First Regular Session of the 121st General Assembly (2019)

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 2018 Regular and Special Session of the General Assembly.

SENATE ENROLLED ACT No. 392

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 12-15-33-9.5, AS ADDED BY HEA 1548-2019, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9.5. (a) The committee shall review, study, and make advisory recommendations concerning the following subjects:

(1) Emergency department coverage and reimbursement to providers.

(2) The reporting of Medicaid prior authorization denials by Medicaid managed care entities, excluding pharmacies.

(3) The reporting of Medicaid denials based on:

(A) administrative and medically necessary criteria; or

(B) errors or omissions made by the managed care entity.

(4) Prompt payment to providers for claims:

(A) within thirty (30) days;

(B) within ninety (90) days;

(C) within one hundred eighty (180) days; and

(D) over three hundred sixty-five (365) days.

(5) The provider appeals process for administrative and medically necessary Medicaid denials and the resolution of appeals, including rates of reversal.

(6) The central credentialing portal.

(7) Policy changes to the Medicaid program with an implementation period for providers or managed care entities of more than thirty (30) days.

(8) The reporting of Medicaid denials due to retro-eligibility status.

(9) Other subjects, as the committee considers necessary.

(b) The committee shall, not later than November 1, 2019, study, make advisory recommendations under section 2 of this chapter, and report and make recommendations to the legislative council in an electronic format under IC 5-14-6, concerning the feasibility of applying for a Medicaid state plan amendment for the following:

(1) Medicaid reimbursement for health care services and school based services provided to specified individuals by a school based health center.

(2) Potential directed payments to school based health centers, including:

(A) alternate fee schedule payments under the risk based managed care program equivalent to the fee that Medicare pays for the service, or if there is not a Medicare rate for the service, an amount determined by the office of Medicaid policy and planning; and

(B) supplemental Medicaid reimbursement payments to qualified school based health centers under the fee for service Medicaid program.

~~(b)~~ **(c)** This section expires July 1, 2021.

SECTION 2. IC 27-8-13-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9. (a) A Medicare supplement policy, contract, or certificate in force in Indiana may not contain benefits that duplicate benefits provided by Medicare. However, a change in Medicare coverage that becomes effective after a Medicare supplement policy, contract, or certificate is in force in Indiana and that causes a duplication of benefits does not void the policy, contract, or certificate.

(b) The commissioner shall adopt rules under IC 4-22-2 to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with Indiana law. No requirement of IC 27 relating to minimum required policy benefits other than the minimum standards contained in this chapter apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;
(7) requirements for replacement;
(8) recurrent conditions; and
(9) definitions of terms.

(c) The commissioner may adopt rules under IC 4-22-2 that specify prohibited policy provisions not specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to a person insured or proposed to be insured under a Medicare supplement policy or certificate.

(d) Notwithstanding any other law, a Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six (6) months after the effective date of the policy because the loss involves a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(e) After June 30, 2020, an issuer that makes a Medicare supplement policy or certificate available to a person who is at least sixty-five (65) years of age and eligible for Medicare benefits as described in 42 U.S.C. 1395c(1) shall make at least one (1) Medicare supplement policy or certificate that meets the requirements of section 9.5 of this chapter available to an individual who is eligible for and enrolled in Medicare by reason of disability as described in 42 U.S.C. 1395c(2).

SECTION 3. IC 27-8-13-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.5. (a) This section applies:**

(1) after June 30, 2020; and
(2) to a Medicare supplement policy or certificate made available under section 9(e) of this chapter to an individual who is eligible for and enrolled in Medicare by reason of disability as described in 42 U.S.C. 1395c(2).

(b) A Medicare supplement policy or certificate described in subsection (a) must meet the following requirements:

(1) Except as provided in this section, meet all requirements of this chapter that apply to a Medicare supplement policy or certificate made available to a person who is at least sixty-five (65) years of age and eligible for Medicare as described in 42 U.S.C. 1395c(1).
(2) Be standardized as Plan A by the federal Centers for Medicare and Medicaid Services.

(c) An individual may enroll in a Medicare supplement policy or certificate under this section as follows:

(1) At any time the individual is authorized or required to enroll under federal law.

(2) On:

(A) July 1, 2020; or

(B) six (6) months after enrolling in Medicare Part B;

whichever is later.

(3) Within six (6) months after receiving notice that the individual has been retroactively enrolled in Medicare Part B due to a retroactive eligibility decision under 42 U.S.C. 1395.

(4) Within six (6) months after experiencing a qualifying event under 42 U.S.C. 1395.

(d) Notwithstanding any other law, an issuer or another entity may provide to an insurance producer or another agent of the issuer or other entity a commission or other compensation of not more than two percent (2%) of the premium for the sale of a Medicare supplement policy or certificate described in subsection (a).

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: ____________ Time: ____________