

February 18, 1998

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# ENGROSSED

## SENATE BILL No. 292

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DIGEST OF SB 292 (Updated February 16, 1998 9:06 pm - DI 97)

**Citations Affected:** IC 2-5; IC 6-3; IC 10-1; IC 16-18; IC 16-22; IC 22-3; IC 27-1; IC 27-4; IC 27-7; IC 27-8; IC 27-12; IC 27-13; IC 34-4; noncode.

**Synopsis:** Various insurance provisions. Provides that the insurance commissioner may revoke an insurance agent's license or refuse to issue an insurance agent's license to an applicant if the agent's or applicant's license has been suspended or revoked in Indiana or any state, province, district, or territory. (Current law gives the insurance commissioner this authority only if the license suspension or revocation has taken place in a state other than Indiana.) Adds health maintenance organizations and limited service health maintenance organizations as types of insurers to which the unauthorized insurers statute applies. Adds limited service health maintenance organizations as insurers to which the provisions of the medical child support statute apply. Provides that dependents of eligible employees are entitled to small group conversion policies. Requires health maintenance organizations to provide coverage for the following: (1) Newly born children. (2)  
(Continued next page)

**Effective:** July 1, 1998.

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### Miller, Simpson, Randolph

(HOUSE SPONSORS — PORTER, BUELL)

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January 8, 1998, read first time and referred to Committee on Health and Environmental Affairs.

January 29, 1998, 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 Insurance, Corporations, and Small Business.

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

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Mammography services. Provides specific features these coverages must include. Requires coverage by group insurers to provide for an annual mammography to a woman who is at least 40 years of age. (Current law provides this coverage only if the woman is at least 50 years of age.) Requires coverage by group insurers to provide for additional mammography views necessary for a physician to make a proper evaluation and for ultrasound services if those services are determined to be medically necessary by the insured's or enrollee's treating physician. Makes the following changes in the insurance law: (1) Requires the filing of the annual report on the state police pension trust with the state board of accounts rather than the insurance commissioner. (2) Requires an insurance agent whose license is expired for more than 24 months to retake the licensure examination and complete certain education requirements before the license may be renewed. (Current law provides a limit of 60 months.) (3) Authorizes the insurance commissioner to suspend, revoke, or refuse to renew the license of an insurance agent who pleads guilty or no contest to a felony or a misdemeanor involving moral turpitude. (4) Requires insurers to file quarterly statements, at no charge, with the department of insurance. (5) Requires the department of insurance, which is required to prepare an annual report concerning worker's compensation insurance rates based on information reported by insurers to the worker's compensation rating bureau, to make the report available upon request. (6) Amends the law on mine subsidence insurance to require an insurer to provide information on the availability of mine subsidence coverage only when proposing to issue a new policy. (7) Relieves an insurer of the duty to inform the policyholder of the availability of mine subsidence coverage when proposing to renew a policy already in force. (8) Provides that an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 2000. (Under current law, an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 1997.) (9) Authorizes the insurance commissioner to disapprove an accident and sickness policy, application, rider, endorsement, or premium rate filing under certain circumstances. (10) Makes a limited service health maintenance organization subject to the law on unfair methods of competition and unfair and deceptive acts and practices. (11) Provides that a health care provider for whom an insurer submits proof of financial responsibility and payment of the surcharge to the department of insurance in an untimely manner may be in compliance with patient compensation fund requirements if certain conditions are met by the insurer. Prohibits a company from conducting the business of insurance under IC 22 or IC 27 or holding itself out as a company in the business of insurance unless it has been issued a certificate of authority. Amends the insurance laws to conform to the federal Health Insurance Portability and Accountability (HIPA) Act of 1996. Provides that a provision concerning guaranteed renewability in compliance with the Health Insurance Portability and Accountability Act must be included in each individual accident and sickness policy and each group accident and sickness policy. Requires the inclusion of a provision concerning group portability in each group accident and sickness policy. Makes the following changes in the law concerning the Indiana comprehensive health insurance association (ICHIA): (1) Adds definitions to the law, including a definition of the term "federally eligible individual". (2) Allows a person to qualify for a health insurance policy issued by ICHIA upon a showing that a conventional insurer has refused to issue the person a policy, except at a rate exceeding the association plan rate, or that the person is a federally

