
ENGROSSED SENATE BILL No. 19

DIGEST OF SB 19 (Updated February 20, 1998 4:11 pm - DI 88)

Citations Affected: IC 12-7; IC 12-10; IC 12-15; IC 12-17; IC 27-8; noncode.

Synopsis: Increases for one year the family income eligibility standard for Medicaid for a child who is less than 19 years of age to 150% of the federal income poverty level. Requires the office of Medicaid policy and planning to use all appropriate federal funds to conduct activities in order to encourage children who are less than 19 years of age and who are eligible for Medicaid but who are not enrolled in the Medicaid program to enroll in the Medicaid program. Provides that Medicaid
(Continued next page)

Effective: Upon Passage; July 1, 1998.

**Johnson, Simpson, Howard,
Randolph, Washington**
(HOUSE SPONSORS — CRAWFORD, BUDAK, DAY)

November 18, 1997, read first time and referred to Committee on Rules and Legislative Procedure.

January 13, 1998, amended, reported favorably; reassigned to Committee on Planning and Public Services.

January 27, 1998, amended, reported favorably — Do Pass.

February 2, 1998, read second time, amended, ordered engrossed.

February 3, 1998, engrossed. Read third time, passed. Yeas 50, nays 0.

HOUSE ACTION

February 10, 1998, read first time and referred to Committee on Ways and Means.

February 17, 1998, amended, reported — Do Pass.

February 20, 1998, read second time, amended, ordered engrossed.

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applications may be made at an enrollment center such as a hospital, school, or clinic. Allows enrollment centers to accept applications for Medicaid, conduct interviews with applicants, and provide each application and accompanying materials to the county office of family and children in the same county as the enrollment center at least once a week. Allows the office of the secretary of family and social services to establish an office of the children's health insurance program within family and social services to obtain health insurance for eligible children. Allows the office to contract with insurers, including health maintenance organizations, limited services health maintenance organizations, and preferred provider plans, to arrange to provide health insurance and other required services to children in the children's health insurance program. Requires the office to establish performance criteria and evaluation measures for insurers. Requires the office to establish requirements a child must meet in order to enroll in the program. Provides a list of services for which the children's health insurance program must provide health insurance coverage. Provides that the office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses. Provides other requirements under which the office and insurers must operate, including requirements to provide incentives to insurers and employers to continue providing private health insurance to insureds and employees. Requires the office, with the assistance of the office of Medicaid policy and planning, to apply for waivers from the Secretary of the United States Department of Health and Human Services that are required to implement the program. Requires the office to submit state plans outlining Indiana's initial and long term children's health insurance program to the Secretary of the United States Department of Health and Human Services. Allows funds from the Medicaid indigent care trust fund to be used to provide the state's share of funds required to implement the children's health insurance program. Requires the office of Medicaid policy and planning and the division of family and children to provide a report to the state budget committee not later than September 1, 1998, that includes recommendations regarding the design and implementation of a presumptive eligibility policy to increase enrollment of Medicaid eligible pregnant women and children. Establishes a pilot program to allow political subdivisions to form a community care network for pooling and administering funds to be used in providing or arranging to provide health services and related items to the employees and residents of the political subdivisions. Provides that certain individuals who are Medicaid eligible and reside in a county home, hospital, nursing facility, or community residential facility for the developmentally disabled are allowed to retain a monthly personal allowance of at least \$35 and not more than \$61.32 beginning July 1, 1998.

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Reprinted
February 23, 1998

Second Regular Session 110th General Assembly (1998)

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 1997 General Assembly.

ENGROSSED SENATE BILL No. 19

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:

1 SECTION 1. IC 12-7-2-120, AS AMENDED BY P.L.26-1994,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 1999]: Sec. 120. (a) "Insurer", for purposes of the statutes
4 listed in subsection (b), means an insurance company, a health
5 maintenance organization (as defined in IC 27-13-1-19), a self-funded
6 employee benefit plan, a pension fund, a retirement system, or a similar
7 entity that:
8 (1) does business in Indiana; and
9 (2) is under an obligation to make payments for medical services
10 as a result of injury, illness, or disease suffered by an individual.
11 (b) ~~This section~~ **Subsection (a)** applies to the following statutes:
12 (1) IC 12-14-1 through IC 12-14-9.
13 (2) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.
14 (c) **"Insurer", for purposes of IC 12-17-18, has the meaning set**
15 **forth in IC 12-17-18-1.**

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1 SECTION 2. IC 12-7-2-134, AS AMENDED BY P.L.108-1997,
 2 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 3 JULY 1, 1999]: Sec. 134. "Office" means the following:

4 (1) Except as provided in ~~subdivision~~ **subdivisions (2) and (3)**,
 5 the office of Medicaid policy and planning established by
 6 IC 12-8-6-1.

7 (2) For purposes of IC 12-10-13, the meaning set forth in
 8 IC 12-10-13-4.

9 **(3) For purposes of IC 12-17-18, the meaning set forth in**
 10 **IC 12-17-18-2.**

11 SECTION 3. IC 12-7-2-139.1 IS ADDED TO THE INDIANA
 12 CODE AS A NEW SECTION TO READ AS FOLLOWS
 13 [EFFECTIVE JULY 1, 1999]: **Sec. 139.1. "Physicians' services", for**
 14 **purposes of IC 12-17-18-18, has the meaning set forth in**
 15 **IC 12-17-18-18(a).**

16 SECTION 4. IC 12-10-6-1, AS AMENDED BY P.L.24-1997,
 17 SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 18 JULY 1, 1998]: Sec. 1. (a) An individual who:

19 (1) is at least sixty-five (65) years of age, blind, or disabled; and

20 (2) is a resident of a county home;

21 is eligible to receive assistance payments from the state if the
 22 individual would be eligible for assistance under the federal
 23 Supplemental Security Income program except for the fact that the
 24 individual is residing in a county home.

25 (b) The amount of nonmedical assistance to be paid on behalf of a
 26 resident in a county home must be based on the daily rate established
 27 by the division. The rate for facilities under this section and licensed
 28 under IC 16-28 may not exceed an upper rate limit established by a rule
 29 adopted by the division.

30 (c) The rate for facilities under this section but not licensed under
 31 IC 16-28 must be the lesser of:

32 (1) an upper rate limit established by a rule adopted by the
 33 division; or

34 (2) a reasonable and adequate rate to meet the costs, determined
 35 by generally accepted accounting principles, that are incurred by
 36 efficiently and economically operated facilities in order to provide
 37 care and services in conformity with quality and safety standards
 38 and applicable laws and rules.

39 (d) The recipient shall be paid or allowed to retain from the
 40 recipient's income a **monthly** personal allowance in an amount to be
 41 established by the division. The amount:

42 (1) may be not less than ~~twenty-eight dollars and fifty cents~~

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1 ~~(\$28.50)~~ **thirty-five dollars (\$35)** and not more than ~~thirty-five~~
 2 **dollars (\$35) monthly; sixty-one dollars and thirty-two cents**
 3 **(\$61.32);**

4 (2) is exempt from income eligibility consideration by the
 5 division; and

6 (3) may be exclusively used by the recipient for personal needs.

7 (e) In addition to the amount that may be retained as a personal
 8 allowance under this section, an individual is allowed to retain an
 9 amount equal to the individual's state and local income tax liability.
 10 The amount that may be retained during a month may not exceed
 11 one-third (1/3) of the individual's state and local income tax liability for
 12 the calendar quarter in which the month occurs. This amount is exempt
 13 from income eligibility consideration by the division. The amount
 14 retained shall be used by the individual to pay state or local income
 15 taxes owed.

16 (f) The division of disability, aging, and rehabilitative services, in
 17 cooperation with the state department of health taking into account
 18 licensure requirements under IC 16-28, shall adopt rules under
 19 IC 4-22-2 governing the reimbursement to facilities under this section.
 20 The rules must be designed to determine the costs that must be incurred
 21 by efficiently and economically operated facilities to provide room,
 22 board, laundry, and other services, along with minimal administrative
 23 direction to individuals who receive residential care in the facilities
 24 under this section. A rule adopted under this subsection by:

25 (1) the division; or

26 (2) the state department of health;

27 must conform to the rules for residential care facilities that are licensed
 28 under IC 16-28.

29 (g) A rate established under this section may be appealed according
 30 to the procedures under IC 4-21.5.

31 (h) The division shall annually review each facility's rate using the
 32 following:

33 (1) Generally accepted accounting principles.

34 (2) The costs incurred by efficiently and economically operated
 35 facilities in order to provide care and services in conformity with
 36 quality and safety standards and applicable laws and rules.

37 SECTION 5. IC 12-10-6-2, AS AMENDED BY P.L.24-1997,
 38 SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 39 JULY 1, 1998]: Sec. 2. (a) An individual who is incapable of residing
 40 in the individual's own home may apply for residential care assistance
 41 under this section. The determination of eligibility for residential care
 42 assistance is the responsibility of the division. Except as provided in



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1 subsections (f) and (h), an individual is eligible for residential care
2 assistance if the division determines that the individual:

- 3 (1) is a recipient of Medicaid or the federal Supplemental Security
4 Income program;
5 (2) is incapable of residing in the individual's own home because
6 of dementia, mental illness, or a physical disability;
7 (3) requires a degree of care less than that provided by a health
8 care facility licensed under IC 16-28; and
9 (4) can be adequately cared for in a residential care setting.

10 (b) Individuals suffering from mental retardation may not be
11 admitted to a home or facility that provides residential care under this
12 section.

