

HOUSE BILL No. 1271

DIGEST OF INTRODUCED BILL

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

Synopsis: Health care prior authorization. Provides that when a health plan makes an adverse determination in response to a health care provider's request for prior authorization of a health care service: (1) the health plan is required to provide the health care provider with an opportunity to have a peer to peer conversation with a clinical peer concerning the adverse determination; and (2) the peer to peer conversation opportunity must be provided not more than seven business days after the health plan receives the health care provider's request for the peer to peer conversation. Provides that after December 31, 2023: (1) if a health plan, during a six month evaluation period, approves at least 90% of a health care provider's requests for prior authorization for a particular type of health care service, the health plan may not require the health care provider to obtain prior authorization for that type of health care service for the entire duration of an exemption period of six calendar months immediately following the evaluation period; and (2) at the conclusion of the initial exemption period, the health plan shall continue a health care provider's exemption for consecutive periods of six months unless the health plan rescinds the health care provider's exemption; (3) a health plan's rescission of a health care provider's exemption must be based on: (A) a determination by a physician that, in cases randomly selected for review, less than 90% of the health care services provided by the health care provider met the health plan's medical necessity criteria; or (B) the health care provider committing health care provider fraud or the health care provider's license or legal authorization to provide health care services being suspended or revoked; (4) a health care provider

(Continued next page)

Effective: July 1, 2022.

Schaibley

January 10, 2022, read first time and referred to Committee on Financial Institutions and Insurance.



whose exemption is rescinded may initiate a review of the rescission by an independent review panel; (5) the independent review panel is required to determine: (A) whether at least 90% of the health care services provided by the health care provider met the health plan's medical necessity criteria; or (B) whether the health care provider committed health care provider fraud or the health care provider's license or legal authorization to provide health care services is suspended or revoked; (6) the health plan is required to restore the health care provider's exemption if the independent review panel's determination is in favor of the health care provider; and (7) if a health care provider whose exemption is rescinded does not initiate a review or if the independent review panel's determination is not in favor of the health care provider, the health plan is not required to determine again whether the health care provider is entitled to an exemption until the first evaluation period beginning at least two years later. Requires the insurance commissioner to adopt rules.



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.

HOUSE BILL No. 1271

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

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

1 SECTION 1. IC 5-10-8-7, AS AMENDED BY P.L.198-2021,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2022]: Sec. 7. (a) The state, excluding state educational
4 institutions, may not purchase or maintain a policy of group insurance,
5 except:
6 (1) life insurance for the state's employees;
7 (2) long term care insurance under a long term care insurance
8 policy (as defined in IC 27-8-12-5), for the state's employees; or
9 (3) an insurance policy that provides coverage that supplements
10 coverage provided under a United States military health care plan.
11 (b) With the consent of the governor, the state personnel department
12 may establish self-insurance programs to provide group insurance other
13 than life or long term care insurance for state employees and retired
14 state employees. The state personnel department may contract with a
15 private agency, business firm, limited liability company, or corporation



for administrative services. A commission may not be paid for the placement of the contract. The department may require, as part of a contract for administrative services, that the provider of the administrative services offer to an employee terminating state employment the option to purchase, without evidence of insurability, an individual policy of insurance.

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

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

- (1) require participation in the plan by employees with six (6) months of continuous, full-time service;
- (2) require an employee to make a contribution to the plan in the form of a payroll deduction;
- (3) require that an employee's benefits under the short term disability plan be subject to a thirty (30) day elimination period and that benefits under the long term plan be subject to a six (6) month elimination period;
- (4) prohibit the termination of an employee who is eligible for benefits under the plan;
- (5) provide, after a seven (7) day elimination period, eighty percent (80%) of base biweekly wages for an employee disabled by injuries resulting from tortious acts, as distinguished from passive negligence, that occur within the employee's scope of state employment;
- (6) provide that an employee's benefits under the plan may be reduced, dollar for dollar, if the employee derives income from:
 - (A) Social Security;
 - (B) the public employees' retirement fund;
 - (C) the Indiana state teachers' retirement fund;
 - (D) pension disability;
 - (E) worker's compensation;
 - (F) benefits provided from another employer's group plan; or
 - (G) remuneration for employment entered into after the disability was incurred.