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eligible individual. (3) Changes composition of the association board of directors. (4) Removes preexisting condition limitations for individuals other than those previously enrolled in an association policy which has terminated for greater than ninety (90) days. (5) Requires that preexisting condition limitations be limited to a period no greater than six (6) months after the effective date with reductions of the period based on continuous coverage under a health insurance plan in the twelve (12) month period immediately preceding enrollment. Makes the following changes in the law on small employer group health insurance: (1) Makes the small employer group health insurance laws apply to an employer that employs only two employees. (2) Restricts a small employer insurer's ability to cancel health insurance coverage or to exclude coverage. (3) Reduces the permissible duration of a preexisting condition exclusion by the amount of time an individual applicant for insurance has continuously served under a preexisting condition clause of a small employer group health insurance policy if the individual applies for the new coverage within 63 days of the expiration of the individual's coverage under the policy. (4) Provides that a pregnancy existing at the time of enrollment in a small employer group health insurance plan may not be excluded as a preexisting condition. (5) Repeals a provision that prohibits a small employer insurer from discriminating against an employer based on the nature of the employer's business and replaces it with a provision requiring a small employer insurer to cover any small employer that applies for coverage. (6) Changes the grounds on which a small employer group health insurance policy may be canceled. (7) Amends the definition of "late enrollee" for purposes of the law on small employer group health insurance. Provides that a group contract or an individual contract with a health maintenance organization must include a provision complying with the guaranteed renewability and group portability requirements of the federal Health Insurance Portability and Accountability Act. Makes changes to the independent contractor provisions concerning election of noncoverage under the law on worker's compensation.

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February 18, 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. 292

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

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

1 SECTION 1. IC 2-5-23-8, AS ADDED BY P.L.11-1995, SECTION  
2 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1,  
3 1998]: Sec. 8. Beginning May 1, 1997, the health policy advisory  
4 committee is established. At the request of the chairman, the health  
5 policy advisory committee shall provide information and otherwise  
6 assist the commission to perform the duties of the commission under  
7 this chapter. The health policy advisory committee members are ex  
8 officio and may not vote. The health policy advisory committee  
9 members shall be appointed from the general public and must include  
10 one (1) individual who represents each of the following:  
11 (1) The interests of public hospitals.  
12 (2) The interests of community mental health centers.  
13 (3) The interests of community health centers.  
14 (4) The interests of the long term care industry.  
15 (5) The interests of health care professionals licensed under  
16 IC 25, but not licensed under IC 25-22.5.

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- 1 (6) The interests of rural hospitals. An individual appointed under
- 2 this subdivision must be licensed under IC 25-22.5.
- 3 (7) The interests of health maintenance organizations (as defined
- 4 in IC 27-13-1-19).
- 5 (8) The interests of for-profit health care facilities (as defined in
- 6 ~~IC 27-8-10-1(g)~~; **IC 27-8-10-1(l)**).
- 7 (9) A statewide consumer organization.
- 8 (10) A statewide senior citizen organization.
- 9 (11) A statewide organization representing people with
- 10 disabilities.
- 11 (12) Organized labor.
- 12 (13) The interests of businesses that purchase health insurance
- 13 policies.
- 14 (14) The interests of businesses that provide employee welfare
- 15 benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.
- 16 (15) A minority community.
- 17 (16) The uninsured. An individual appointed under this
- 18 subdivision must be and must have been chronically uninsured.
- 19 (17) An individual who is not associated with any organization,
- 20 business, or profession represented in this subsection other than
- 21 as a consumer.