13 (c) A service coordinator employed by the division may:

- 14 (1) evaluate a person seeking admission to a home or facility
15 under subsection (a); or
16 (2) evaluate a person who has been admitted to a home or facility
17 under subsection (a), including a review of the existing
18 evaluations in the person's record at the home or facility.

19 If the service coordinator determines the person evaluated under this
20 subsection is mentally retarded, the service coordinator may
21 recommend an alternative placement for the person.

22 (d) Except as provided in section 5 of this chapter, residential care
23 consists of only room, board, and laundry, along with minimal
24 administrative direction. State financial assistance may be provided for
25 such care in a boarding or residential home of the applicant's choosing
26 that is licensed under IC 16-28 or a Christian Science facility listed and
27 certified by the Commission for Accreditation of Christian Science
28 Nursing Organizations/Facilities, Inc., that meets certain life safety
29 standards considered necessary by the state fire marshal. Payment for
30 such care shall be made to the provider of the care according to
31 division directives and supervision. The amount of nonmedical
32 assistance to be paid on behalf of a recipient living in a boarding home,
33 residential home, or Christian Science facility shall be based on the
34 daily rate established by the division. The rate for facilities that are
35 referred to in this section and licensed under IC 16-28 may not exceed
36 an upper rate limit established by a rule adopted by the division. The
37 recipient may retain from the recipient's income a **monthly** personal
38 allowance in an amount to be established by the division, but not less
39 than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars**
40 **(\$35)** or more than ~~thirty-five dollars (\$35) monthly.~~ **sixty-one dollars**
41 **and thirty-two cents (\$61.32)**. This amount is exempt from income
42 eligibility consideration by the division and may be exclusively used by

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1 the recipient for the recipient's personal needs. However, if the
 2 recipient's income is less than the amount of the personal allowance,
 3 the division shall pay to the recipient the difference between the
 4 amount of the personal allowance and the recipient's income. A reserve
 5 or an accumulated balance from such a source, together with other
 6 sources, may not be allowed to exceed the state's resource allowance
 7 allowed for adults eligible for state supplemental assistance or
 8 Medicaid as established by the rules of the office of Medicaid policy
 9 and planning.

10 (e) In addition to the amount that may be retained as a personal
 11 allowance under this section, an individual shall be allowed to retain
 12 an amount equal to the individual's state and local income tax liability.
 13 The amount that may be retained during a month may not exceed
 14 one-third (1/3) of the individual's state and local income tax liability for
 15 the calendar quarter in which that month occurs. This amount is
 16 exempt from income eligibility consideration by the division. The
 17 amount retained shall be used by the individual to pay any state or local
 18 income taxes owed.

19 (f) The rate of payment to the provider shall be determined in
 20 accordance with a prospective prenegotiated payment rate predicated
 21 on a reasonable cost related basis, with a growth of profit factor, as
 22 determined in accordance with generally accepted accounting
 23 principles and methods, and written standards and criteria, as
 24 established by the division. The division shall establish an
 25 administrative appeal procedure to be followed if rate disagreement
 26 occurs if the provider can demonstrate to the division the necessity of
 27 costs in excess of the allowed or authorized fee for the specific
 28 boarding or residential home. The amount may not exceed the
 29 maximum established under subsection (d).

30 (g) The personal allowance for one (1) month for an individual
 31 described in subsection (a) whose employment is part of the
 32 individual's personal habilitation plan or who is working in a sheltered
 33 workshop or day activity center is the amount that an individual would
 34 be entitled to retain under subsection (d) plus an amount equal to
 35 one-half (1/2) of the remainder of:

- 36 (1) gross earned income for that month; minus
 37 (2) the sum of:
 38 (A) sixteen dollars (\$16); plus
 39 (B) the amount withheld from the person's paycheck for that
 40 month for payment of state income tax, federal income tax,
 41 and the tax prescribed by the federal Insurance Contribution
 42 Act (26 U.S.C. 3101 et seq.); plus



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- 1 (C) transportation expenses for that month.
- 2 (h) An individual who, before September 1, 1983, has been admitted
- 3 to a home or facility that provides residential care under this section is
- 4 eligible for residential care in the home or facility.
- 5 (i) The director of the division may contract with the division of
- 6 mental health or the division of disability, aging, and rehabilitative
- 7 services to purchase services for individuals suffering from mental
- 8 illness or a developmental disability by providing money to supplement
- 9 the appropriation for community residential care programs established
- 10 under IC 12-22-2 or community residential care programs established under
- 11 IC 12-11-1-1.
- 12 (j) A person with a mental illness may not be placed in a Christian
- 13 Science facility listed and certified by the Commission for
- 14 Accreditation of Christian Science Nursing Organizations/Facilities,
- 15 Inc., unless the facility is licensed under IC 16-28.
- 16 SECTION 6. IC 12-15-1-18 IS ADDED TO THE INDIANA CODE
- 17 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
- 18 UPON PASSAGE]: **Sec. 18. The office shall use all funds that are**
- 19 **appropriated to the office under 42 U.S.c. 1397ee to conduct**
- 20 **activities allowed under 42 U.S.C. 1397bb(c)(1) in order to**
- 21 **encourage children who are:**
- 22 (1) less than nineteen (19) years of age;
- 23 (2) eligible for Medicaid; and
- 24 (3) not enrolled in the Medicaid program;
- 25 **to apply for and enroll in the Medicaid program.**
- 26 SECTION 7. IC 12-15-2-15.6 IS ADDED TO THE INDIANA
- 27 CODE AS A NEW SECTION TO READ AS FOLLOWS
- 28 [EFFECTIVE JULY 1, 1998]: **Sec. 15.6. (a) Notwithstanding sections**
- 29 **15 and 15.5 of this chapter, an individual:**
- 30 (1) whose family income does not exceed one hundred fifty
- 31 percent (150%) of the federal income poverty level for the
- 32 same size family;
- 33 (2) who is otherwise eligible for Medicaid under section 15 or
- 34 15.5 of this chapter; and
- 35 (3) who is not otherwise eligible for Medicaid under this
- 36 chapter;
- 37 **is eligible for Medicaid.**
- 38 (b) The state's share of any treatment received by an individual
- 39 who is eligible for Medicaid under this section is calculated under
- 40 Section 1905(u) of the federal Social Security Act (42 U.S.C.
- 41 1396d(u)).
- 42 (c) This section expires June 30, 1999.

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1 SECTION 8. IC 12-15-4-1 IS AMENDED TO READ AS
 2 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) An
 3 application or a request for Medicaid for an individual must be **made**
 4 ~~(1) made to the county office of the county in which the applicant~~
 5 ~~resides; and (2) in the manner required by the office at enrollment~~
 6 ~~centers specified by the office.~~

7 (b) Enrollment centers:

8 (1) shall be located at each county office; and

9 (2) may be located at other locations including the following:

10 (A) A hospital licensed under IC 16-21.

11 (B) The office of a provider who is eligible to receive
 12 payments under this article.

13 (C) A public or private elementary or secondary school.

14 (D) A day care center licensed under IC 12-17.2.

15 (E) The county health department.

16 (F) A federally qualified health center (as defined in 42
 17 U.S.C. 1396d(1)(2)(B)).

18 (G) A rural health clinic (as defined in 42 U.S.C.
 19 1396d(1)(1)).

20 (c) An entity described in subsection (b) other than the county
 21 office must enter into an agreement with the office for
 22 authorization to serve as an enrollment center where individuals
 23 may apply for Medicaid.

24 (d) One (1) or more authorized workers at each enrollment
 25 center may:

26 (1) accept applications for Medicaid; and

27 (2) conduct interviews with applicants;

28 during hours and days of the week agreed upon by the office and
 29 the enrollment center.

30 (e) The office shall provide each enrollment center with the
 31 materials and training needed by the enrollment center to comply
 32 with this section.

33 (f) An enrollment center shall provide:

34 (1) each application taken by the enrollment center; and

35 (2) any accompanying materials;

36 to the county office located in the same county as the enrollment
 37 center at least one (1) time each week by any reasonable means.
 38 The county office staff shall make the final determination of an
 39 applicant's eligibility for Medicaid.

40 SECTION 9. IC 12-15-7-2 IS AMENDED TO READ AS
 41 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. Not less than
 42 twenty-eight dollars and fifty cents (\$28.50) ~~thirty-five dollars (\$35)~~



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1 or more than ~~thirty-five dollars (\$35)~~ **sixty-one dollars and thirty-two**
 2 **cents (\$61.32)** monthly may be exempt from income eligibility
 3 consideration.

4 SECTION 10. IC 12-15-32-6 IS AMENDED TO READ AS
 5 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. The office shall
 6 allow a resident of a facility who is receiving Medicaid to retain a
 7 **monthly** personal allowance of at least ~~twenty-eight dollars and fifty~~
 8 **cents (\$28.50) thirty-five dollars (\$35)** but not more than ~~fifty dollars~~
 9 **(~~\$50~~) each month: sixty-one dollars and thirty-two cents (\$61.32).**

10 SECTION 11. IC 12-17-18 IS ADDED TO THE INDIANA CODE
 11 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 12 JULY 1, 1999]:

13 **Chapter 18. Children's Health Insurance Program**

14 **Sec. 1. (a) As used in this chapter, "insurer" means any person**
 15 **who provides health insurance in Indiana. The term includes the**
 16 **following:**

- 17 (1) A licensed insurance company.
 18 (2) A health maintenance organization.
 19 (3) A multiple employer welfare arrangement.
 20 (4) Any person providing a plan of health insurance subject to
 21 state insurance law.

