March 24, 2017

ENGROSSED
HOUSE BILL No. 1439

DIGEST OF HB 1439 (Updated March 22, 2017 12:47 pm - DI 104)

Citations Affected: IC 12-7; IC 12-15; IC 16-38.

Synopsis: FSSA matters. Allows a Medicaid recipient who is incarcerated to have the recipient's Medicaid suspended for up to two years instead of one year before terminating the recipient's Medicaid eligibility. Defines "comprehensive risk contract" and "managed care organization" for purposes of Medicaid. Specifies that if a provision of Indiana insurance law conflicts with the administration of a law applying to a managed care organization with respect to the managed care organization's Medicaid responsibilities, the law applying to the managed care organization with respect to the Medicaid responsibilities is controlling. Changes language in the Medicaid law to reflect the existence of more than one risk based managed care program. Removes obsolete references to "primary care case management". Removes references to "insurer", "insurance", and "health maintenance organization" in the law concerning the healthy Indiana plan (plan) to reflect the sole use of managed care organizations to provide coverage under the plan. Allows the secretary of the office of family and social services to determine the amount, based on the individual's annual household income per year, that an individual must continue to contribute to the individual's health care account in order to participate in the plan. Requires that the federal government approve the contribution amount determined by the secretary. Makes conforming amendments. Makes a technical correction to a federal Code citation.

Effective: July 1, 2017.

Kirchhofer, Zent, Shackleford

(SENATE SPONSOR — CHARBONNEAU)

January 17, 2017, read first time and referred to Committee on Public Health.
January 26, 2017, amended, reported — Do Pass.
January 30, 2017, read second time, ordered engrossed. Engrossed.
January 31, 2017, read third time, passed. Yeas 98, nays 0.

SENATE ACTION

February 20, 2017, read first time and referred to Committee on Health and Provider Services.
March 23, 2017, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

March 24, 2017

First Regular Session of the 120th General Assembly (2017)

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 2016 Regular Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1439

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

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

SECTION 1. IC 12-7-2-40.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 40.4. "Comprehensive risk contract" has the meaning set forth in 42 CFR 438.2.**

SECTION 2. IC 12-7-2-126.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 126.9. "Managed care organization" means a person that has a comprehensive risk contract with the office of Medicaid policy and planning under IC 12-15.**

SECTION 3. IC 12-15-1-20.4, AS AMENDED BY P.L.185-2015, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 20.4. (a) If a Medicaid recipient is:

(1) adjudicated to be a delinquent child and placed in:

(A) a community based correctional facility for children;

(B) a juvenile detention facility; or

(C) a secure facility, not including a facility licensed as a

childcaring institution under IC 31-27; or

(2) incarcerated in a prison or jail; and

ineligible to participate in the Medicaid program during the placement described in subdivision (1) or (2) because of federal Medicaid law, the division of family resources, upon notice that a child has been adjudicated to be a delinquent child and placed in a facility described in subdivision (1) or upon notice that a person is incarcerated in a prison or jail and placed in a facility described in subdivision (2), shall suspend the person's participation in the Medicaid program for up to ~~one (1) year~~ **two (2) years** before terminating the person's eligibility.

(b) If the division of family resources receives:

(1) a dispositional decree under IC 31-37-19-28; or

(2) a modified disposition order under IC 31-37-22-9;

and the department of correction gives the division at least forty (40) days notice that a person will be released from a facility described in subsection (a)(1)(C) or (a)(2), the division of family resources shall take action necessary to ensure that a person described in subsection (a) is eligible to participate in the Medicaid program upon the person's release, if the person is eligible to participate.

SECTION 4. IC 12-15-2-14, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2017 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 14. (a) An individual:

(1) who is less than nineteen (19) years of age;

(2) who is not described in ~~42 U.S.C. 1396a(a)(10)(A)(I);~~ **42 U.S.C. 1396a(a)(10)(A)(i)(I);** and

(3) whose family income does not exceed the income level established in subsection (b);

is eligible to receive Medicaid.

(b) An individual described in this section is eligible to receive Medicaid, subject to 42 U.S.C. 1396a et seq., if the individual's family income does not exceed one hundred fifty percent (150%) of the federal income poverty level for the same size family.

~~(c) The office may apply a resource standard in determining the eligibility of an individual described in this section. This subsection expires December 31, 2013.~~

SECTION 5. IC 12-15-5-5, AS AMENDED BY P.L.101-2005, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 5. (a) The office may provide a prescription drug benefit to a Medicaid recipient in ~~the~~ **a** Medicaid risk based managed care program.

(b) If the office provides a prescription drug benefit to a Medicaid

recipient in ~~the~~ **a** Medicaid risk based managed care program:

(1) the office shall develop a procedure and provide the recipient's risk based managed care provider with information concerning the recipient's prescription drug utilization for the risk based managed care provider's case management program; and

(2) the provisions of IC 12-15-35.5 apply.

(c) If the office does not provide a prescription drug benefit to a Medicaid recipient in ~~the~~ **a** Medicaid risk based managed care program, a ~~Medicaid~~ managed care organization shall provide coverage and reimbursement for outpatient single source legend drugs subject to IC 12-15-35-46, IC 12-15-35-47, and IC 12-15-35.5.