22 SECTION 2. IC 10-1-2-2, AS AMENDED BY P.L.40-1997,  
 23 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 24 JULY 1, 1998]: Sec. 2. (a) Authority is granted to the department to  
 25 establish and operate an actuarially sound pension plan governed by a  
 26 pension trust and to make the necessary annual contribution in order to  
 27 prevent any deterioration in the actuarial status of the trust fund.

28 (b) Contributions shall be made to the trust fund by the department  
 29 and by each employee beneficiary through authorized monthly  
 30 deductions from wages.

31 (c) The trust fund may not be commingled with any other funds and  
 32 shall be invested only in accordance with Indiana laws for the  
 33 investment of trust funds, together with such other investments as are  
 34 specifically designated in the pension trust. Subject to the terms of the  
 35 pension trust, the trustee, with the approval of the Department and the  
 36 Pension Advisory Board, may establish investment guidelines and  
 37 limits on all types of investments (including, but not limited to, stocks  
 38 and bonds) and take other action necessary to fulfill its duty as a  
 39 fiduciary for the trust fund. However, the trustee shall invest the trust  
 40 fund assets with the same care, skill, prudence, and diligence that a  
 41 prudent person acting in a like capacity and familiar with such matters  
 42 would use in the conduct of an enterprise of a like character with like

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1 aims. The trustee shall also diversify such investments in accordance  
 2 with prudent investment standards. The investment of trust funds is  
 3 subject to section 2.5 of this chapter.

4 (d) The trustee shall receive and hold as trustee for the uses and  
 5 purposes set forth in the pension trust any and all funds paid by the  
 6 department, the employee beneficiaries, or by any other person or  
 7 persons.

8 (e) The trustee shall engage pension consultants to supervise and  
 9 assist in the technical operation of the pension plan in order that there  
 10 may be no deterioration in the actuarial status of the plan.

11 (f) Before October 1 of each year, the trustee, with the aid of the  
 12 pension consultants, shall prepare and file a report with the department  
 13 and the ~~insurance commissioner~~ **state board of accounts**. The report  
 14 must include the following with respect to the fiscal year ending on the  
 15 preceding June 30:

16 SCHEDULE I. Receipts and disbursements.

17 SCHEDULE II. Assets of the pension trust, listing investments as  
 18 to book value and current market value at the end of the fiscal  
 19 year.

20 SCHEDULE III. List of terminations, showing cause and amount  
 21 of refund.

22 SCHEDULE IV. The application of actuarially computed "reserve  
 23 factors" to the payroll data, properly classified for the purpose of  
 24 computing the reserve liability of the trust fund as of the end of  
 25 the fiscal year.

26 SCHEDULE V. The application of actuarially computed "current  
 27 liability factors" to the payroll data, properly classified for the  
 28 purpose of computing the liability of the trust fund for the end of  
 29 the fiscal year.

30 SCHEDULE VI. An actuarial computation of the pension liability  
 31 for all employees retired before the close of the fiscal year.

32 (g) The minimum annual contribution by the department must be of  
 33 sufficient amount, as determined by the pension consultants, to prevent  
 34 any deterioration in the actuarial status of the pension plan during that  
 35 year. If the department fails to make the minimum contribution for five  
 36 (5) successive years, the pension trust terminates and the trust fund  
 37 shall be liquidated.

38 (h) In the event of liquidation, all expenses of the pension trust shall  
 39 be paid, adequate provision shall be made for continuing pension  
 40 payments to retired persons, and each employee beneficiary shall  
 41 receive the net amount paid into the trust fund from wages. Any  
 42 remaining sum shall be equitably divided among employee

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1 beneficiaries in proportion to the net amount paid from their wages into  
2 the trust fund.