22 (b) For purposes of section 7(b) of this chapter, the term
 23 includes a limited service health maintenance organization (as
 24 defined in IC 27-13-34-4) and a preferred provider plan (as defined
 25 in IC 27-8-11-1).

26 **Sec. 2. As used in this chapter, "office" refers to the office of the**
 27 **children's health insurance program that may be established under**
 28 **this chapter.**

29 **Sec. 3. The secretary may establish:**

- 30 (1) the office; and
 31 (2) a children's health insurance program.

32 **Sec. 4. A child may apply at an enrollment center as provided in**
 33 **IC 12-15-4-1 to receive health care services if the child:**

- 34 (1) meets the qualifications described in section 12 of this
 35 chapter; or
 36 (2) receives health care services through the Hoosier
 37 Healthwise program under IC 12-15.

38 **Sec. 5. A child who enrolls in the children's health insurance**
 39 **program shall receive the health care services described in section**
 40 **18 of this chapter.**

41 **Sec. 6. The office may design and administer a system to obtain**
 42 **health insurance for eligible children.**



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1 **Sec. 7. (a) The office may contract with insurers under IC 5-22**
 2 **to arrange to provide health insurance and other services to a child**
 3 **who is enrolled in the children's health insurance program. A**
 4 **contract under this subsection must require an insurer to do the**
 5 **following:**

6 **(1) Establish locations where an applicant may apply to**
 7 **receive services provided by the children's health insurance**
 8 **program.**

9 **(2) Provide education concerning the following:**

10 **(A) The responsible use of health facilities and**
 11 **information.**

12 **(B) Preventive care.**

13 **(C) Parental responsibilities for a child's health care.**

14 **(3) Provide outreach and evaluation activities for the**
 15 **children's health insurance program.**

16 **(b) The office may contract with insurers to arrange to provide**
 17 **the services described in section 18(b) of this chapter. An insurer**
 18 **under this subsection must:**

19 **(1) be eligible to receive reimbursement from the office; and**

20 **(2) comply with subsection (a).**

21 **Sec. 8. (a) The office shall establish performance criteria and**
 22 **evaluation measures for an insurer with which the office contracts**
 23 **under section 7 of this chapter.**

24 **(b) The office shall assess monetary penalties on an insurer that**
 25 **fails to comply with the requirements of this chapter or a rule**
 26 **adopted under this chapter.**

27 **Sec. 9. The office may adopt a sliding scale formula that**
 28 **specifies the premiums, if any, to be paid by the parent or guardian**
 29 **of a child enrolled in the children's health insurance program**
 30 **based on the parent's or guardian's annual income.**

31 **Sec. 10. (a) The office shall annually adjust the children's health**
 32 **insurance program to reflect the amount of money available to**
 33 **obtain health insurance for children enrolled in the children's**
 34 **health insurance program.**

35 **(b) The office shall use only the funds appropriated to the office**
 36 **to operate the children's health insurance program.**

37 **Sec. 11. The office may establish and administer a children's**
 38 **health insurance program fund to provide premium assistance**
 39 **from the state to children enrolled in the children's health**
 40 **insurance program.**

41 **Sec. 12. The office shall establish requirements that a child must**
 42 **meet in order to enroll in the children's health insurance program.**



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1 **Sec. 13. To be eligible to receive reimbursement from the office,**
2 **an insurer shall arrange to provide health care services required**
3 **by this chapter to an eligible child without:**

- 4 (1) regard to the child's health status; and
- 5 (2) imposing a preexisting condition exclusion;

6 **except that a preexisting condition exclusion may be applied if**
7 **health care services are provided through a group health plan or**
8 **group health insurance coverage, consistent with the limitations on**
9 **imposing preexisting condition exclusions provided in state and**
10 **federal law.**

11 **Sec. 14. Premium and cost sharing amounts established by the**
12 **office are limited to the following:**

13 (1) Deductibles, coinsurance, or other cost sharing are not
14 permitted with respect to benefits for well-baby and well-child
15 care, including age appropriate immunizations.

16 (2) For children whose family income is equal to or less than
17 one hundred fifty percent (150%) of the federal income
18 poverty level:

19 (A) premiums, enrollment fees, or similar charges may not
20 exceed the maximum monthly charge permitted consistent
21 with standards established to carry out section 1916(b)(1)
22 of the Social Security Act (42 U.S.C. 301 et seq.); and

23 (B) deductibles and other cost sharing shall not exceed a
24 nominal amount that is consistent with standards provided
25 under Section 1916(a)(3) of the Social Security Act (42
26 U.S.C. 301 et seq.), as adjusted.

27 (3) For children whose family income is greater than one
28 hundred fifty percent (150%) of the federal income poverty
29 level, premiums, deductibles, and other cost sharing may be
30 imposed on a sliding scale related to family income. However,
31 the total annual aggregate cost sharing with respect to all
32 children in a family under this chapter may not exceed five
33 percent (5%) of the family's income for the year.

34 **Sec. 15. Insurers shall use existing health insurance sales and**
35 **marketing methods, including the use of agents and payment of**
36 **commissions, to do the following:**

37 (1) Inform families of the availability of the children's health
38 insurance program.

39 (2) Assist families in obtaining health insurance coverage for
40 children under the children's health insurance program.

41 **Sec. 16. A child who is eligible to participate in the children's**
42 **health insurance program is eligible for coverage with a**

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1 participating plan regardless of the child's health status.

2 **Sec. 17.** A child who is participating in the children's health
3 insurance program may change between participating plans only
4 during an annual coverage renewal period, unless the child moves
5 outside of the geographic service area of the participating plan in
6 which the child is enrolled.

7 **Sec. 18. (a)** As used in this section, "physicians' services" has the
8 meaning set forth in 42 U.S.C. 1395x(q).

9 **(b)** The office shall offer health insurance coverage for the
10 following:

- 11 (1) Inpatient and outpatient hospital services.
- 12 (2) Physicians' services.
- 13 (3) Laboratory and x-ray services.
- 14 (4) Well-baby and well-child care, including age appropriate
15 immunizations.
- 16 (5) Prescription drugs.
- 17 (6) Mental health services.
- 18 (7) Vision services.
- 19 (8) Hearing services.
- 20 (9) Dental services.

21 **(c)** Notwithstanding subsection (b), the office shall offer health
22 insurance coverage for the same services provided under the early
23 and periodic screening, diagnosis, and treatment program
24 (EPSDT) under IC 12-15.

25 **(d)** Notwithstanding subsections (b) and (c), the office may not
26 impose treatment limitations or financial requirements on the
27 coverage of services for a mental illness if similar treatment
28 limitations or financial requirements are not imposed on coverage
29 for services for other illnesses.

30 **Sec. 19.** The office shall do the following:

- 31 (1) Establish a penalty to be paid by the following:
 - 32 (A) An insurer, insurance agent, or insurance broker, for
33 knowingly or intentionally referring an insured or the
34 dependent of an insured to the children's health insurance
35 program in order to receive health care when the insured
36 receives health insurance through an employer's health
37 care plan that is underwritten by the insurer.
 - 38 (B) An employer, for knowingly or intentionally referring
39 an employee or the dependent of an employee to the
40 children's health insurance program in order to receive
41 health care when the employee receives health insurance
42 through the employer's health care plan.



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- 1 (C) An employer that knowingly or intentionally changes
2 the terms of coverage for or premiums paid by an
3 employee in order to force an employee or the dependent
4 of an employee to apply to the children's health insurance
5 program in order to receive health care.
6 (2) Create standards to minimize the incentive for:
7 (A) an employer to eliminate or reduce health care
8 coverage for an employee's dependents; or
9 (B) an individual to eliminate or reduce health care
10 coverage for a dependent of the individual.
- 11 Sec. 20. Not later than June 30 of each year, the office shall
12 provide a report describing the office's activities during the
13 preceding calendar year to the state budget committee.
- 14 Sec. 21. The office shall adopt rules under IC 4-22-2 to
15 implement this chapter.
- 16 SECTION 12. IC 27-8-23-4, AS ADDED BY P.L.133-1995,
17 SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
18 JULY 1, 1999]: Sec. 4. As used in this chapter, "insurer" has the
19 meaning set forth in ~~IC 12-7-2-120~~: **IC 12-7-2-120(a)**.
- 20 SECTION 13. [EFFECTIVE JULY 1, 1998] (a) **Not later than**
21 **September 1, 1998, the office of Medicaid policy and planning and**
22 **the division of family and children shall provide a report to the**
23 **state budget committee that includes recommendations regarding**
24 **the design and implementation of a presumptive eligibility policy**
25 **to increase enrollment of Medicaid eligible pregnant women and**
26 **children.**
- 27 (b) **This SECTION expires January 1, 1999.**
- 28 SECTION 14. [EFFECTIVE JULY 1, 1999] (a) As used in this
29 SECTION, "office" refers to the office of the children's health
30 insurance program under IC 12-17-18, as added by this act.
- 31 (b) The office, with the assistance of the office of Medicaid
32 policy and planning, shall apply under Section 1115 of the federal
33 Social Security Act to the Secretary of the United States
34 Department of Health and Human Services for any waivers
35 required to implement the children's health insurance program.
36 The intent of a waiver under this SECTION is to allow the state to
37 offer the same health care services both to children who enroll in
38 the children's health insurance program and to children who
39 currently receive health care services under the Medicaid
40 program.
- 41 (c) **This SECTION expires January 1, 2001.**
- 42 SECTION 15. [EFFECTIVE UPON PASSAGE] (a) **The office of**

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1 Medicaid policy and planning shall submit a state plan outlining
 2 Indiana's initial children's health insurance program to the
 3 Secretary of the United States Department of Health and Human
 4 Services before July 1, 1998.

