the health plan's Internet web site for not less than seventy-two (72) hours.

Sec. 8. (a) Not later than February 1 of each calendar year, a health plan must post on the health plan's Internet web site:

(1) the thirty (30) most frequently submitted CPT codes that were submitted by participating providers for prior authorization during the previous calendar year; and

(2) the percentage of the thirty (30) most frequently submitted CPT codes that were approved in the previous calendar year, disaggregated by CPT code.

(b) A health plan must maintain the information required under subsection (a) on the health plan's Internet web site, organized by year and on a single and easily accessible web page.

Sec. 9. (a) A health plan must file with the department:

(1) not later than February 1 of each calendar year, the amount of administrative fees charged by the health plan for each administrative service only contract for self-insured health plans, disaggregated by each contract, from the previous calendar year;

(2) not later than March 1 of each calendar year, the health plan's annual financial statement from the previous calendar year;

(3) not later than May 15 of each calendar year, the health plan's first quarter financial statement from the current calendar year;

(4) not later than August 15 of each calendar year, the health plan's second quarter financial statement from the current calendar year; and

(5) not later than November 15 of each calendar year, the health plan's third quarter financial statement from the current calendar year.

(b) The department must post the information filed under subsection (a) not later than ten (10) business days after receiving the information on the department's Internet web site on a single and easily accessible web page.

SECTION 8. IC 27-2-28 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]:

Chapter 28. Premium Rate Increases

Sec. 1. As used in this chapter, "health insurance policy" includes the following:

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

(2) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

Sec. 2. If the premium rate for a health insurance policy will increase five percent (5%) or greater as compared to the previous calendar year:

(1) the insurer must submit:

(A) the planned premium rate increase; and

(B) written justification for the planned premium rate increase;

to the commissioner or the commissioner's designee for review and approval prior to the planned premium rate increase going into effect. The department must post the written justification for the planned premium rate increase on the department's Internet web site not later than ten (10) calendar days after receiving the written justification for the planned premium rate increase;

(2) after reviewing the insurer's written justification for the planned premium rate increase, the commissioner or the commissioner's designee must approve or deny the insurer's planned premium rate increase in writing within twenty (20) calendar days;

(3) if the insurer's planned premium rate increase is denied by the commissioner or the commissioner's designee under subdivision (2), the insurer may submit:

(A) a lower planned premium rate increase; and

(B) written justification for the lower planned premium rate increase;

to the commissioner or the commissioner's designee for review and approval prior to the lower planned premium rate increase going into effect. The department must post the written justification for the lower planned premium rate increase on the department's Internet web site not later than ten (10) calendar days after receiving the written justification for the planned premium rate increase;

(4) after reviewing the insurer's written justification for the lower planned premium rate increase, the commissioner or the commissioner's designee must approve or deny the insurer's lower planned premium rate increase in writing

within twenty (20) calendar days; and

(5) if the commissioner or the commissioner's designee denies an insurer's lower planned premium rate increase submitted under subdivision (3), the insurer may not increase the premium rate five percent (5%) or more for that calendar year.

Sec. 3. If an insurer's planned premium rate increase of five percent (5%) or more is approved under section 2 of this chapter, the insurer must provide written justification of the premium rate increase to an individual or entity covered by the health insurance policy not less than thirty (30) days prior to the premium rate increase going into effect.

SECTION 9. IC 27-8-5.7-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 2.5. As used in this chapter, "CPT code" refers to the medical billing code that applies to a specific health care service, as published in the Current Procedural Terminology code set maintained by the American Medical Association.**

SECTION 10. IC 27-8-5.7-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 5. (a) An insurer shall pay or deny each clean claim in accordance with ~~section~~ **sections** 6 **and 6.5** of this chapter.

(b) An insurer 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 an insurer to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

SECTION 11. IC 27-8-5.7-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 6.5. (a) An insurer may not:**

(1) alter the CPT code submitted for a clean claim; and

(2) pay for a CPT code of lesser monetary value;

unless the medical record of the clean claim has been reviewed by an employee of the insurer who is licensed under IC 25-22.5. An employee of an insurer who is licensed under IC 25-22.5 and reviews medical records under this subsection is subject to review by the medical licensing board created by IC 25-22.5-2-1 for violations of the standards for the competent practice of medicine.