(The department of state revenue and the department of workforce



development shall cooperate with the state personnel department to confirm that an employee has disclosed complete and accurate information necessary to administer this subdivision.);

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

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

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

(B) submit information necessary for claim administration; or

(C) submit to examinations by designated physicians;

the employee forfeits benefits under the plan.

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

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

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

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

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

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



1 health plan; and

2 (2) are exempt from levy, sale, garnishment, attachment, or other
3 legal process.

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

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

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

26 SECTION 2. IC 27-1-3-36 IS ADDED TO THE INDIANA CODE
27 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
28 1, 2022] **Sec. 36. Before July 1, 2023, the insurance commissioner**
29 **shall adopt rules under IC 4-22-2 to administer IC 27-1-37.6,**
30 **including rules concerning:**

31 **(1) the duties of a health plan:**

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

35 **(B) to continue a health care provider's exemption for**
36 **consecutive exemption periods unless the exemption is**
37 **rescinded; and**

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

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

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



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

(B) the procedure for:

(i) initiating; and

(ii) conducting;

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

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

SECTION 3. IC 27-1-37.5-17 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 17. (a) As used in this section, "adverse determination" means:

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

(2) a denial of a request for benefits for an individual on the ground that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; or

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

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

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

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

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

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

SECTION 4. IC 27-1-37.6 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]:



Chapter 37.6. Exemption From Health Care Service Prior Authorization

Sec. 1. This chapter applies after December 31, 2023.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage of health care services under a health plan.

Sec. 3. As used in this chapter, "evaluation period" refers to:

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

(2) the period of six (6) calendar months beginning July 1; during which a health care provider may qualify under section 10(c) of this chapter for an exemption from the requirement to obtain prior authorization from a particular health plan for a particular type of health care service.

Sec. 4. As used in this chapter, "exemption period" refers to the period of six (6) calendar months during which a health care provider, under section 10(c) or 10(d) of this chapter, is exempt from the requirement to request prior authorization from a particular health plan for a particular type of health care service.

Sec. 5. As used in this chapter, "health care provider" means an individual or entity that:

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

(2) is authorized to provide health care services.

Sec. 6. (a) As used in this chapter, "health care provider fraud" means knowingly or intentionally taking any of the following actions:

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

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

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

(b) The term includes the following:

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

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

(3) Knowingly ordering a medically unnecessary health care



1 service for a patient.

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

3 Sec. 7. (a) As used in this chapter, "health care service" means
4 a health care related service or product rendered or sold by a
5 health care provider within the scope of the health care provider's
6 license or legal authorization, including hospital, medical, surgical,
7 mental health, and substance abuse services and products.

8 (b) The term does not include the following:

9 (1) Dental services.

10 (2) Vision services.

11 (3) Long term rehabilitation treatment.

12 (4) Pharmaceutical services or products.

13 Sec. 8. (a) As used in this chapter, "health plan" means any of
14 the following:

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

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

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

23 (b) The term includes the following:

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

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

28 (3) The entity with which the state contracts for the
29 administration of the self-insurance program established
30 under IC 5-10-8-7(b) to provide health care coverage.

31 Sec. 9. As used in this chapter, "prior authorization" means a
32 health plan's approval of a health care service which, according to
33 a requirement established by the health plan, must be obtained
34 from the health plan before the health care service is provided in
35 order for the health care service to be covered by the health plan.

36 Sec. 10. (a) The first evaluation period during which a health
37 plan is required to determine whether health care providers are
38 entitled to an exemption from requesting prior authorization
39 begins on January 1, 2024. Each succeeding evaluation period
40 begins immediately upon the expiration of the previous evaluation
41 period.

42 (b) During each evaluation period, a health plan shall determine



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

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

(d) After an exemption period during which a health care provider is entitled to an exemption under subsection (c) with respect to a particular type of health care service, the health care provider shall continue to be exempt from requesting prior approval from the health plan for that type of health care service for consecutive exemption periods unless the health plan rescinds the health care provider's exemption from prior authorization under section 12 of this chapter.