5 (b) If an office of the children's health insurance program is
 6 established under IC 12-17-18, as added by this act, the office of
 7 the children's health insurance program shall amend the state plan
 8 outlining Indiana's children's health insurance program to
 9 describe a children's health insurance program, including the
 10 elements required under IC 12-17-18, as added by this act, before
 11 July 1, 1999.

12 (c) The state may transfer funds from the Medicaid indigent
 13 care trust fund under IC 12-15-20 to pay for the state's share of
 14 funds required to receive federal financial participation under the
 15 children's health insurance program.

16 (d) This SECTION expires January 1, 2001.

17 SECTION 16. [EFFECTIVE JULY 1, 1998] (a) This SECTION
 18 does not apply to services provided by a facility licensed under
 19 IC 16-28.

20 (b) As used in this SECTION, "community care network"
 21 means a system of providing or arranging for health services and
 22 related items for the residents of a community within the needs and
 23 resources of the community.

24 (c) As used in this SECTION, "political subdivision" has the
 25 meaning set forth in IC 34-4-16.5-2.

26 (d) One (1) or more political subdivisions may elect to
 27 participate in a pilot program under this SECTION by forming a
 28 community care network for the purpose of pooling and
 29 administering funds to be used in providing or arranging to
 30 provide health services and related items to at least one (1) of the
 31 following groups:

32 (1) The employees of the political subdivisions.

33 (2) Enrollees whose health services and items are provided
 34 under IC 12-15, if approved by the office of the secretary.

35 (3) The enrollees of the children's health insurance program
 36 under IC 12-17-18.

37 (4) The employees of private employers, if appropriate.

38 (5) Other groups of residents approved for inclusion by the
 39 board of directors as provided under subsection (f).

40 (e) A community care network is authorized to pool funds
 41 provided to the community care network by:

42 (1) the political subdivisions participating in the community



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- care network;
 - (2) private employers;
 - (3) state and federal entities;
 - (4) grants; and
 - (5) any other source;
- for financing and arranging to provide health services and related items to the employees and residents of the political subdivisions.
- (f) A community care network is governed by a board of directors.
- (g) A board of directors must have an odd number of members that is not less than five (5) members but not more than eleven (11) members.
- (h) Members of a board of directors must include the following:
- (1) Representatives of the political subdivisions establishing the community care network.
 - (2) Representatives of the employees of the political subdivisions establishing the community care network.
 - (3) Representatives of the residents, if applicable, of the political subdivisions establishing the community care network.
 - (4) Representatives of providers that will provide health services and related items to individuals receiving health care through the community care network.
- The political subdivisions establishing the community care network must agree to the number of representatives under subdivisions (1) through (4).
- (i) Each member of a board of directors must have demonstrated expertise in health care financing or health care delivery systems, or both.
- (j) The executives of the political subdivisions establishing the community care network must:
- (1) agree to the number of members each executive may appoint; and
 - (2) after reaching agreement under subdivision (1), appoint members;
- to the board of directors.
- (k) The board of directors of each community care network shall establish a community care network fund to pay for health services and related items for participants in the network.
- (l) The board of directors shall establish guidelines for the community care network that include the following:
- (1) Quality assurance.

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- 1 **(2) Benefit levels.**
- 2 **(3) Improved access to health care.**
- 3 **(4) Cost containment through early intervention.**
- 4 **(5) Medical staff expertise.**
- 5 **(6) Coordination of community resources.**
- 6 **(7) Community, parental, and school involvement.**
- 7 **(m) A community care network must be approved annually by:**
- 8 **(1) the department of insurance; and**
- 9 **(2) the office of the secretary of family and social services.**
- 10 **(n) The department of insurance must certify that a community**
- 11 **care network possesses necessary financial reserves.**
- 12 **(o) A community care network may contract with:**
- 13 **(1) an accident and sickness insurance company, including**
- 14 **reimbursement agreements under IC 27-8-11;**
- 15 **(2) a health care provider (as defined in IC 27-12-2-14); or**
- 16 **(3) a nonprofit agency that provides health care services;**
- 17 **to provide or arrange for the provision of health services and items**
- 18 **for the employees and residents of the political subdivisions**
- 19 **establishing the community care network.**
- 20 **(p) A contract under subsection (o) may be awarded only after**
- 21 **the community care network uses a public bidding process for the**
- 22 **contract.**
- 23 **(q) A community care network established under this**
- 24 **SECTION:**
- 25 **(1) may contract with the state to provide services under**
- 26 **IC 12-14, IC 12-15, and IC 12-17-18; and**
- 27 **(2) is a body corporate and politic.**
- 28 **(r) Any plan of self-insurance must include an aggregate**
- 29 **stop-loss provision.**
- 30 **(s) The political subdivisions establishing the community care**
- 31 **network:**
- 32 **(1) shall appropriate to the community care network any**
- 33 **funds necessary to provide health services and related items**
- 34 **for employees of the political subdivisions; and**
- 35 **(2) may appropriate funds for health services and items**
- 36 **provided to other residents of the political subdivisions.**
- 37 **(t) If Medicaid funds are used by a community care network to**
- 38 **pay for health services and related items, the office of Medicaid**
- 39 **policy and planning:**
- 40 **(1) shall assure that patients served by federally qualified**
- 41 **health centers, rural health clinics, and other primary care**
- 42 **providers that target uninsured or Medicaid patients have**

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1 equal or better access to comprehensive quality primary care
2 services; and

3 (2) may apply to the Secretary of the United States
4 Department of Health and Human Services for any waivers
5 necessary to implement this SECTION.

6 (u) If the office of Medicaid policy and planning seeks a waiver
7 under IC 12-15 to establish a managed care program or other
8 demonstration project, the office of Medicaid policy and planning
9 shall not seek a waiver of:

10 (1) federally qualified health centers and rural health clinic
11 services as mandatory Medicaid services under:

12 (A) 42 U.S.C. 1396a(10)(A);

13 (B) 42 U.S.C. 1396d(a)(2)(B); and

14 (C) 42 U.S.C. 1396d(a)(2)(C); or

15 (2) reasonable cost reimbursement for federally qualified
16 health centers and rural health clinics under 42 U.S.C.
17 1396a(a)(13)(E).

18 (v) A community care network established under this SECTION
19 shall file a report with the department of insurance and the office
20 of the secretary of family and social services not later than March
21 1 of each year that provides information about the community care
22 network during the preceding calendar year that is requested by
23 the department of insurance and the office of the secretary of
24 family and social services.

25 (w) Not later than January 1, 2002, the department of insurance
26 and the office of the secretary of family and social services shall
27 begin to evaluate the community care networks established under
28 this SECTION.

29 (x) Not later than November 1, 2002, the department of
30 insurance and the office of the secretary of family and social
31 services shall report to the legislative council and the governor
32 regarding whether community care networks should be established
33 legislatively on an ongoing basis.

34 (y) A community care network may not begin operation before
35 January 1, 1999.

36 (z) This SECTION expires January 1, 2003.

37 SECTION 17. An emergency is declared for this act.

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SENATE MOTION

Mr. President: I move that Senator Garton be removed as author of Senate Bill 19 and that Senator Johnson be substituted therefor.

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COMMITTEE REPORT

Mr. President: The Senate Committee on Rules and Legislative Procedure, to which was referred Senate Bill 19, 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:

Delete the title and insert the following:

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

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill be reassigned to the Senate Committee on Planning and Public Services.

(Reference is to Senate Bill 19 as introduced.)

GARTON, Chairperson

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COMMITTEE REPORT

Mr. President: The Senate Committee on Planning and Public Services, to which was referred Senate Bill 19, 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 6, line 16, after "3." insert "(a).

Page 6, between lines 18 and 19, begin a new paragraph and insert:

"(b) Notwithstanding section 1(2) of this chapter and subsection (a), the office shall consider the following to be qualified entities:

- (1) A disproportionate share provider under IC 12-15-16-1(a).**
- (2) An enhanced disproportionate share provider under IC 12-15-16-1(b).**
- (3) A federally qualified health clinic.**
- (4) A rural health clinic."**

Page 7, line 17, after "office" insert "or an enrollment center".

Page 7, line 18, after "resides" insert "(as provided in IC 12-15-4-1)".

Page 7, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 7. IC 12-15-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) An application or a request for Medicaid for an individual must be made:

(1) made to the county office of the county in which the applicant resides; and

(2) in the manner required by the office; and

(2) at one (1) of the following locations in the county where the applicant resides:

- (A) A hospital licensed under IC 16-21.**
- (B) The office of a provider who is eligible to receive payments under this article.**
- (C) A public or private elementary or secondary school.**
- (D) A day care center licensed under IC 12-17.2.**
- (E) The county health department.**
- (F) A federally qualified health center (as defined in 42 U.S.C. 1396d(1)(2)(B)).**
- (G) A rural health clinic (as defined in 42 U.S.C. 1396d(1)(1)).**
- (H) The county office.**
- (I) Any other location approved by the office under subsection (b).**

(b) An entity described in subsection (a)(2) other than the county office may apply to the office, on a form provided by the office, for authorization to serve as an enrollment center where



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individuals may apply for Medicaid.

(c) One (1) or more employees at each enrollment center shall:

- (1) accept applications for Medicaid; and
- (2) conduct interviews with applicants;

during hours and days of the week agreed upon by the office and the enrollment center.