3 SECTION 3. IC 16-18-2-163, AS AMENDED BY P.L.188-1995,  
4 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
5 JANUARY 1, 1999]: Sec. 163. (a) "Health care provider", for purposes  
6 of IC 16-21 and IC 16-41, means any of the following:

7 (1) An individual, a partnership, a corporation, a professional  
8 corporation, a facility, or an institution licensed or legally  
9 authorized by this state to provide health care or professional  
10 services as a licensed physician, a psychiatric hospital, a hospital,  
11 a health facility, an emergency ambulance service (IC 16-31-3),  
12 a dentist, a registered or licensed practical nurse, a midwife, an  
13 optometrist, a pharmacist, a podiatrist, a chiropractor, a physical  
14 therapist, a respiratory care practitioner, an occupational therapist,  
15 a psychologist, a paramedic, an emergency medical technician, or  
16 an advanced emergency technician, or a person who is an officer,  
17 employee, or agent of the individual, partnership, corporation,  
18 professional corporation, facility, or institution acting in the  
19 course and scope of the person's employment.

20 (2) A college, university, or junior college that provides health  
21 care to a student, a faculty member, or an employee, and the  
22 governing board or a person who is an officer, employee, or agent  
23 of the college, university, or junior college acting in the course  
24 and scope of the person's employment.

25 (3) A blood bank, community mental health center, community  
26 mental retardation center, community health center, or migrant  
27 health center.

28 (4) A home health agency (as defined in IC 16-27-1-2).

29 (5) A health maintenance organization (as defined in  
30 IC 27-13-1-19).

31 (6) A health care organization whose members, shareholders, or  
32 partners are health care providers under subdivision (1).

33 (7) A corporation, partnership, or professional corporation not  
34 otherwise qualified under this subsection that:

35 (A) provides health care as one (1) of the corporation's,  
36 partnership's, or professional corporation's functions;

37 (B) is organized or registered under state law; and

38 (C) is determined to be eligible for coverage as a health care  
39 provider under IC 27-12 for the corporation's, partnership's, or  
40 professional corporation's health care function.

41 Coverage for a health care provider qualified under this  
42 subdivision is limited to the health care provider's health care

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1 functions and does not extend to other causes of action.

2 (b) "Health care provider", for purposes of IC 16-22-3-9.5 and  
3 IC 16-22-8-39.5, means an individual who holds a valid license  
4 under Indiana law to practice:

- 5 (1) chiropractic;  
6 (2) optometry; or  
7 (3) podiatry.

8 ~~(b)~~ (c) "Health care provider", for purposes of IC 16-35:

- 9 (1) has the meaning set forth in subsection (a); ~~However, for~~  
10 ~~purposes of IC 16-35, the term also and~~  
11 (2) includes a health facility (as defined in section 167 of this  
12 chapter).

13 SECTION 4. IC 16-22-3-9.5 IS ADDED TO THE INDIANA CODE  
14 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE  
15 JANUARY 1, 1999]: **Sec. 9.5. (a) The governing board may**  
16 **delineate privileges for the provision of patient care services by a**  
17 **health care provider.**

18 (b) A health care provider is eligible for privileges to provide  
19 patient care services, but the board shall establish and enforce  
20 reasonable standards and rules concerning a health care provider's  
21 qualifications for the following:

- 22 (1) Practice in the hospital.  
23 (2) The granting of privileges to a provider.  
24 (3) The retention of privileges.

25 (c) The fact that an applicant for privileges to provide patient  
26 care services is a health care provider may not serve as a basis for  
27 denying the applicant privileges to provide patient care services  
28 that are allowed under the professional license held by the  
29 applicant.

30 (d) The board may determine the kinds of health care  
31 procedures and treatments that are appropriate for an inpatient or  
32 outpatient hospital setting.

33 (e) The standards and rules described in subsection (b) may, in  
34 the interest of good patient care, allow the board to do the  
35 following:

- 36 (1) Consider a health care provider's postgraduate education,  
37 training, experience, and other facts concerning the provider  
38 that may affect the provider's professional competence.  
39 (2) Consider the scope of practice allowed under the  
40 professional license held by a health care provider.  
41 (3) Limit privileges for admitting patients to the hospital to  
42 physicians licensed under IC 25-22.5.