SECTION 6. IC 12-15-5-13, AS AMENDED BY P.L.8-2016, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 13. (a) The office shall provide coverage for treatment of opioid or alcohol dependence that includes the following:

(1) Counseling services that address the psychological and behavioral aspects of addiction.

(2) When medically indicated, drug treatment involving agents approved by the federal Food and Drug Administration for the:

(A) treatment of opioid or alcohol dependence; or

(B) prevention of relapse to opioids or alcohol after detoxification.

(3) Inpatient detoxification:

(A) in accordance with:

(i) the most current edition of the American Society of Addiction Medicine Patient Placement Criteria; or

(ii) other clinical criteria that are determined by the office and are evidence based and peer reviewed; and

(B) when determined by the treatment plan to be medically necessary.

(b) The office shall:

(1) develop quality measures to ensure; and

(2) require a ~~Medicaid~~ managed care organization to report;

compliance with the coverage required under subsection (a).

(c) The office may implement quality capitation withholding of reimbursement to ensure that a ~~Medicaid~~ managed care organization has provided the coverage required under subsection (a).

(d) The office shall report the clinical use of the medications covered under this section to the mental health Medicaid quality advisory committee established by IC 12-15-35-51. The mental health Medicaid quality advisory committee may make recommendations to the office concerning this section.

SECTION 7. IC 12-15-11.5-0.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 0.5. This chapter does not apply to a managed care ~~contractor~~ **organization** that, on or before July 1, 2000, did not directly contract with a hospital (as defined in section 1 of this chapter) for the provision of services under the office's managed care program.

SECTION 8. IC 12-15-11.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 2. The office's managed care ~~contractor~~ **organization** shall regard a hospital as a contracted provider in the office's managed care ~~services~~ program, which provides a capitated prepayment managed care system, for the provision of medical services to each individual who:

(1) is eligible to receive services under IC 12-15 and has enrolled in the office's managed care services program;

(2) resides in the same city in which the hospital is located; and

(3) has selected a primary care provider who:

(A) is a contracted provider with the office's managed care ~~contractor;~~ **organization;** and

(B) has medical staff privileges at the hospital.

SECTION 9. IC 12-15-11.5-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 6. A claim for reimbursement for services shall be treated as a disputed claim under this chapter if:

(1) it is submitted within one hundred twenty (120) days after the date that services are rendered;

(2) it is denied by the managed care ~~contractor;~~ **organization;**

(3) the hospital submits a written notice of dispute for the claim to the managed care ~~contractor~~ **organization** not more than sixty (60) days after the receipt of the denial notice;

(4) it is appealed in accordance with the managed care ~~contractor's~~ **organization's** internal appeals process; and

(5) payment for the claim is denied by the managed care ~~contractor~~ **organization** following its internal appeals process.

SECTION 10. IC 12-15-11.5-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 7. The office's managed care ~~contractor~~ **organization** must conclude an appeal under section 6(4) of this chapter and notify the hospital of its decision not more than thirty-five (35) days after the managed care ~~contractor~~ **organization** receives a notice from the hospital disputing the managed care ~~contractor's~~ **organization's** denial of a claim.

SECTION 11. IC 12-15-11.5-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 8. (a) A contract

entered into by a hospital with the office's managed care ~~contractor~~ **organization** for the provision of services under the office's managed care ~~services~~ program must include a dispute resolution procedure for all disputed claims. Unless agreed to in writing by the hospital and the office's managed care ~~contractor,~~ **organization,** the dispute resolution procedure must include the following requirements:

(1) That submission of disputed claims must be made to an independent arbitrator selected under subsection (b).

(2) Each claim must set forth with specificity the issues to be arbitrated, the amount involved, and the relief sought.

(3) That the hospital and the office's managed care ~~contractor~~ **organization** shall attempt in good faith to resolve all disputed claims.

(4) The hospital shall submit to the arbitrator any claims that remain in dispute sixty (60) calendar days after the hospital receives written notice as provided under section 7 of this chapter.

(5) That resolution of disputes by the arbitrator must occur not later than ninety (90) calendar days after submission of disputed claims to the arbitrator, unless the parties mutually agree otherwise.

(6) That determinations of the arbitrator are final and binding and not subject to any appeal or review procedure.

(7) That the arbitrator does not have the authority to award any punitive or exemplary damages or to vary or ignore the terms of any contract between the parties and shall be bound by controlling law.

(8) That judgment upon the award rendered by the arbitrator may be entered and enforced in and is subject to the jurisdiction of a court with jurisdiction in Indiana.

(9) That the cost of the arbitrator must be shared equally by the parties, and each party must bear its own attorney and witness fees.

(b) The parties to a contract described in subsection (a) shall mutually agree on an independent arbitrator, or, if the parties are unable to reach agreement on an independent arbitrator, the following procedure must be followed:

(1) Each party shall select an independent representative, and the independent representatives shall select a panel of three (3) independent arbitrators who have experience in institutional and professional health care delivery practices and procedures and have had no prior dealing with either party other than as an arbitrator.

(2) The parties will each strike one (1) arbitrator from the panel selected under subdivision (1), and the remaining arbitrator serves as the arbitrator of the disputed claims under subsection (a).

(3) The procedures for selecting an arbitrator under this section must be completed not later than twenty (20) calendar days after the hospital provides written notice of at least one (1) disputed claim.