(b) An insurer may not deny payment for a clean claim based

solely on the location of the service, if the location of the service is in the contracted network of the insurer.

(c) An insurer may not alter a clean claim to only pay for the CPT codes necessary for an individual's final diagnosis, if the CPT codes billed were deemed medically necessary to reach the final diagnosis.

SECTION 12. IC 27-8-11-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 3. (a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with an insurer under subsection (a)(1), the insurer shall make available to the provider a written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(c) No hospital, physician, pharmacist, or other provider designated in IC 27-8-6-1 willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the terms and conditions established by the insurer for providers entering into

agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer's denial; and

(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

(d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

(e) No cause of action shall arise against any person or insurer for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.

Nor shall such a cause of action arise against any person or provider for furnishing personal or privileged information to an insurer. However, this subsection provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person, provider, or insurer.

(f) Nothing in this chapter abrogates the privileges and immunities established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).

(g) An insurer that enters into an agreement with a provider under subsection (a)(1) must provide the provider a current reimbursement rate schedule:

(1) every two (2) years; and

(2) when three (3) or more CPT code (as defined in IC 27-1-37.5-3) rates under the agreement are changed in a twelve (12) month period.

SECTION 13. IC 27-8-11-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 14. (a) As used in this section, "contracted provider" means a provider that has entered into an agreement with an insurer under section 3 of this chapter.**

(b) As used in this section, "material change" means a change to an agreement between a contracted provider and an insurer under section 3 of this chapter, the occurrence and timing of which are not otherwise clearly identified in the agreement, that:

(1) decreases the contracted provider's payment or compensation; or

(2) changes the administrative procedures in a way that may reasonably be expected to significantly increase the contracted provider's administrative expense.

The term includes changes to network requirements and inclusion

in any new or modified insurance products.

(c) Each insurer offering a preferred provider plan must establish procedures for modifying an existing agreement with a contracted provider that meet the requirements of this section.

(d) If an insurer offering a preferred provider plan intends to make a material change to an agreement it has entered into with a contracted provider under section 3 of this chapter, the insurer must provide the contracted provider with notice at least ninety (90) days prior to the proposed effective date of the material change. The notice must include:

(1) the proposed effective date of the material change;

(2) a description of the material change;

(3) a statement that the contracted provider has the option to either accept or reject the material change under this section;

(4) the name, business address, telephone number, and electronic mail address of a representative of the insurer who may discuss the material change, if requested by the contracted provider;

(5) notice of the opportunity to request a meeting using real time communication or to communicate via electronic mail to discuss the material change, if requested by the contracted provider; and

(6) notice that upon three (3) material changes in a twelve (12) month period, the contracted provider may request a copy of the agreement with the material changes incorporated into it.

Provision of a copy of the agreement by the insurer is for informational purposes only and does not affect the terms and conditions of the agreement.

(e) If a proposed material change relates to the contracted provider's inclusion in any new or modified insurance products or proposes changes to the contracted provider's networks:

(1) the material change will only take effect upon the acceptance of the contracted provider, evidenced by a written signature; and

(2) the notice of the material change must be sent by certified mail, return receipt requested.

(f) For any other proposed material change not addressed in subsection (e), the following requirements apply:

(1) The material change must take effect on the date provided in the notice, unless the contracted provider objects to the change under subdivision (2).

(2) A contracted provider who wishes to object to a material

change under this subsection must do so in writing, and the written protest must be delivered not later than thirty (30) days after the date the contracted provider receives notice of the material change.

(3) Not later than thirty (30) days after the insurer receives the contracted provider's objection under subdivision (2), the insurer and the contracted provider must confer in an effort to reach an agreement on the material change or any counter proposals offered by the contracted provider.

(4) If the insurer and the contracted provider fail to reach an agreement during the thirty (30) day period as described in subdivision (3), the insurer and the contracted provider are allowed thirty (30) days to unwind their relationship, provide notice to patients and other affected parties, and terminate the agreement pursuant to its original terms.