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1           **(4) Limit responsibility for the management of a patient's care**  
 2           **to physicians licensed under IC 25-22.5.**

3           **(5) Limit or preclude a health care provider's performance of**  
 4           **x-rays or other imaging procedures in an inpatient or**  
 5           **outpatient hospital setting. However, this subdivision does not**  
 6           **affect the ability of a health care provider to order x-rays**  
 7           **under that provider's scope of practice.**

8           **(f) The standards and rules described in subsection (b) may**  
 9           **include a requirement for the following:**

10           **(1) Submitting proof that a health care provider is qualified**  
 11           **under IC 27-12-3-2.**

12           **(2) Performing patient care and related duties in a manner**  
 13           **that is not disruptive to the delivery of quality care in the**  
 14           **hospital setting.**

15           **(3) Maintaining standards of quality care that recognize the**  
 16           **efficient and effective utilization of hospital resources as**  
 17           **developed by the hospital's medical staff.**

18           **(g) The standards and rules described in subsection (b) must**  
 19           **allow a health care provider who applies for privileges an**  
 20           **opportunity to appear before a peer review committee that is**  
 21           **established by the board to make recommendations regarding**  
 22           **applications for privileges by health care providers before the peer**  
 23           **review committee makes its recommendations regarding the**  
 24           **applicant's request for privileges.**

25           **(h) The board must provide for a hearing before a peer review**  
 26           **committee for a health care provider whose privileges have been**  
 27           **recommended for termination.**

28           **SECTION 5. IC 16-22-8-39.5 IS ADDED TO THE INDIANA**  
 29           **CODE AS A NEW SECTION TO READ AS FOLLOWS**  
 30           **[EFFECTIVE JANUARY 1, 1999]: Sec. 39.5. (a) The governing**  
 31           **board may delineate privileges for the provision of patient care**  
 32           **services by a health care provider.**

33           **(b) A health care provider is eligible for privileges to provide**  
 34           **patient care services, but the board shall establish and enforce**  
 35           **reasonable standards and rules concerning a health care provider's**  
 36           **qualifications for the following:**

37           **(1) Practice in the hospital.**

38           **(2) The granting of privileges to a provider.**

39           **(3) The retention of privileges.**

40           **(c) The fact that an applicant for privileges to provide patient**  
 41           **care services is a health care provider may not serve as a basis for**  
 42           **denying the applicant privileges to provide patient care services**



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1 that are allowed under the professional license held by the  
2 applicant.

3 (d) The board may determine the kinds of health care  
4 procedures and treatments that are appropriate for an inpatient or  
5 outpatient hospital setting.

6 (e) The standards and rules described in subsection (b) may, in  
7 the interest of good patient care, allow the board to do the  
8 following:

9 (1) Consider a health care provider's postgraduate education,  
10 training, experience, and other facts concerning the provider  
11 that may affect the provider's professional competence.

12 (2) Consider the scope of practice allowed under the  
13 professional license held by a health care provider.

14 (3) Limit privileges for admitting patients to the hospital to  
15 physicians licensed under IC 25-22.5.

16 (4) Limit responsibility for the management of a patient's care  
17 to physicians licensed under IC 25-22.5.

18 (5) Limit or preclude a health care provider's performance of  
19 x-rays or other imaging procedures in an inpatient or  
20 outpatient hospital setting. However, this subdivision does not  
21 affect the ability of a health care provider to order x-rays  
22 under that provider's scope of practice.

23 (f) The standards and rules described in subsection (b) may  
24 include a requirement for the following:

25 (1) Submitting proof that a health care provider is qualified  
26 under IC 27-12-3-2.

27 (2) Performing patient care and related duties in a manner  
28 that is not disruptive to the delivery of quality care in the  
29 hospital setting.

30 (3) Maintaining standards of quality care that recognize the  
31 efficient and effective utilization of hospital resources as  
32 developed by the hospital's medical staff.

33 (g) The standards and rules described in subsection (b) must  
34 allow a health care provider who applies for privileges an  
35 opportunity to appear before a peer review committee that is  
36 established by the board to make recommendations regarding  
37 applications for privileges by health care providers before the peer  
38 review committee makes its recommendations regarding the  
39 applicant's request for privileges.