SECTION 12. IC 12-15-11.5-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 9. The arbitration process described in section 8 of this chapter shall also be followed for resolution of disputed claims between a hospital and the office's managed care ~~contractor,~~ **organization,** if the hospital is not a contracted provider in the office's managed health care ~~services~~ program.

SECTION 13. IC 12-15-11.5-10, AS ADDED BY P.L.220-2011, SECTION 265, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 10. A hospital and the managed care ~~contractor~~ **organization** of the office shall use the arbitration procedure in section 8 of this chapter for the resolution of all disputed claims that have accrued as of March 17, 2000.

SECTION 14. IC 12-15-12-0.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 0.9. (a) This section applies only with respect to the responsibilities of a managed care organization under:**

(1) this article;

(2) IC 12-17.6;

(3) 42 CFR 438; or

(4) a rule adopted under a law described in subdivision (1) or (2).

(b) If a provision of, or rule adopted under, IC 27 conflicts with the administration of the programs under a law described in subsection (a), the law described in subsection (a) is controlling.

SECTION 15. IC 12-15-12-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 15. ~~The office, for purposes of the primary care case management program, and~~ A managed care ~~contractor, for purposes of the risk-based managed care program,~~ **organization** shall:

(1) cover and pay for all medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition; and

(2) beginning July 1, 2001, ~~not~~ **neither** deny ~~or~~ **nor** fail to process a claim for reimbursement for emergency services on the basis

that the enrollee's primary care provider's authorization code for the services was not obtained before or after the services were rendered.

SECTION 16. IC 12-15-12-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 17. (a) This section applies to post-stabilization care services provided to an individual enrolled in

~~(1) the~~ **a** Medicaid ~~risk-based~~ **risk based** managed care program.

~~or~~

~~(2) the Medicaid primary care case management program.~~

(b) The ~~office, if the individual is enrolled in the primary care case management program, or the~~ managed care organization ~~if the~~ **through which an** individual is enrolled in ~~the~~ **a** ~~risk-based~~ **risk based** managed care program, is financially responsible for the following services provided to ~~an~~ **the** enrollee:

(1) Post-stabilization care services that are ~~pre-approved~~ **preapproved** by ~~a representative of the office or~~ the managed care organization. ~~as applicable.~~

(2) Post-stabilization care services that are not ~~pre-approved~~ **preapproved** by ~~a representative of the office or~~ the managed care organization, ~~as applicable,~~ but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the ~~office or the~~ managed care organization for ~~pre-approval~~ **preapproval** of further post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not ~~pre-approved~~ **preapproved** by ~~a representative of the office or~~ the managed care organization, ~~as applicable,~~ but that are administered to maintain, improve, or resolve the enrollee's stabilized condition if the ~~office or the~~ managed care organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating physician concerning the enrollee's care, and a physician representing the ~~office or the~~ managed care organization ~~as applicable,~~ is not available for consultation.

(c) If the conditions described in subsection (b)(3)(C) exist, ~~the office or~~ the managed care organization ~~as applicable,~~ shall give the enrollee's treating physician an opportunity to consult with a physician representing the ~~office or the~~ managed care organization. The enrollee's

treating physician may continue with care of the enrollee until a physician representing the ~~office or the~~ managed care organization ~~as applicable,~~ is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing the ~~office or the~~ managed care organization; ~~as applicable;~~ and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing the ~~office or the~~ managed care organization ~~as applicable,~~ assumes responsibility for the enrollee's care through transfer.

(3) A representative of the ~~office or the~~ managed care organization ~~as applicable,~~ and the treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(d) This subsection applies to post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) to an individual enrolled in ~~the~~ **a** Medicaid ~~risk-based~~ **risk based** managed care program by a provider who has not contracted with ~~a Medicaid risk-based~~ **the individual's** managed care organization to provide post-stabilization care services under subsection (b)(1), (b)(2), and (b)(3) to the individual. Payment for post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for such services.

(e) This section does not prohibit a managed care organization from entering into a subcontract with another ~~Medicaid risk-based~~ managed care organization providing for the latter **managed care** organization to assume financial responsibility for making the payments required under this section.

(f) This section does not limit the ability of the office or the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the post-stabilization care services provided to an enrollee for purposes of determining coverage for such services.

SECTION 17. IC 12-15-12-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 18. (a) Except as provided in subsection (b), this section applies to:

(1) emergency services provided to an individual enrolled in ~~the~~ **a** Medicaid ~~risk-based~~ **risk based** managed care program; and

(2) medically necessary screening services provided to an

individual enrolled in ~~the~~ **a** Medicaid ~~risk-based~~ **risk based** managed care program;

who presents to an emergency department with an emergency medical condition.

(b) This section does not apply to emergency services or screening services provided to an individual enrolled in ~~the~~ **a** Medicaid ~~risk-based~~ **risk based** managed care program by a provider who has contracted with ~~a Medicaid risk-based~~ **the individual's** managed care organization to provide emergency services to the individual.

(c) Payment for emergency services and medically necessary screening services in the emergency department of a hospital licensed under IC 16-21 must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for such services.

(d) Payment under subsection (c) is the responsibility of the enrollee's ~~risk-based~~ managed care organization. This subsection does not prohibit the ~~risk-based~~ managed care organization from entering into a subcontract with another ~~Medicaid risk-based~~ managed care organization providing for the latter **managed care** organization to assume financial responsibility for making the payments required under this section.