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

Sec. 11. (a) Not more than ten (10) business days after a health care provider qualifies under section 10(c) of this chapter for an exemption from requesting prior authorization, the health plan shall provide to the health care provider a notice that includes:

- (1) a statement that the health care provider is entitled to the exemption;
- (2) a list of each type of health care service and each health plan to which the exemption applies; and
- (3) a statement concerning:
 - (A) the duration of the initial exemption period; and
 - (B) the continuance of the exemption for consecutive exemption periods under section 10(d) of this chapter.



(b) If a health plan determines that a health care provider that requested prior authorization for a particular type of health care service during an evaluation period is not entitled under section 10(c) of this chapter to an exemption from requesting prior authorization for that type of health care service, the health plan shall provide to the health care provider:

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

(2) other detailed information;

sufficient to demonstrate that the health care provider is not entitled to the exemption under section 10(c) of this chapter.

(c) If a health care provider submits a request for prior authorization for a health care service although the health care provider is exempt under section 10(c) or 10(d) of this chapter from requesting prior authorization for the health care service, the health plan must promptly provide a notice to the health care provider that includes:

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

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

Sec. 12. (a) Except as provided in subsection (b), a health plan may rescind a health care provider's exemption from prior authorization only if the following conditions are met:

(1) The health plan may rescind the exemption:

(A) only in January or July; and

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

(2) A determination must be made, based on a retrospective review of a random sample of at least five (5) and not more than twenty (20) health care services of the type to which the exemption relates that were provided by the health care provider during the exemption period, that less than ninety percent (90%) of the health care services met the medical necessity criteria used by the health plan in determining eligibility for an exemption under section 10(c) of this chapter.

(3) The determination under subdivision (2):

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

(B) if the health care provider is a physician, must be made by a physician licensed under IC 25-22.5 who is qualified to practice in the same medical specialty as the health care



provider, or in a similar specialty.

(4) The health plan must:

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

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

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

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

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

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

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

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

The rescission of a health care provider's exemption under this subsection takes effect upon the health plan's notification of the health care provider that the health care provider's exemption has been rescinded under this subsection.

(c) If a health care provider's exemption is rescinded under subsection (a) and the health care provider initiates a review of the rescission under section 13 of this chapter less than thirty (30) business days after the day on which the health care provider receives notification of the rescission, the rescission of the health care provider's exemption is stayed pending the outcome of the review. If a health care provider's exemption is rescinded under subsection (b) and the health care provider initiates a review of the rescission, the rescission of the health care provider's exemption is not stayed pending the outcome of the review.

Sec. 13. (a) A health care provider whose exemption from requesting prior approval is rescinded under section 12(a) or 12(b) of this chapter may initiate review of the rescission according to the rules adopted under IC 27-1-3-36.

(b) The review of the rescission of a health care provider's



1 exemption shall be conducted by an independent review panel
 2 recognized by the insurance commissioner as meeting the
 3 qualifications established by the rules adopted under IC 27-1-3-36.
 4 The independent review panel shall review the rescission of the
 5 exemption according to:

6 (1) section 14 or 15 of this chapter; and

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

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

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

16 Sec. 14. (a) If a health care provider whose exemption from
 17 requesting prior approval is rescinded under section 12(a) of this
 18 chapter initiates a review of the rescission, the independent review
 19 panel shall review the rescission according to one (1) of the
 20 following:

21 (1) Except as provided in subdivision (2), the independent
 22 review panel shall determine whether at least ninety percent
 23 (90%) of the random sample of health care services reviewed
 24 under section 12(a)(2) of this chapter met the medical
 25 necessity criteria used by the health plan in determining
 26 eligibility for an exemption under section 10(c) of this chapter.

27 (2) The health care provider may request that the
 28 independent review panel consider a new random sample of
 29 not less than five (5) and not more than twenty (20) cases in
 30 which the health care provider provided health care services
 31 of the type to which the health care provider's exemption
 32 relates during the exemption period that was the subject of
 33 the review under section 12(a)(2) of this chapter. If the health
 34 care provider makes a request under this subdivision, the
 35 independent review panel shall base its determination on
 36 whether at least ninety percent (90%) of the health care
 37 services in the random sample reviewed under this
 38 subdivision met the medical necessity criteria used by the
 39 health plan in determining eligibility for an exemption under
 40 section 10(c) of this chapter.