40 (h) The board must provide for a hearing before a peer review  
41 committee for a health care provider whose privileges have been  
42 recommended for termination.



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1 SECTION 6. IC 22-3-5-6 IS AMENDED TO READ AS FOLLOWS  
 2 [EFFECTIVE APRIL 1, 1998]: Sec. 6. (a) The worker's compensation  
 3 supplemental administrative fund is established for the purpose of  
 4 carrying out the administrative purposes and functions of the worker's  
 5 compensation board. The fund consists of fees collected from  
 6 employers under sections 1 through 2 of this chapter. ~~and from fees~~  
 7 ~~collected under IC 22-3-2-14.5 and IC 22-3-7-34.5.~~ The fund shall be  
 8 administered by the worker's compensation board. ~~Money in the fund~~  
 9 ~~is annually appropriated to the worker's compensation board for its use~~  
 10 ~~in carrying out the administrative purposes and functions of the~~  
 11 ~~worker's compensation board.~~

12 (b) The money in the fund is not to be used to replace funds  
 13 otherwise appropriated to the board. Money in the fund at the end of  
 14 the state fiscal year does not revert to the state general fund.

15 SECTION 7. IC 22-3-6-1, AS AMENDED BY P.L.258-1997(ss),  
 16 SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 17 APRIL 1, 1998]: Sec. 1. In IC 22-3-2 through IC 22-3-6, unless the  
 18 context otherwise requires:

19 (a) "Employer" includes the state and any political subdivision, any  
 20 municipal corporation within the state, any individual or the legal  
 21 representative of a deceased individual, firm, association, limited  
 22 liability company, or corporation or the receiver or trustee of the same,  
 23 using the services of another for pay. If the employer is insured, the  
 24 term includes the employer's insurer so far as applicable. However, the  
 25 inclusion of an employer's insurer within this definition does not allow  
 26 an employer's insurer to avoid payment for services rendered to an  
 27 employee with the approval of the employer.

28 (b) "Employee" means every person, including a minor, in the  
 29 service of another, under any contract of hire or apprenticeship, written  
 30 or implied, except one whose employment is both casual and not in the  
 31 usual course of the trade, business, occupation, or profession of the  
 32 employer.

33 (1) An executive officer elected or appointed and empowered in  
 34 accordance with the charter and bylaws of a corporation, other  
 35 than a municipal corporation or governmental subdivision or a  
 36 charitable, religious, educational, or other nonprofit corporation,  
 37 is an employee of the corporation under IC 22-3-2 through  
 38 IC 22-3-6.

39 (2) An executive officer of a municipal corporation or other  
 40 governmental subdivision or of a charitable, religious,  
 41 educational, or other nonprofit corporation may, notwithstanding  
 42 any other provision of IC 22-3-2 through IC 22-3-6, be brought

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1 within the coverage of its insurance contract by the corporation by  
 2 specifically including the executive officer in the contract of  
 3 insurance. The election to bring the executive officer within the  
 4 coverage shall continue for the period the contract of insurance is  
 5 in effect, and during this period, the executive officers thus  
 6 brought within the coverage of the insurance contract are  
 7 employees of the corporation under IC 22-3-2 through IC 22-3-6.

8 (3) Any reference to an employee who has been injured, when the  
 9 employee is dead, also includes the employee's legal  
 10 representatives, dependents, and other persons to whom  
 11 compensation may be payable.