(e) This section does not limit the ability of the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the services provided in a hospital's emergency department for purposes of determining coverage for such services.

SECTION 18. IC 12-15-12-19 IS REPEALED [EFFECTIVE JULY 1, 2017]. ~~Sec. 19. (a) This section applies to an individual who is a Medicaid recipient.~~

~~(b) Subject to subsection (c), the office shall develop the following programs regarding individuals described in subsection (a):~~

~~(1) A disease management program for recipients with any of the following chronic diseases:~~

~~(A) Asthma.~~

~~(B) Diabetes.~~

~~(C) Congestive heart failure or coronary heart disease.~~

~~(D) Hypertension.~~

~~(E) Kidney disease.~~

~~(2) A case management program for recipients described in subsection (a) who are at high risk of chronic disease, that is based on a combination of cost measures, clinical measures, and~~

~~health outcomes identified and developed by the office with input and guidance from the state department of health and other experts in health care case management or disease management programs.~~

~~(c) The office shall implement:~~

~~(1) a pilot program for at least two (2) of the diseases listed in subsection (b) not later than July 1, 2003; and~~

~~(2) a statewide chronic disease program as soon as practicable after the office has done the following:~~

~~(A) Evaluated a pilot program described in subdivision (1).~~

~~(B) Made any necessary changes in the program based on the evaluation performed under clause (A).~~

~~(d) The office shall develop and implement a program required under this section in cooperation with the state department of health and shall use the following persons to the extent possible:~~

~~(1) Community health centers.~~

~~(2) Federally qualified health centers (as defined in 42 U.S.C. 1396d(l)(2)(B)).~~

~~(3) Rural health clinics (as defined in 42 U.S.C. 1396d(l)(1)).~~

~~(4) Local health departments.~~

~~(5) Hospitals.~~

~~(6) Public and private third party payers.~~

~~(e) The office may contract with an outside vendor or vendors to assist in the development and implementation of the programs required under this section.~~

~~(f) The office and the state department of health shall provide the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6 with an evaluation and recommendations on the costs, benefits, and health outcomes of the pilot programs required under this section. The evaluations required under this subsection must be provided not more than twelve (12) months after the implementation date of the pilot programs.~~

~~(g) The office and the state department of health shall report to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6 not later than November 1 of each year regarding the programs developed under this section.~~

~~(h) The disease management program services for a recipient diagnosed with diabetes or hypertension must include education for the recipient on kidney disease and the benefits of having evaluations and treatment for chronic kidney disease according to accepted practice~~

~~guidelines.~~

SECTION 19. IC 12-15-12-20, AS ADDED BY P.L.135-2005, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 20. The office shall develop the following:

(1) A measure to evaluate the performance of a ~~Medicaid~~ managed care organization in screening a child who is less than six (6) years of age for lead poisoning.

(2) A system to maintain the results of an evaluation under subdivision (1) in written form.

(3) A performance incentive program for ~~Medicaid~~ managed care organizations evaluated under subdivision (1).

SECTION 20. IC 12-15-12-21, AS ADDED BY P.L.113-2008, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 21. (a) Not later than January 1, 2011, the following must be accredited by the National Committee for Quality Assurance or its successor:

(1) A managed care organization that has contracted with the office before July 1, 2008, to provide Medicaid services under ~~the~~ **a** risk based managed care program.

(2) A behavioral health managed care organization that has contracted before July 1, 2008, with a managed care organization described in subdivision (1).

(b) A:

(1) managed care organization that has contracted with the office after June 30, 2008, to provide Medicaid services under ~~the~~ **a** risk based managed care program; or

(2) behavioral health managed care organization that has contracted after June 30, 2008, with a managed care organization described in subdivision (1);

must begin the accreditation process and obtain accreditation by the National Committee for Quality Assurance or its successor at the earliest time that the National Committee for Quality Assurance allows a managed care organization to be accredited.

SECTION 21. IC 12-15-12-22, AS ADDED BY P.L.113-2008, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 22. A:

(1) managed care organization that has a contract with the office to provide Medicaid services under ~~the~~ **a** risk based managed care program; or

(2) behavioral health managed care organization that has contracted with a managed care organization described in subdivision (1);

shall accept, receive, and process claims for payment that are filed electronically by a Medicaid provider.

SECTION 22. IC 12-15-13-6, AS AMENDED BY P.L.153-2011, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 6. (a) Except as provided by IC 12-15-35-50, a notice or bulletin that is issued by:

(1) the office;

(2) a contractor of the office; or

(3) a managed care ~~plan under the office;~~ **organization;**

concerning a change to the Medicaid program, including a change to prior authorization, claims processing, payment rates, and medical policies, that does not require use of the rulemaking process under IC 4-22-2 may not become effective until thirty (30) days after the date the notice or bulletin is communicated to the parties affected by the notice or bulletin.

(b) The office must provide a written notice or bulletin described in subsection (a) within five (5) business days after the date on the notice or bulletin.

(c) If the office, a contractor of the office, or a managed care ~~plan under the office~~ **organization** does not comply with the requirements in subsections (a) and (b):

(1) the notice or bulletin is void;

(2) a claim may not be denied because the claim does not comply with the void notice or bulletin; and

(3) the office, a contractor of the office, or a managed care ~~plan under the office~~ **organization** may not reissue the bulletin or notice for thirty (30) days unless the change is required by the federal government to be implemented earlier.