(d) The office shall provide each enrollment center with the materials and training needed by the enrollment center to comply with this section.

(e) An enrollment center shall provide:

- (1) each application taken by the enrollment center; and
- (2) any accompanying materials;

to the county office located in the same county as the enrollment center at least one (1) time each week by any reasonable means. The county office shall then make the final determination of an applicant's eligibility for Medicaid."

Page 8, delete lines 17 through 20, begin a new paragraph and insert:

"SECTION 9. IC 16-18-2-255.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 255.5. "Office", for purposes of IC 16-35-6, has the meaning set forth in IC 16-35-6-1.

SECTION 10. IC 16-18-2-282.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 282.2. (a) "Physicians' services", for purposes of IC 16-35-6-18, has the meaning set forth in IC 16-35-16-18(a)."

Page 9, line 21, delete "program" and insert "office".

Page 9, line 21, after "the" insert "office of the".

Page 9, delete line 28.

Page 9, line 29, delete "(3)" and insert "(2)".

Page 9, line 30, delete "(4)" and insert "(3)".

Page 9, line 31, delete "(5)" and insert "(4)".

Page 9, line 35, delete "to receive services provided by the" and insert "at an enrollment center to receive health care services".

Page 9, line 36, delete "program".

Page 9, line 41, after "in the" insert "children's health insurance".

Page 10, line 3, delete "program" and insert "office".

Page 10, line 5, delete "program" and insert "office".

Page 10, line 7, after "the" insert "children's health insurance".

Page 10, line 15, after "the" insert "children's health insurance".

Page 10, line 21, after "the" insert "children's health insurance".

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- Page 10, line 23, delete "program" and insert "**office**".
- Page 10, line 24, delete "program" and insert "**office**".
- Page 10, line 26, delete "program" and insert "**office**".
- Page 10, line 29, delete "program" and insert "**office**".
- Page 10, line 31, after "in the" insert "**children's health insurance**".
- Page 10, line 33, after "10." insert "(a)".
- Page 10, between lines 35 and 36, begin a new paragraph and insert:
"(b) The children's health insurance program shall operate within available funds appropriated to the program."
- Page 10, line 36, delete "program" and insert "**office**".
- Page 10, line 36, after "a" insert "**children's health insurance**".
- Page 10, line 38, after "the" insert "**children's health insurance**".
- Page 10, line 39, delete "(a)".
- Page 10, line 39, after "the" insert "**children's health insurance**".
- Page 11, delete lines 7 through 8.
- Page 11, line 10, delete "program," and insert "**office**,".
- Page 11, line 10, after "offer" delete "program" and insert "**health care**".
- Page 11, line 10, after "services" insert "**required by this chapter**".
- Page 11, line 15, delete "program" and insert "**health care**".
- Page 11, line 19, delete "under the program" and insert "**established by the office**".
- Page 12, line 2, before "program" insert "**children's health insurance**".
- Page 12, line 4, after "the" insert "**children's health insurance**".
- Page 12, line 5, after "the" insert "**children's health insurance**".
- Page 12, line 6, delete "provider" and insert "**plan**".
- Page 12, line 8, after "the" insert "**children's health insurance**".
- Page 12, line 8, after "may" insert "**change only between participating plans during an annual coverage renewal period, unless the child moves outside of the geographic service area of the participating plan in which the child is enrolled.**".
- Page 12, delete lines 9 through 12.
- Page 12, line 13, delete "The period required for the notice to be sent under" and insert "**A child who moves to an area outside the geographic service area of the participating plan in which the child is enrolled shall provide notice to the participating plan at least sixty (60) days before the child may change participating plans.**".
- Page 12, delete lines 14 through 17.
- Page 12, line 18, after "(a)" insert "**As used in this section, 'physicians' services' has the meaning set forth in 42 U.S.C. 1395x(q).**".



Page 12, line 18, before "The" begin a new paragraph and insert:
"(b)".

Page 12, line 18, delete "program" and insert "**office**".

Page 12, line 21, delete "surgical and medical".

Page 12, line 25, delete "program" and insert "**office**".

Page 12, line 27, delete "of at least seventy-five percent (75%) of the" and insert "**equal to**".

Page 12, line 35, delete "program" and insert "**office**".

Page 12, between lines 38 and 39, begin a new paragraph and insert:

"(d) Notwithstanding subsections (a) and (b), the office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses."

Page 12, line 40, delete "program" and insert "**office**".

Page 12, line 41, delete "program" and insert "**office**".

Page 12, line 42, delete "program" and insert "**office**".

Page 13, line 1, delete "program's" and insert "**office's**".

Page 13, line 3, delete "program" and insert "**office**".

Page 13, line 6, delete ""program"" and insert ""**office**"".

Page 13, line 6, after "the" insert "**office of the**".

Page 13, line 8, delete "program" and insert "**office**".

Page 13, line 19, delete ""program"" and insert ""**office**"".

Page 13, line 19, after "the" insert "**office of the**".

Page 13, line 21, delete "program" and insert "**office**".

Page 13, line 25, delete "program" and insert "**office**".

Page 13, line 26, after "a" insert "**children's health insurance**".

Page 13, line 28, after "." insert "**The state plan amendment required under this SECTION must include identification of the benchmark program that will be used by the office, as provided in IC 16-35-6-18, as added by this act.**".

Page 13, between lines 33 and 34, begin a new paragraph and insert:

"SECTION 13. [EFFECTIVE JULY 1, 1998] (a) This SECTION does not apply to services provided by a facility licensed under IC 16-28.

(b) As used in this SECTION, "community care network" means a system of providing or arranging for health services and related items for the residents of a community within the needs and resources of the community.

(c) As used in this SECTION, "political subdivision" has the meaning set forth in IC 34-4-16.5-2.

(d) One (1) or more political subdivisions may elect to



participate in a pilot program under this SECTION by forming a community care network for the purpose of pooling and administering funds to be used in providing or arranging to provide health services and related items to at least one (1) of the following groups:

- (1) The employees of the political subdivisions.
- (2) Enrollees whose health services and items are provided under IC 12-15, if approved by the office of the secretary.
- (3) The enrollees of the children's health insurance program under IC 16-35-6.
- (4) The employees of private employers, if appropriate.
- (5) Other groups of residents approved for inclusion by the board of directors as provided under subsection (f).

(e) A community care network is authorized to pool funds provided to the community care network by:

- (1) the political subdivisions participating in the community care network;
- (2) private employers;
- (3) state and federal entities;
- (4) grants; and
- (5) any other source;

for financing and arranging to provide health services and related items to the employees and residents of the political subdivisions.

(f) A community care network is governed by a board of directors.

(g) A board of directors must have an odd number of members that is not less than five (5) members but not more than eleven (11) members.

(h) Members of a board of directors must include the following:

- (1) Representatives of the political subdivisions establishing the community care network.
- (2) Representatives of the employees of the political subdivisions establishing the community care network.
- (3) Representatives of the residents, if applicable, of the political subdivisions establishing the community care network.
- (4) Representatives of providers that will provide health services and related items to individuals receiving health care through the community care network.

The political subdivisions establishing the community care network must agree to the number of representatives under subdivisions (1) through (4).



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(i) Each member of a board of directors must have demonstrated expertise in health care financing or health care delivery systems, or both.

(j) The executives of the political subdivisions establishing the community care network must:

- (1) agree to the number of members each executive may appoint; and
- (2) after reaching agreement under subdivision (1), appoint members;

to the board of directors.

(k) The board of directors of each community care network shall establish a community care network fund to pay for health services and related items for participants in the network.

(l) The board of directors shall establish guidelines for the community care network that include the following:

- (1) Quality assurance.
- (2) Benefit levels.
- (3) Improved access to health care.
- (4) Cost containment through early intervention.
- (5) Medical staff expertise.
- (6) Coordination of community resources.
- (7) Community, parental, and school involvement.

(m) A community care network must be approved annually by:

- (1) the department of insurance; and
- (2) the office of the secretary of family and social services.

(n) The department of insurance must certify that a community care network possesses necessary financial reserves.

(o) A community care network may contract with:

- (1) an accident and sickness insurance company, including reimbursement agreements under IC 27-8-11;
- (2) a health care provider (as defined in IC 27-12-2-14); or
- (3) a nonprofit agency that provides health care services;

to provide or arrange for the provision of health services and items for the employees and residents of the political subdivisions establishing the community care network.

(p) A contract under subsection (o) may be awarded only after the community care network uses a public bidding process for the contract.

(q) A community care network established under this SECTION may contract with the state to provide services under IC 12-14, IC 12-15, and IC 16-35-6.

(r) Any plan of self-insurance must include an aggregate

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stop-loss provision.

(s) The political subdivisions establishing the community care network:

(1) shall appropriate to the community care network any funds necessary to provide health services and related items for employees of the political subdivisions; and

(2) may appropriate funds for health services and items provided to other residents of the political subdivisions.

(t) If Medicaid funds are used by a community care network to pay for health services and related items, the office of Medicaid policy and planning:

(1) shall assure that patients served by federally qualified health centers, rural health clinics, and other primary care providers that target uninsured or Medicaid patients have equal or better access to comprehensive quality primary care services; and

(2) may apply to the Secretary of the United States Department of Health and Human Services for any waivers necessary to implement this SECTION.