41 (b) If the independent review panel determines under subsection
 42 (a)(1) or (a)(2) that at least ninety percent (90%) of the health care



1 services reviewed met the medical necessity criteria used by the
 2 health plan in determining eligibility for an exemption under
 3 section 10(c) of this chapter, the health plan is bound by the
 4 determination under this subsection and shall restore the health
 5 care provider's exemption.

6 (c) If the independent review panel determines under subsection
 7 (a)(1) or (a)(2) that less than ninety percent (90%) of the health
 8 care services reviewed met the medical necessity criteria used by
 9 the health plan in determining eligibility for an exemption under
 10 section 10(c) of this chapter, the rescission of the health care
 11 provider's exemption takes effect five (5) business days after the
 12 day on which the independent review panel makes its
 13 determination under this section.

14 Sec. 15. (a) If a health care provider whose exemption from
 15 requesting prior approval is rescinded under section 12(b) of this
 16 chapter initiates a review of the rescission, the independent review
 17 panel's review of the rescission is limited to a determination of:

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

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

24 whichever applies.

25 (b) If the independent review panel determines that the health
 26 care provider did not commit health care provider fraud or that
 27 the health care provider's license or legal authorization is not
 28 suspended or has not been revoked, the health plan is bound by the
 29 determination under this subsection and shall restore the health
 30 care provider's exemption.

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

36 Sec. 16. (a) A health plan:

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

39 (A) the health care provider; or

40 (B) the independent review panel;

41 for the purposes of; and

42 (2) shall pay all costs of:



1 a review conducted by an independent review panel under sections
2 13 through 15 of this chapter.

3 Sec. 17. (a) This section applies under any of the following
4 circumstances:

5 (1) A health plan rescinds a health care provider's exemption
6 from prior authorization under section 12(a) of this chapter
7 and the health care provider does not initiate a review of the
8 recision within the period allowed by section 12(c) of this
9 chapter.

10 (2) A health plan rescinds a health care provider's exemption
11 from prior authorization under section 12(a) of this chapter,
12 the health care provider initiates a review of the recision, and
13 the determination of the independent review panel, as
14 described in section 14(c) of this chapter, is not in favor of the
15 health care provider.

16 (3) A health plan rescinds a health care provider's exemption
17 from prior authorization under section 12(b) of this chapter
18 and the health care provider does not initiate a review of the
19 recision within the period allowed by section 12(c) of this
20 chapter.

21 (4) A health plan rescinds a health care provider's exemption
22 from prior authorization under section 12(b) of this chapter,
23 the health care provider initiates a review of the recision, and
24 the determination of the independent review panel, as
25 described in section 15(c) of this chapter, is not in favor of the
26 health care provider.

27 (b) Under the circumstances set forth in subsection (a)(1), the
28 first evaluation period during which the health plan is again
29 required to determine under section 10(c) of this chapter whether
30 the health care provider is entitled to an exemption from
31 requesting prior authorization is the first evaluation period
32 beginning at least two (2) years after the health plan's recision of
33 the health care provider's exemption from prior authorization
34 takes effect under section 12(a) of this chapter.

35 (c) Under the circumstances set forth in subsection (a)(2), the
36 first evaluation period during which the health plan is again
37 required to determine under section 10(c) of this chapter whether
38 the health care provider is entitled to an exemption from
39 requesting prior authorization is the first evaluation period
40 beginning at least two (2) years after the health plan's recision of
41 the health care provider's exemption from prior authorization
42 takes effect under section 14(c) of this chapter.



1 (d) Under the circumstances set forth in subsection (a)(3), the
2 first evaluation period during which the health plan is again
3 required to determine under section 10(c) of this chapter whether
4 the health care provider is entitled to an exemption from
5 requesting prior authorization is the first evaluation period
6 beginning at least two (2) years after the health plan's rescission of
7 the health care provider's exemption from prior authorization
8 takes effect under section 12(b) of this chapter.

9 (e) Under the circumstances set forth in subsection (a)(4), the
10 first evaluation period during which the health plan is again
11 required to determine under section 10(c) of this chapter whether
12 the health care provider is entitled to an exemption from
13 requesting prior authorization is the first evaluation period
14 beginning at least two (2) years after the health plan's rescission of
15 the health care provider's exemption from prior authorization
16 takes effect under section 12(b) of this chapter.