SECTION 23. IC 12-15-15-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 2.5. (a) Payment for physician services provided in the emergency department of a hospital licensed under IC 16-21 must be at a rate of one hundred percent (100%) of rates payable under the Medicaid fee structure.

(b) The payment under subsection (a) must be calculated using the same methodology used for all other physicians participating in the Medicaid program.

(c) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American

Medical Association, without authorization by the enrollee's primary medical provider.

~~(d) Payment for all other physician services provided in an emergency department of a hospital to enrollees in the Medicaid primary care case management program must be at a rate of one hundred percent (100%) of the Medicaid fee structure rates, provided the service is authorized, prospectively or retrospectively, by the enrollee's primary medical provider.~~

~~(c)~~ **(d)** This section does not apply to a person enrolled in ~~the~~ **a** Medicaid ~~risk-based~~ **risk based** managed care program.

SECTION 24. IC 12-15-30-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 3. The office shall select an approach to finance and administer Medicaid claims consisting of one (1) of the following:

(1) A direct provider payment plan administered by the office.

(2) A direct provider payment plan administered by a fiscal agent.

(3) A ~~Medicaid insurance plan administered by a health insurer.~~ **managed care organization.**

(4) Any combination of the plans described in this section.

SECTION 25. IC 12-15-35-18.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 18.7. A formulary established by a ~~Medicaid~~ managed care organization is subject to sections 46 and 47 of this chapter.

SECTION 26. IC 12-15-35-20 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 20. The board is composed of the following:

(1) Four (4) individuals licensed and actively engaged in the practice of medicine or osteopathic medicine in Indiana under IC 25-22.5.

(2) Four (4) individuals licensed under IC 25-26 and actively engaged in the practice of pharmacy in Indiana.

(3) One (1) individual with expertise in therapeutic pharmacology who is neither a physician or a pharmacist.

(4) A representative of the office who shall serve as an ex-officio nonvoting member of the board.

(5) One (1) individual who:

(A) is employed by a health maintenance organization that has a pharmacy benefit; and

(B) has expertise in formulary development and pharmacy benefit administration.

The individual appointed under this subdivision may not be employed by a health maintenance organization that is ~~under~~

~~contract or subcontract with the state to provide services to Medicaid recipients under this article.~~ **a managed care organization.**

(6) One (1) individual who is a health economist.

SECTION 27. IC 12-15-35-28, AS AMENDED BY P.L.210-2015, SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 28. (a) The board has the following duties:

(1) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.

(2) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria and standards for appropriate prescribing are based on the compendia and developed with professional input with provisions for timely revisions and assessments as necessary.

(3) The development, selection, application, and assessment of interventions for physicians, pharmacists, and patients that are educational and not punitive in nature.

(4) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year. The report issued to the legislative council must be in an electronic format under IC 5-14-6.

(5) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:

(A) The Indiana board of pharmacy.

(B) The medical licensing board of Indiana.

(C) The SURS staff.

(6) The establishment of a grievance and appeals process for physicians or pharmacists under this chapter.

(7) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and

recipients.

(B) Potential or actual severe or adverse reactions to drugs.

(C) Therapeutic appropriateness.

(D) Overutilization or underutilization.

(E) Appropriate use of generic drugs.

(F) Therapeutic duplication.

(G) Drug-disease contraindications.

(H) Drug-drug interactions.

(I) Incorrect drug dosage and duration of drug treatment.

(J) Drug allergy interactions.

(K) Clinical abuse and misuse.

(8) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual physicians, pharmacists, or recipients.

(9) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3.1 and 42 CFR 483.60.

(10) The research, development, and approval of a preferred drug list for:

(A) Medicaid's fee for service program;

~~(B) Medicaid's primary care case management program;~~

~~(C)~~ Medicaid's **(B) a** risk based managed care program, if the office provides a prescription drug benefit and subject to IC 12-15-5; and

~~(D)~~ **(C)** the children's health insurance program under IC 12-17.6;

in consultation with the therapeutics committee.

(11) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.

(12) The preparation and submission of a report concerning the preferred drug list at least one (1) time per year to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6.

(13) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder or attention deficit hyperactivity disorder.

(14) Advising the Indiana comprehensive health insurance

association established by IC 27-8-10-2.1 concerning implementation of chronic disease management and pharmaceutical management programs under IC 27-8-10-3.5.

(b) The board shall use the clinical expertise of the therapeutics committee in developing a preferred drug list. The board shall also consider expert testimony in the development of a preferred drug list.

(c) In researching and developing a preferred drug list under subsection (a)(10), the board shall do the following:

(1) Use literature abstracting technology.

(2) Use commonly accepted guidance principles of disease management.

(3) Develop therapeutic classifications for the preferred drug list.

(4) Give primary consideration to the clinical efficacy or appropriateness of a particular drug in treating a specific medical condition.

(5) Include in any cost effectiveness considerations the cost implications of other components of the state's Medicaid program and other state funded programs.

(d) Prior authorization is required for coverage under a program described in subsection (a)(10) of a drug that is not included on the preferred drug list.

(e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date on which the manufacturer notifies the board in writing of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an additional sixty (60) days to make a determination from the date that the board receives adequate information to perform the board's review. Prior authorization may not be automatically required for a single source drug that is newly approved by the federal Food and Drug Administration, and that is:

(1) in a therapeutic classification:

(A) that has not been reviewed by the board; and

(B) for which prior authorization is not required; or

(2) the sole drug in a new therapeutic classification that has not been reviewed by the board.