(5) The notice of a material change under this subsection must be sent in an orange envelope with the phrase "ATTENTION! AGREEMENT AMENDMENT ENCLOSED!" in at least 14 point bold font printed on the front of the envelope. This color of envelope must be used for the sole purpose of communicating material changes and may not be used for other types of communication from an insurer.

(g) If an insurer offering a preferred provider plan makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the insurer must provide notice of the change to a contracted provider not later than fifteen (15) days prior to the change.

(h) Any notice required to be mailed under this section must be sent to the contracted provider's point of contact, as set forth in the agreement. If no point of contact is set forth in the agreement, the insurer must send the notice to the contracted provider's place of business, addressed to the contracted provider.

SECTION 14. IC 27-13-15-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: 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) A health maintenance organization that enters into a contract with a participating provider must provide the participating provider with a current reimbursement rate schedule:

(1) every two (2) years; and

(2) when three (3) or more CPT code (as defined in IC 27-1-37.5-3) rates under the contract change in a twelve (12) month period.

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

SECTION 15. IC 27-13-15-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 7. (a) As used in this section, "material change" means a change to a contract between a participating provider and a health maintenance organization, the occurrence and timing of which are not otherwise clearly identified in the contract, that:**

(1) decreases the participating provider's payment or compensation; or

(2) changes the administrative procedures in a way that may reasonably be expected to significantly increase the participating provider's administrative expense.

The term includes changes to network requirements and inclusion in any new or modified insurance products.

(b) A health maintenance organization must establish procedures for modifying an existing contract with a participating provider that meet the requirements of this section.

(c) If a health maintenance organization intends to make a material change to a contract it has entered into with a participating provider under section 1 of this chapter, the health maintenance organization must provide the participating provider with notice at least ninety (90) days prior to the proposed effective date of the material change. The notice must include:

(1) the proposed effective date of the material change;

(2) a description of the material change;

(3) a statement that the participating provider has the option to either accept or reject the material change under this section;

(4) the name, business address, telephone number, and electronic mail address of a representative of the health maintenance organization who may discuss the material change, if requested by the participating provider;

(5) notice of the opportunity to request a meeting using real time communication or to communicate via electronic mail to discuss the material change, if requested by the participating provider; and

(6) notice that upon three (3) material changes in a twelve (12) month period, the participating provider may request a copy of the contract with the material changes incorporated into it.

Provision of a copy of the contract by the health maintenance organization is for informational purposes only and does not affect the terms and conditions of the contract.

(d) If a proposed material change relates to a participating provider's inclusion in any new or modified insurance products or proposes changes to a participating provider's networks:

(1) the material change will only take effect upon the acceptance of the participating provider, evidenced by a written signature; and

(2) the notice of the material change must be sent by certified mail, return receipt requested.

(e) For any other proposed material change not addressed in subsection (d), the following requirements apply:

(1) The material change must take effect on the date provided in the notice, unless the participating provider objects to the change under subdivision (2).

(2) A participating provider who wishes to object to a material change under this subsection must do so in writing, and the written protest must be delivered not later than thirty (30) days after the date the participating provider receives

notice of the material change.

(3) Not later than thirty (30) days after the health maintenance organization receives the participating provider's objection under subdivision (2), the health maintenance organization and the participating provider must confer in an effort to reach an agreement on the material change or any counter proposals offered by the participating provider.

(4) If the health maintenance organization and the participating provider fail to reach an agreement during the thirty (30) day period as described in subdivision (3), the health maintenance organization and the participating provider are allowed thirty (30) days to unwind their relationship, provide notice to patients and other affected parties, and terminate the contract pursuant to its original terms.

(5) The notice of a material change under this subsection must be sent in an orange envelope with the phrase "ATTENTION! AGREEMENT AMENDMENT ENCLOSED!" in at least 14 point bold font printed on the front of the envelope. This color of envelope must be used for the sole purpose of communicating material changes and may not be used for other types of communication from a health maintenance organization.

(f) If a health maintenance organization makes a change to a contract that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the health maintenance organization must provide notice of the change to a participating provider not later than fifteen (15) days prior to the change.

(g) Any notice required to be mailed under this section must be sent to the participating provider's point of contact, as set forth in the contract. If no point of contact is set forth in the contract, the health maintenance organization must send the notice to the participating provider's place of business, addressed to the participating provider.