(u) If the office of Medicaid policy and planning seeks a waiver under IC 12-15 to establish a managed care program or other demonstration project, the office of Medicaid policy and planning shall not seek a waiver of:

(1) federally qualified health centers and rural health clinic services as mandatory Medicaid services under:

(A) 42 U.S.C. 1396a(10)(A);

(B) 42 U.S.C. 1396d(a)(2)(B); and

(C) 42 U.S.C. 1396d(a)(2)(C); or

(2) reasonable cost reimbursement for federally qualified health centers and rural health clinics under 42 U.S.C. 1396a(a)(13)(E).

(v) A community care network established under this SECTION shall file a report with the department of insurance and the office of the secretary of family and social services not later than March 1 of each year that provides information about the community care network during the preceding calendar year that is requested by the department of insurance and the office of the secretary of family and social services.

(w) Not later than January 1, 2002, the department of insurance and the office of the secretary of family and social services shall begin to evaluate the community care networks established under this SECTION.



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(x) Not later than November 1, 2002, the department of insurance and the office of the secretary of family and social services shall report to the legislative council and the governor regarding whether community care networks should be established legislatively on an ongoing basis.

(y) A community care network may not begin operation before January 1, 1999.

(z) This SECTION expires January 1, 2003."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 19 as printed January 14, 1998.)

JOHNSON, Chairperson

Committee Vote: Yeas 10, Nays 0.

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SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 5, line 7, delete "Title XXI" and insert "**Section 1905(u)**".

Page 5, line 7, delete "42 U.S.C. 1396aa et" and insert "**42 U.S.C. 1396d(u)**".

Page 5, delete line 8.

Page 5, line 14, delete "11" and insert "**14**".

Page 12, line 2, delete "program" and insert "**office**".

Page 12, line 4, after "the" insert "**children's health insurance**".

Page 12, line 5, delete "children's health insurance program" and insert "**office**".

Page 12, line 5, after "operate" insert "**the children's health insurance program**".

Page 12, line 6, delete "program" and insert "**office**".

Page 12, line 17, after "the" insert "**children's health insurance**".

Page 12, line 20, delete "program" and insert "**office**".

Page 12, line 39, after "fees" insert ",".

Page 13, line 1, delete "(b)" and insert "**(B)**".

Page 13, line 22, delete "only".

Page 13, line 22, after "plans" insert "**only**".

Page 13, line 39, delete "(b)" and insert "**(c)**".

Page 13, line 41, after "to" insert "**the**".

Page 14, line 6, delete "(c)" and insert "**(d)**".

Page 14, line 6, delete "(a) and (b)" and insert "**(b) and (c)**".

Page 14, line 10, delete "(d)" and insert "**(e)**".

Page 14, line 10, delete "(a) and (b)" and insert "**(b), (c), and (d)**".

Page 14, line 30, after "the" insert "**children's health insurance**".

Page 14, line 32, after "the" insert "**children's health insurance**".

Page 15, line 3, after "program" insert ",".

(Reference is to Senate Bill 19 as printed January 28, 1998.)

JOHNSON

 SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 5, line 29, delete "that".

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Page 5, line 30, after "(A)" insert **"that"**.

Page 5, line 30, after "payments" insert **"and provide items and services"**.

Page 5, line 31, after "(B)" insert **"that"**.

Page 5, line 35, after "(C)" insert **"that"**.

Page 5, line 36, after ";" delete "and".

Page 5, line 37, after "(D)" insert **"that"**.

Page 5, line 38, delete "." and insert **"; and"**.

Page 5, between lines 38 and 39, begin a new line double block indented and insert:

"(E) that the office has determined is capable of making a determination that the family income of a pregnant woman does not exceed the income level of eligibility under IC 12-15-2."

Page 6, delete line 12, and insert **"that the family income of a child does not exceed the income level of eligibility under IC 12-15-2."**

Page 6, line 14, after "for" insert ":".

Page 6, line 14, before "Medicaid" begin a new line block indented and insert:

"(1)".

Page 6, line 15, delete "." and insert **"; or"**.

Page 6, between lines 15 and 16, begin a new line block indented and insert:

"(2) services from the children's health insurance program under IC 16-35-6."

Page 6, line 36, delete ", including a certified".

Page 6, delete line 37.

Page 7, line 23, before "that" insert **"at the time a determination is made"**.

Page 7, line 24, delete "or an enrollment center".

Page 7, line 25, after "resides" insert **"or an enrollment center"**.

Page 7, between lines 34 and 35, begin a new paragraph and insert:

"Sec. 9. If a child or pregnant woman:

(1) is determined to be presumptively eligible for Medicaid under this chapter; and

(2) appoints, in writing, an agent of a qualified entity under section 3(b)(1) or 3(b)(2) of this chapter as the child's or pregnant woman's authorized representative for purposes of completing all aspects of the Medicaid application process;

the county office shall conduct any face-to-face interview with the child's or pregnant woman's authorized representative that is necessary to determine the child's or pregnant woman's eligibility



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for Medicaid.

Sec. 10. If a child or pregnant woman is:

- (1) determined to be presumptively eligible for Medicaid under this chapter; and**
- (2) subsequently determined not to be eligible for Medicaid after filing an application for Medicaid as required under section 8 of this chapter;**

a qualified entity under section 3(b)(1) or 3(b)(2) of this chapter that determined that the child or pregnant woman was presumptively eligible for Medicaid shall reimburse the office for all funds expended by the office in paying for care for the child or pregnant woman during the child's or pregnant woman's period of presumptive eligibility."

Page 7, line 35, delete "9" and insert "11".

Page 7, line 36, after "chapter" insert "**, including rules that may impose additional requirements for qualified entities that are consistent with federal regulations"**."

Page 11, line 3, after "center" insert "**or at the office of a qualified entity under IC 12-15-2.2"**."

(Reference is to Senate Bill 19 as printed January 28, 1998.)

JOHNSON

SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 10, line 35, after "2." insert "(a)".

Page 10, after line 42, begin a new paragraph and insert:

"(b) For purposes of section 7(b) of this chapter, the term includes a limited service health maintenance organization (as defined in IC 27-13-34-4) and a preferred provider plan (as defined in IC 27-8-11-1)."

Page 11, line 15, after "7." insert "(a)".

Page 11, line 18, delete "section" and insert "**subsection"**."

Page 11, between lines 33 and 34, begin a new paragraph and insert:
"(b) The office may contract with providers to provide the services described in section 18(c) of this chapter. A provider under this subsection must:

- (1) be eligible to receive reimbursement from the office; and**



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(2) comply with subsection (a)(3), (a)(4), and (a)(5)."

(Reference is to Senate Bill 19 as printed January 28, 1998.)

JOHNSON

SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 17, line 19, after "SECTION" insert ":",

Page 17, line 20, before "may" begin a new line block indented and insert:

"(1)".

Page 17, line 21, delete "." and insert "; and".

Page 17, between lines 21 and 22, begin a new line block indented and insert:

"(2) is a body corporate and politic."

(Reference is to Senate Bill 19 as printed January 28, 1998.)

SIMPSON

SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 14, between lines 14 and 15, begin a new paragraph and insert:

"Sec. 19. The office shall do the following:

(1) Establish a penalty to be paid by the following:

(A) An insurer, insurance agent, or insurance broker, for knowingly or intentionally referring an insured or the dependent of an insured to the children's health insurance program in order to receive health care when the insured receives health insurance through an employer's health care plan that is underwritten by the insurer.

(B) An employer, for knowingly or intentionally referring an employee or the dependent of an employee to the children's health insurance program in order to receive health care when the employee receives health insurance



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through the employer's health care plan.

(C) An employer that knowingly or intentionally changes the terms of coverage for or premiums paid by an employee in order to force an employee or the dependent of an employee to apply to the children's health insurance program in order to receive health care.

(2) Create standards to minimize the incentive for:

(A) an employer to eliminate or reduce health care coverage for an employee's dependents; or

(B) an individual to eliminate or reduce health care coverage for a dependent of the individual."

Page 14, line 15, delete "19" and insert "20".

Page 14, line 18, delete "20" and insert "21".

Page 14, line 21, delete "21" and insert "22".

(Reference is to Senate Bill 19 as printed January 28, 1998.)

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SENATE MOTION

Mr. President: I move that Senator Simpson be added as second author and Senator Howard and Randolph be added as coauthors of Senate Bill 19.

JOHNSON

SENATE MOTION

Mr. President: I move that Senator Washington be added as coauthor of Senate Bill 19.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred Senate Bill 19, 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 4, between lines 25 and 26, begin a new paragraph and insert:

"SECTION 3. IC 12-10-6-1, AS AMENDED BY P.L.24-1997, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) An individual who:

- (1) is at least sixty-five (65) years of age, blind, or disabled; and
- (2) is a resident of a county home;

is eligible to receive assistance payments from the state if the individual would be eligible for assistance under the federal Supplemental Security Income program except for the fact that the individual is residing in a county home.

(b) The amount of nonmedical assistance to be paid on behalf of a resident in a county home must be based on the daily rate established by the division. The rate for facilities under this section and licensed under IC 16-28 may not exceed an upper rate limit established by a rule adopted by the division.

(c) The rate for facilities under this section but not licensed under IC 16-28 must be the lesser of:

- (1) an upper rate limit established by a rule adopted by the division; or
- (2) a reasonable and adequate rate to meet the costs, determined by generally accepted accounting principles, that are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with quality and safety standards and applicable laws and rules.

(d) The recipient shall be paid or allowed to retain from the recipient's income a **monthly** personal allowance in an amount to be established by the division. The amount:

- (1) may be not less than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** and not more than ~~thirty-five dollars (\$35) monthly;~~ **sixty-one dollars and thirty-two cents (\$61.32);**
- (2) is exempt from income eligibility consideration by the division; and
- (3) may be exclusively used by the recipient for personal needs.