(f) The board may not exclude a drug from the preferred drug list based solely on price.

(g) The following requirements apply to a preferred drug list developed under subsection (a)(10):

(1) Except as provided by IC 12-15-35.5-3(b) and

IC 12-15-35.5-3(c), the office or the board may require prior authorization for a drug that is included on the preferred drug list under the following circumstances:

(A) To override a prospective drug utilization review alert.

(B) To permit reimbursement for a medically necessary brand name drug that is subject to generic substitution under IC 16-42-22-10.

(C) To prevent fraud, abuse, waste, overutilization, or inappropriate utilization.

(D) To permit implementation of a disease management program.

(E) To implement other initiatives permitted by state or federal law.

(2) All drugs described in IC 12-15-35.5-3(b) must be included on the preferred drug list.

(3) The office may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list without prior approval from the board.

(4) The board may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list.

(h) At least one (1) time each year, the board shall provide a report to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6. The report must contain the following information:

(1) The cost of administering the preferred drug list.

(2) Any increase in Medicaid physician, laboratory, or hospital costs or in other state funded programs as a result of the preferred drug list.

(3) The impact of the preferred drug list on the ability of a Medicaid recipient to obtain prescription drugs.

(4) The number of times prior authorization was requested, and the number of times prior authorization was:

(A) approved; and

(B) disapproved.

(i) The board shall provide the first report required under subsection (h) not later than six (6) months after the board submits an initial preferred drug list to the office.

SECTION 28. IC 12-15-35-45, AS AMENDED BY P.L.101-2005, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 45. (a) The chairman of the board, subject to the approval of the board members, may appoint an advisory committee to make recommendations to the board on the development of a Medicaid

outpatient drug formulary.

(b) If the office decides to establish a Medicaid outpatient drug formulary, the formulary shall be developed by the board.

(c) A formulary, preferred drug list, or prescription drug benefit used by a ~~Medicaid~~ managed care organization is subject to IC 12-15-5-5, IC 12-15-35.5, and sections 46 and 47 of this chapter.

SECTION 29. IC 12-15-35-46 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 46. (a) This section applies to a managed care organization that enters into an initial contract with the office to be a ~~Medicaid~~ managed care organization after May 13, 1999.

(b) Before a ~~Medicaid~~ managed care organization described in subsection (a) implements a formulary, the managed care organization shall submit the formulary to the office at least thirty-five (35) days before the date that the managed care organization implements the formulary for Medicaid recipients.

(c) The office shall forward the formulary to the board for the board's review and recommendation.

(d) The office shall provide at least thirty (30) days notification to the public that the board will review a ~~Medicaid~~ managed care organization's proposed formulary at a particular board meeting. The notification shall contain the following information:

(1) A statement of the date, time, and place at which the board meeting will be convened.

(2) A general description of the subject matter of the board meeting.

(3) An explanation of how a copy of the formulary to be discussed may be obtained.

The board shall meet to review the formulary at least thirty (30) days but not more than sixty (60) days after the notification.

(e) In reviewing the formulary, the board shall do the following:

(1) Make a determination, after considering evidence and credible information provided to the board by the office and the public, that the use of the formulary will not:

(A) impede the quality of patient care in the Medicaid program; or

(B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.

(2) Make a determination that:

(A) there is access to at least two (2) alternative drugs within each therapeutic classification, if available, on the formulary;

(B) a process is in place through which a Medicaid member

has access to medically necessary drugs; and

(C) the managed care organization otherwise meets the requirements of IC 27-13-38.

(f) The board shall consider:

(1) health economic data;

(2) cost data; and

(3) the use of formularies in the non-Medicaid markets;

in developing its recommendation to the office.

(g) Within thirty (30) days after the board meeting, the board shall make a recommendation to the office regarding whether the proposed formulary should be approved, disapproved, or modified.

(h) The office shall rely significantly on the clinical expertise of the board. If the office does not agree with the recommendations of the board, the office shall, at a public meeting, discuss the disagreement with the board and present any additional information to the board for the board's consideration. The board's consideration of additional information must be conducted at a public meeting.

(i) Based on the final recommendations of the board, the office shall approve, disapprove, or require modifications to the ~~Medicaid~~ managed care organization's proposed formulary. The office shall notify the managed care organization of the office's decision within fifteen (15) days of receiving the board's final recommendation.

(j) The managed care organization must comply with the office's decision within sixty (60) days after receiving notice of the office's decision.

(k) Notwithstanding the other provisions of this section, the office may temporarily approve a ~~Medicaid~~ managed care organization's proposed formulary pending a final recommendation from the board.

SECTION 30. IC 12-15-35-47 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 47. (a) This section applies to the following changes to a formulary used by a ~~Medicaid~~ managed care organization for Medicaid recipients:

(1) Removing one (1) or more drugs from the formulary.

(2) Placing new restrictions on one (1) or more drugs on the formulary.

(b) Before a ~~Medicaid~~ managed care organization makes a change described in subsection (a), the managed care organization shall submit the proposed change to the office.

(c) The office shall forward the proposed change to the board for the board's review and recommendation.

(d) The office shall provide at least thirty (30) days notification to the public that the board will:

(1) review the proposed change; and

(2) consider evidence and credible information provided to the board;

at the board's regular board meeting before making a recommendation to the office regarding whether the proposed change should be approved or disapproved.

(e) Based on the final recommendation of the board, the office may approve or disapprove the proposed change. If a proposed change is not disapproved within ninety (90) days after the date the managed care organization submits the proposed change to the office, the managed care organization may implement the change to the formulary.

(f) A ~~Medicaid~~ managed care organization:

(1) may add a drug to the managed care organization's formulary without the approval of the office; and

(2) shall notify the office of any addition to the managed care organization's formulary within thirty (30) days after making the addition.

SECTION 31. IC 12-15-35-48, AS AMENDED BY P.L.53-2014, SECTION 106, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 48. (a) The board shall review the prescription drug program of a managed care organization that participates in ~~the state's risk-based~~ **a risk based** managed care program at least one (1) time per year. The board's review of a prescription drug program must include the following:

(1) An analysis of the single source drugs requiring prior authorization, including the number of drugs requiring prior authorization in comparison to other managed care organizations' prescription drug programs that participate in the state's Medicaid program.

(2) A determination and analysis of the number and the type of drugs subject to a restriction.

(3) A review of the rationale for:

(A) the prior authorization of a drug described in subdivision (1); and

(B) a restriction on a drug.

(4) A review of the number of requests a managed care organization received for prior authorization, including the number of times prior authorization was approved and the number of times prior authorization was disapproved.

(5) A review of:

(A) patient and provider satisfaction survey reports; and

(B) pharmacy-related grievance data for a twelve (12) month

period.

(b) A managed care organization described in subsection (a) shall provide the board with the information necessary for the board to conduct its review under subsection (a).

(c) The board shall report to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6 at least one (1) time per year on the board's review under subsection (a).

SECTION 32. IC 12-15-44.5-3, AS AMENDED BY P.L.30-2016, SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 3. (a) The healthy Indiana plan is established.

(b) The office shall administer the plan.

(c) The following individuals are eligible for the plan:

(1) The adult group described in 42 CFR 435.119.

(2) Parents and caretaker relatives eligible under 42 CFR 435.110.

(3) Low income individuals who are:

(A) at least nineteen (19) years of age; and

(B) less than twenty-one (21) years of age;

and eligible under 42 CFR 435.222.

(4) Individuals, for purposes of receiving transitional medical assistance.

An individual must meet the Medicaid residency requirements under IC 12-15-4-4 and this article to be eligible for the plan.

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

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

(2) An individual who is otherwise eligible and enrolled for medical assistance.

(e) The department of insurance and the office of the secretary shall provide oversight of the marketing practices of the plan.

(f) The office shall promote the plan and provide information to potential eligible individuals who live in medically underserved rural areas of Indiana.

(g) The office shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Indiana in proportion to the number of individuals throughout Indiana who are eligible for participation in the plan.

(h) The office shall establish standards for consumer protection, including the following:

(1) Quality of care standards.

(2) A uniform process for participant grievances and appeals.

(3) Standardized reporting concerning provider performance,

consumer experience, and cost.

(i) A health care provider that provides care to an individual who receives health ~~insurance~~ coverage under the plan shall also participate in the Medicaid program under this article.

(j) The following do not apply to the plan:

(1) IC 12-15-6.

(2) IC 12-15-12.

(3) IC 12-15-13.

(4) IC 12-15-14.

(5) IC 12-15-15.

(6) IC 12-15-21.

(7) IC 12-15-26.

(8) IC 12-15-31.1.

(9) IC 12-15-34.

(10) IC 12-15-35.

(11) IC 16-42-22-10.

SECTION 33. IC 12-15-44.5-4.7, AS ADDED BY P.L.30-2016, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 4.7. (a) To participate in the plan, an individual must apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

(b) A pregnant woman is not subject to the cost sharing provisions of the plan. Subsections (c) through (g) do not apply to a pregnant woman participating in the plan.

(c) An applicant who is approved to participate in the plan does not begin benefits under the plan until a payment of at least:

(1) one-twelfth (1/12) of the ~~two percent (2%) of~~ annual income contribution amount; or

(2) ten dollars ($10);

is made to the individual's health care account established under section 4.5 of this chapter for the individual's participation in the plan. To continue to participate in the plan, an individual must contribute to the individual's health care account at least two percent (2%) of the individual's annual household income per year **or an amount determined by the secretary that is based on the individual's annual household income per year,** but not less than one dollar ($1) per month. **The amount determined by the secretary under this subsection must be approved by the United States Department of Health and Human Services.**

(d) If an applicant who is approved to participate in the plan fails to make the initial payment into the individual's health care account, at least the following must occur:

(1) If the individual has an annual income that is at or below one hundred percent (100%) of the federal poverty income level, the individual's benefits are reduced as specified in subsection (e)(1).

(2) If the individual has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual is not enrolled in the plan.

(e) If an enrolled individual's required monthly payment to the plan is not made within sixty (60) days after the required payment date, the following, at a minimum, occur:

(1) For an individual who has an annual income that is at or below one hundred percent (100%) of the federal income poverty level, the individual is:

(A) transferred to a plan that has a material reduction in benefits, including the elimination of benefits for vision and dental services; and

(B) required to make copayments for the provision of services that may not be paid from the individual's health care account.