(e) In addition to the amount that may be retained as a personal allowance under this section, an individual is allowed to retain an amount equal to the individual's state and local income tax liability.

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The amount that may be retained during a month may not exceed one-third (1/3) of the individual's state and local income tax liability for the calendar quarter in which the month occurs. This amount is exempt from income eligibility consideration by the division. The amount retained shall be used by the individual to pay state or local income taxes owed.

(f) The division of disability, aging, and rehabilitative services, in cooperation with the state department of health taking into account licensure requirements under IC 16-28, shall adopt rules under IC 4-22-2 governing the reimbursement to facilities under this section. The rules must be designed to determine the costs that must be incurred by efficiently and economically operated facilities to provide room, board, laundry, and other services, along with minimal administrative direction to individuals who receive residential care in the facilities under this section. A rule adopted under this subsection by:

- (1) the division; or
- (2) the state department of health;

must conform to the rules for residential care facilities that are licensed under IC 16-28.

(g) A rate established under this section may be appealed according to the procedures under IC 4-21.5.

(h) The division shall annually review each facility's rate using the following:

- (1) Generally accepted accounting principles.
- (2) The costs incurred by efficiently and economically operated facilities in order to provide care and services in conformity with quality and safety standards and applicable laws and rules.

SECTION 5. IC 12-10-6-2, AS AMENDED BY P.L.24-1997, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. (a) An individual who is incapable of residing in the individual's own home may apply for residential care assistance under this section. The determination of eligibility for residential care assistance is the responsibility of the division. Except as provided in subsections (f) and (h), an individual is eligible for residential care assistance if the division determines that the individual:

- (1) is a recipient of Medicaid or the federal Supplemental Security Income program;
- (2) is incapable of residing in the individual's own home because of dementia, mental illness, or a physical disability;
- (3) requires a degree of care less than that provided by a health care facility licensed under IC 16-28; and
- (4) can be adequately cared for in a residential care setting.



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(b) Individuals suffering from mental retardation may not be admitted to a home or facility that provides residential care under this section.

(c) A service coordinator employed by the division may:

- (1) evaluate a person seeking admission to a home or facility under subsection (a); or
- (2) evaluate a person who has been admitted to a home or facility under subsection (a), including a review of the existing evaluations in the person's record at the home or facility.

If the service coordinator determines the person evaluated under this subsection is mentally retarded, the service coordinator may recommend an alternative placement for the person.

(d) Except as provided in section 5 of this chapter, residential care consists of only room, board, and laundry, along with minimal administrative direction. State financial assistance may be provided for such care in a boarding or residential home of the applicant's choosing that is licensed under IC 16-28 or a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., that meets certain life safety standards considered necessary by the state fire marshal. Payment for such care shall be made to the provider of the care according to division directives and supervision. The amount of nonmedical assistance to be paid on behalf of a recipient living in a boarding home, residential home, or Christian Science facility shall be based on the daily rate established by the division. The rate for facilities that are referred to in this section and licensed under IC 16-28 may not exceed an upper rate limit established by a rule adopted by the division. The recipient may retain from the recipient's income a **monthly** personal allowance in an amount to be established by the division, but not less than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** or more than ~~thirty-five dollars (\$35) monthly.~~ **sixty-one dollars and thirty-two cents (\$61.32)**. This amount is exempt from income eligibility consideration by the division and may be exclusively used by the recipient for the recipient's personal needs. However, if the recipient's income is less than the amount of the personal allowance, the division shall pay to the recipient the difference between the amount of the personal allowance and the recipient's income. A reserve or an accumulated balance from such a source, together with other sources, may not be allowed to exceed the state's resource allowance allowed for adults eligible for state supplemental assistance or Medicaid as established by the rules of the office of Medicaid policy and planning.

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(e) In addition to the amount that may be retained as a personal allowance under this section, an individual shall be allowed to retain an amount equal to the individual's state and local income tax liability. The amount that may be retained during a month may not exceed one-third (1/3) of the individual's state and local income tax liability for the calendar quarter in which that month occurs. This amount is exempt from income eligibility consideration by the division. The amount retained shall be used by the individual to pay any state or local income taxes owed.

(f) The rate of payment to the provider shall be determined in accordance with a prospective prenegotiated payment rate predicated on a reasonable cost related basis, with a growth of profit factor, as determined in accordance with generally accepted accounting principles and methods, and written standards and criteria, as established by the division. The division shall establish an administrative appeal procedure to be followed if rate disagreement occurs if the provider can demonstrate to the division the necessity of costs in excess of the allowed or authorized fee for the specific boarding or residential home. The amount may not exceed the maximum established under subsection (d).

(g) The personal allowance for one (1) month for an individual described in subsection (a) whose employment is part of the individual's personal habilitation plan or who is working in a sheltered workshop or day activity center is the amount that an individual would be entitled to retain under subsection (d) plus an amount equal to one-half (1/2) of the remainder of:

- (1) gross earned income for that month; minus
- (2) the sum of:
 - (A) sixteen dollars (\$16); plus
 - (B) the amount withheld from the person's paycheck for that month for payment of state income tax, federal income tax, and the tax prescribed by the federal Insurance Contribution Act (26 U.S.C. 3101 et seq.); plus
 - (C) transportation expenses for that month.

(h) An individual who, before September 1, 1983, has been admitted to a home or facility that provides residential care under this section is eligible for residential care in the home or facility.

(i) The director of the division may contract with the division of mental health or the division of disability, aging, and rehabilitative services to purchase services for individuals suffering from mental illness or a developmental disability by providing money to supplement the appropriation for community residential care programs established



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under IC 12-22-2 or community residential programs established under IC 12-11-1-1.

(j) A person with a mental illness may not be placed in a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., unless the facility is licensed under IC 16-28."

Page 9, between lines 24 and 25, begin a new paragraph and insert:

"SECTION 8. IC 12-15-7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. Not less than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** or more than ~~thirty-five dollars (\$35)~~ **sixty-one dollars and thirty-two cents (\$61.32)** monthly may be exempt from income eligibility consideration.

SECTION 9. IC 12-15-32-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. The office shall allow a resident of a facility who is receiving Medicaid to retain a **monthly** personal allowance of at least ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** but not more than ~~fifty dollars (\$50)~~ **each month: sixty-one dollars and thirty-two cents (\$61.32)**."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 19 as reprinted February 3, 1998.)

BAUER, Chair

Committee Vote: yeas 22, nays 0.

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HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 19 be amended to read as follows:

Page 1, delete lines 1 through 15.

Delete pages 2 through 3.

Page 4, delete lines 1 through 25, begin a new paragraph and insert:

"SECTION 2. IC 12-7-2-120, AS AMENDED BY P.L.26-1994, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 120. (a) "Insurer", for purposes of the statutes listed in subsection (b), means an insurance company, a health maintenance organization (as defined in IC 27-13-1-19), a self-funded employee benefit plan, a pension fund, a retirement system, or a similar entity that:

(1) does business in Indiana; and

(2) is under an obligation to make payments for medical services as a result of injury, illness, or disease suffered by an individual.

(b) ~~This section~~ **Subsection (a)** applies to the following statutes:

(1) IC 12-14-1 through IC 12-14-9.

(2) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(c) **"Insurer", for purposes of IC 12-17-18, has the meaning set forth in IC 12-17-18-1.**

SECTION 3. IC 12-7-2-134, AS AMENDED BY P.L.108-1997, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 134. "Office" means the following:

(1) Except as provided in ~~subdivision~~ **subdivisions (2) and (3)**, the office of Medicaid policy and planning established by IC 12-8-6-1.

(2) For purposes of IC 12-10-13, the meaning set forth in IC 12-10-13-4.

(3) **For purposes of IC 12-17-18, the meaning set forth in IC 12-17-18-2.**

SECTION 4. IC 12-7-2-139.1 IS ADDED TO THE INDIANA CODE AS A **NEW SECTION TO READ AS FOLLOWS** [EFFECTIVE JULY 1, 1999]: **Sec. 139.1. "Physicians' services", for purposes of IC 12-17-18-18, has the meaning set forth in IC 12-17-18-18(a).**"

Page 8, line 29, delete "for outreach purposes" and insert **"under 42 U.S.C. 1397ee"**.

Page 8, line 30, delete "outreach".

Page 8, line 30, after "activities" insert **"allowed under 42 U.S.C. 1397bb(c)(1)"**.

Page 9, delete lines 10 through 42.

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Delete pages 10 through 11.

Page 12, delete lines 1 through 26.

Page 12, line 28, delete the effective date "[EFFECTIVE JULY 1, 1998]" and insert the effective date "[EFFECTIVE UPON PASSAGE]".

Page 12, line 29, delete ":".

Page 12, line 30, strike "(1)".

Page 12, line 32, delete "; and" and insert "**at enrollment centers specified by the office.**".

Page 12, delete lines 33 through 34, begin a new paragraph and insert:

"(b) Enrollment centers:

(1) shall be located at each county office; and

(2) may be located at other locations including the following:".

Page 13, delete lines 3 through 5.

Page 13, line 6, delete "(b)" and insert "(c)".

Page 13, line 6, delete "(a)(2)" and insert "(b)".

Page 13, line 7, delete "may apply to" and insert "**must enter into an agreement with**".

Page 13, line 7, delete ", on a form provided by the".

Page 13, line 8, delete "office,".