(2) For an individual who has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual shall be terminated from the plan and may not reenroll in the plan for at least six (6) months.

(f) The state shall contribute to the individual's health care account the difference between the individual's payment required under this section and the plan deductible set forth in section 4.5(c) of this chapter.

(g) A member shall remain enrolled with the same ~~health plan~~ **managed care organization** during the member's benefit period. A member may change ~~health plans~~ **managed care organizations** as follows:

(1) Without cause:

(A) before making a contribution or before finalizing enrollment in accordance with subsection (d)(1); or

(B) during the annual plan renewal process.

(2) For cause, as determined by the office.

SECTION 34. IC 12-15-44.5-5, AS ADDED BY P.L.213-2015, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 5. (a) ~~An insurer or health maintenance~~ **A managed care** organization that contracts with the office to provide health ~~insurance~~ coverage, dental coverage, or vision coverage to an individual who participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a rate that is not less than the rate

established by the secretary. The rate set by the secretary must be based on a reimbursement formula that is:

(A) comparable to the federal Medicare reimbursement rate for the service provided by the provider; or

(B) one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(b) ~~An insurer or health maintenance~~ **A managed care** organization that contracts with the office to provide health ~~insurance~~ coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

SECTION 35. IC 12-15-44.5-8, AS ADDED BY P.L.213-2015, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 8. The following requirements apply to funds appropriated by the general assembly to the plan and the incremental fee used for purposes of IC 16-21-10-13.3:

(1) At least eighty-seven percent (87%) of the funds must be used to fund payment for health care services.

(2) An amount determined by the office of the secretary to fund:

(A) administrative costs of; and

(B) any profit made by;

~~an insurer or~~ a ~~health maintenance~~ **managed care** organization under a contract with the office to provide health ~~insurance~~ coverage under the plan. The amount determined under this subdivision may not exceed thirteen percent (13%) of the funds.

SECTION 36. IC 16-38-6-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 2. The state department, with the cooperation of the office of Medicaid policy and planning, shall establish a chronic disease registry for the purpose of:

(1) recording chronic disease cases that are diagnosed or treated in Indiana; and

(2) compiling necessary and appropriate information determined by the state department concerning cases described in subdivision (1) in order to do the following:

(A) Conduct epidemiologic and environmental surveys of chronic disease and use appropriate preventive and control measures.

(B) Inform citizens regarding programs designed to manage chronic disease.

~~(C) Provide guidance to the office of Medicaid policy and planning to identify and develop cost and clinical measures for use in a program required by IC 12-15-12-19.~~

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1439, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 6, line 30, delete "is inconsistent" and insert "**conflicts**".

Page 6, line 31, after "with" insert "**the administration of the programs under**".

and when so amended that said bill do pass.

(Reference is to HB 1439 as introduced.)

KIRCHHOFER

Committee Vote: yeas 11, nays 0.

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1439, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 22, delete lines 17 through 42, begin a new paragraph and insert:

"SECTION 33. IC 12-15-44.5-4.7, AS ADDED BY P.L.30-2016, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 4.7. (a) To participate in the plan, an individual must apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

(b) A pregnant woman is not subject to the cost sharing provisions of the plan. Subsections (c) through (g) do not apply to a pregnant woman participating in the plan.

(c) An applicant who is approved to participate in the plan does not begin benefits under the plan until a payment of at least:

(1) one-twelfth (1/12) of the ~~two percent (2%) of~~ annual income contribution amount; or

(2) ten dollars ($10);

is made to the individual's health care account established under section 4.5 of this chapter for the individual's participation in the plan. To continue to participate in the plan, an individual must contribute to

the individual's health care account at least two percent (2%) of the individual's annual household income per year **or an amount determined by the secretary that is based on the individual's annual household income per year,** but not less than one dollar ($1) per month. **The amount determined by the secretary under this subsection must be approved by the United States Department of Health and Human Services.**

(d) If an applicant who is approved to participate in the plan fails to make the initial payment into the individual's health care account, at least the following must occur:

(1) If the individual has an annual income that is at or below one hundred percent (100%) of the federal poverty income level, the individual's benefits are reduced as specified in subsection (e)(1).

(2) If the individual has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual is not enrolled in the plan.

(e) If an enrolled individual's required monthly payment to the plan is not made within sixty (60) days after the required payment date, the following, at a minimum, occur:

(1) For an individual who has an annual income that is at or below one hundred percent (100%) of the federal income poverty level, the individual is:

(A) transferred to a plan that has a material reduction in benefits, including the elimination of benefits for vision and dental services; and

(B) required to make copayments for the provision of services that may not be paid from the individual's health care account.

(2) For an individual who has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual shall be terminated from the plan and may not reenroll in the plan for at least six (6) months.

(f) The state shall contribute to the individual's health care account the difference between the individual's payment required under this section and the plan deductible set forth in section 4.5(c) of this chapter.

(g) A member shall remain enrolled with the same ~~health plan~~ **managed care organization** during the member's benefit period. A member may change ~~health plans~~ **managed care organizations** as follows:

(1) Without cause:

(A) before making a contribution or before finalizing enrollment in accordance with subsection (d)(1); or

(B) during the annual plan renewal process.

(2) For cause, as determined by the office.".

Page 23, delete lines 1 through 30.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to HB 1439 as printed January 27, 2017.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 9, Nays 0.