Page 13, line 10, delete "(c)" and insert "(d)".

Page 13, line 10, delete "employees" and insert "**authorized workers**".

Page 13, line 10, delete "shall" and insert "**may**".

Page 13, line 15, delete "(d)" and insert "(e)".

Page 13, line 18, delete "(e)" and insert "(f)".

Page 13, line 23, after "office" insert "**staff**".

Page 13, line 23, delete "then".

Page 13, delete lines 37 through 42, begin a new paragraph and insert:

"SECTION 12. IC 12-17-18 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Chapter 18. Children's Health Insurance Program

Sec. 1. (a) As used in this chapter, "insurer" means any person who provides health insurance in Indiana. The term includes the following:

(1) A licensed insurance company.

(2) A health maintenance organization.

(3) A multiple employer welfare arrangement.

(4) Any person providing a plan of health insurance subject to



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state insurance law.

(b) For purposes of section 7(b) of this chapter, the term includes a limited service health maintenance organization (as defined in IC 27-13-34-4) and a preferred provider plan (as defined in IC 27-8-11-1).

Sec. 2. As used in this chapter, "office" refers to the office of the children's health insurance program that may be established under this chapter.

Sec. 3. The secretary may establish:

- (1) the office; and
- (2) a children's health insurance program.

Sec. 4. A child may apply at an enrollment center as provided in IC 12-15-4-1 to receive health care services if the child:

- (1) meets the qualifications described in section 12 of this chapter; or
- (2) receives health care services through the Hoosier Healthwise program under IC 12-15.

Sec. 5. A child who enrolls in the children's health insurance program shall receive the health care services described in section 18 of this chapter.

Sec. 6. The office may design and administer a system to obtain health insurance for eligible children.

Sec. 7. (a) The office may contract with insurers under IC 5-22 to arrange to provide health insurance and other services to a child who is enrolled in the children's health insurance program. A contract under this subsection must require an insurer to do the following:

- (1) Establish locations where an applicant may apply to receive services provided by the children's health insurance program.
- (2) Provide education concerning the following:
 - (A) The responsible use of health facilities and information.
 - (B) Preventive care.
 - (C) Parental responsibilities for a child's health care.
- (3) Provide outreach and evaluation activities for the children's health insurance program.

(b) The office may contract with insurers to arrange to provide the services described in section 18(b) of this chapter. An insurer under this subsection must:

- (1) be eligible to receive reimbursement from the office; and
- (2) comply with subsection (a).



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Sec. 8. (a) The office shall establish performance criteria and evaluation measures for an insurer with which the office contracts under section 7 of this chapter.

(b) The office shall assess monetary penalties on an insurer that fails to comply with the requirements of this chapter or a rule adopted under this chapter.

Sec. 9. The office may adopt a sliding scale formula that specifies the premiums, if any, to be paid by the parent or guardian of a child enrolled in the children's health insurance program based on the parent's or guardian's annual income.

Sec. 10. (a) The office shall annually adjust the children's health insurance program to reflect the amount of money available to obtain health insurance for children enrolled in the children's health insurance program.

(b) The office shall use only the funds appropriated to the office to operate the children's health insurance program.

Sec. 11. The office may establish and administer a children's health insurance program fund to provide premium assistance from the state to children enrolled in the children's health insurance program.

Sec. 12. The office shall establish requirements that a child must meet in order to enroll in the children's health insurance program.

Sec. 13. To be eligible to receive reimbursement from the office, an insurer shall arrange to provide health care services required by this chapter to an eligible child without:

- (1)** regard to the child's health status; and
- (2)** imposing a preexisting condition exclusion;

except that a preexisting condition exclusion may be applied if health care services are provided through a group health plan or group health insurance coverage, consistent with the limitations on imposing preexisting condition exclusions provided in state and federal law.

Sec. 14. Premium and cost sharing amounts established by the office are limited to the following:

- (1)** Deductibles, coinsurance, or other cost sharing are not permitted with respect to benefits for well-baby and well-child care, including age appropriate immunizations.
- (2)** For children whose family income is equal to or less than one hundred fifty percent (150%) of the federal income poverty level:
 - (A)** premiums, enrollment fees, or similar charges may not exceed the maximum monthly charge permitted consistent



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with standards established to carry out section 1916(b)(1) of the Social Security Act (42 U.S.C. 301 et seq.); and (B) deductibles and other cost sharing shall not exceed a nominal amount that is consistent with standards provided under Section 1916(a)(3) of the Social Security Act (42 U.S.C. 301 et seq.), as adjusted.

(3) For children whose family income is greater than one hundred fifty percent (150%) of the federal income poverty level, premiums, deductibles, and other cost sharing may be imposed on a sliding scale related to family income. However, the total annual aggregate cost sharing with respect to all children in a family under this chapter may not exceed five percent (5%) of the family's income for the year.

Sec. 15. Insurers shall use existing health insurance sales and marketing methods, including the use of agents and payment of commissions, to do the following:

- (1) Inform families of the availability of the children's health insurance program.
- (2) Assist families in obtaining health insurance coverage for children under the children's health insurance program.

Sec. 16. A child who is eligible to participate in the children's health insurance program is eligible for coverage with a participating plan regardless of the child's health status.

Sec. 17. A child who is participating in the children's health insurance program may change between participating plans only during an annual coverage renewal period, unless the child moves outside of the geographic service area of the participating plan in which the child is enrolled.

Sec. 18. (a) As used in this section, "physicians' services" has the meaning set forth in 42 U.S.C. 1395x(q).

(b) The office shall offer health insurance coverage for the following:

- (1) Inpatient and outpatient hospital services.
- (2) Physicians' services.
- (3) Laboratory and x-ray services.
- (4) Well-baby and well-child care, including age appropriate immunizations.
- (5) Prescription drugs.
- (6) Mental health services.
- (7) Vision services.
- (8) Hearing services.
- (9) Dental services.



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(c) Notwithstanding subsection (b), the office shall offer health insurance coverage for the same services provided under the early and periodic screening, diagnosis, and treatment program (EPSDT) under IC 12-15.

(d) Notwithstanding subsections (b) and (c), the office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses.

Sec. 19. The office shall do the following:

(1) Establish a penalty to be paid by the following:

(A) An insurer, insurance agent, or insurance broker, for knowingly or intentionally referring an insured or the dependent of an insured to the children's health insurance program in order to receive health care when the insured receives health insurance through an employer's health care plan that is underwritten by the insurer.

(B) An employer, for knowingly or intentionally referring an employee or the dependent of an employee to the children's health insurance program in order to receive health care when the employee receives health insurance through the employer's health care plan.

(C) An employer that knowingly or intentionally changes the terms of coverage for or premiums paid by an employee in order to force an employee or the dependent of an employee to apply to the children's health insurance program in order to receive health care.

(2) Create standards to minimize the incentive for:

(A) an employer to eliminate or reduce health care coverage for an employee's dependents; or

(B) an individual to eliminate or reduce health care coverage for a dependent of the individual.

Sec. 20. Not later than June 30 of each year, the office shall provide a report describing the office's activities during the preceding calendar year to the state budget committee.

Sec. 21. The office shall adopt rules under IC 4-22-2 to implement this chapter."

Delete pages 14 through 19.

Page 20, delete lines 1 through 16, begin a new paragraph and insert:

"SECTION 17. IC 27-8-23-4, AS ADDED BY P.L.133-1995, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

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JULY 1, 1999]: Sec. 4. As used in this chapter, "insurer" has the meaning set forth in ~~IC 12-7-2-120~~. **IC 12-7-2-120(a)**.

SECTION 18. [EFFECTIVE JULY 1, 1998] (a) Not later than September 1, 1998, the office of Medicaid policy and planning and the division of family and children shall provide a report to the state budget committee that includes recommendations regarding the design and implementation of a presumptive eligibility policy to increase enrollment of Medicaid eligible pregnant women and children.

(b) This SECTION expires January 1, 1999."

Page 20, line 17, delete the effective date "[EFFECTIVE UPON PASSAGE]" and insert the effective date "[EFFECTIVE JULY 1, 1999]".

Page 20, line 17, delete ":".

Page 20, line 19, delete "IC 16-35-6" and insert "**IC 12-17-18**".

Page 20, line 31, delete "(a) As used in this".

Page 20, delete lines 32 through 33.

Page 20, line 34, delete "(b)" and insert "**(a)**".

Page 20, line 34, after "office" insert "**of Medicaid policy and planning**".

Page 20, line 38, delete "(c) The" and insert "**(b) If an office of the children's health insurance program is established under IC 12-17-18, as added by this act, the**".

Page 20, line 38, after "office" insert "**of the children's health insurance program**".

Page 20, line 41, delete "IC 16-35-6" and insert "**IC 12-17-18**".

Page 20, line 41, delete "April" and insert "**July**".

Page 20, line 41, delete "The state".

Page 20, delete line 42.

Page 21, delete lines 1 through 2.

Page 21, line 3, delete "(d)" and insert "**(c)**".

Page 21, line 3, delete "shall" and insert "**may**".

Page 21, line 5, after "the" insert "**children's health insurance**".

Page 21, line 7, delete "(e)" and insert "**(d)**".

Page 21, line 8, delete ":".

Page 21, line 27, delete "IC 16-35-6" and insert "**IC 12-17-18**".

Page 23, line 17, delete "IC 16-35-6" and insert "**IC 12-17-18**".

Renumber all SECTIONS consecutively.

(Reference is to Engrossed Senate Bill 19 as printed February 18, 1998.)

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