12 (4) An owner of a sole proprietorship may elect to include the  
 13 owner as an employee under IC 22-3-2 through IC 22-3-6 if the  
 14 owner is actually engaged in the proprietorship business. If the  
 15 owner makes this election, the owner must serve upon the owner's  
 16 insurance carrier and upon the board written notice of the  
 17 election. No owner of a sole proprietorship may be considered an  
 18 employee under IC 22-3-2 through IC 22-3-6 until the notice has  
 19 been received. ~~If the owner of a sole proprietorship is an~~  
 20 ~~independent contractor in the construction trades and does not~~  
 21 ~~make the election provided under this subdivision; the owner~~  
 22 ~~must obtain an affidavit of exemption under IC 22-3-2-14.5.~~

23 (5) A partner in a partnership may elect to include the partner as  
 24 an employee under IC 22-3-2 through IC 22-3-6 if the partner is  
 25 actually engaged in the partnership business. If a partner makes  
 26 this election, the partner must serve upon the partner's insurance  
 27 carrier and upon the board written notice of the election. No  
 28 partner may be considered an employee under IC 22-3-2 through  
 29 IC 22-3-6 until the notice has been received. ~~If a partner in a~~  
 30 ~~partnership is an independent contractor in the construction trades~~  
 31 ~~and does not make the election provided under this subdivision;~~  
 32 ~~the partner must obtain an affidavit of exemption under~~  
 33 ~~IC 22-3-2-14.5.~~

34 (6) Real estate professionals are not employees under IC 22-3-2  
 35 through IC 22-3-6 if:

- 36 (A) they are licensed real estate agents;
- 37 (B) substantially all their remuneration is directly related to
- 38 sales volume and not the number of hours worked; and
- 39 (C) they have written agreements with real estate brokers
- 40 stating that they are not to be treated as employees for tax
- 41 purposes.

42 ~~(7) A person is an independent contractor in the construction~~

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1 ~~trades and not an employee under IC 22-3-2 through IC 22-3-6 if~~  
 2 ~~the person is an independent contractor under the guidelines of~~  
 3 ~~the United States Internal Revenue Service.~~  
 4 ~~(8) (7)~~ An owner-operator that provides a motor vehicle and the  
 5 services of a driver under a written contract that is subject to  
 6 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 1057, to a motor  
 7 carrier is not an employee of the motor carrier for purposes of  
 8 IC 22-3-2 through IC 22-3-6. The owner-operator may elect to be  
 9 covered and have the owner-operator's drivers covered under a  
 10 worker's compensation insurance policy or authorized  
 11 self-insurance that insures the motor carrier if the owner-operator  
 12 pays the premiums as requested by the motor carrier. An election  
 13 by an owner-operator under this subdivision does not terminate  
 14 the independent contractor status of the owner-operator for any  
 15 purpose other than the purpose of this subdivision.  
 16 ~~(9) (8)~~ A member or manager in a limited liability company may  
 17 elect to include the member or manager as an employee under  
 18 IC 22-3-2 through IC 22-3-6 if the member or manager is actually  
 19 engaged in the limited liability company business. If a member or  
 20 manager makes this election, the member or manager must serve  
 21 upon the member's or manager's insurance carrier and upon the  
 22 board written notice of the election. A member or manager may  
 23 not be considered an employee under IC 22-3-2 through IC 22-3-6  
 24 until the notice has been received.  
 25 (c) "Minor" means an individual who has not reached seventeen  
 26 (17) years of age.  
 27 (1) Unless otherwise provided in this subsection, a minor  
 28 employee shall be considered as being of full age for all purposes  
 29 of IC 22-3-2 through IC 22-3-6.  
 30 (2) If the employee is a minor who, at the time of the accident, is  
 31 employed, required, suffered, or permitted to work in violation of  
 32 IC 20-8.1-4-25, the amount of compensation and death benefits,  
 33 as provided in IC 22-3-2 through IC 22-3-6, shall be double the  
 34 amount which would otherwise be recoverable. The insurance  
 35 carrier shall be liable on its policy for one-half (1/2) of the  
 36 compensation or benefits that may be payable on account of the  
 37 injury or death of the minor, and the employer shall be liable for  
 38 the other one-half (1/2) of the compensation or benefits. If the  
 39 employee is a minor who is not less than sixteen (16) years of age  
 40 and who has not reached seventeen (17) years of age and who at  
 41 the time of the accident is employed, suffered, or permitted to  
 42 work at any occupation which is not prohibited by law, this

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subdivision does not apply.

(3) A minor employee who, at the time of the accident, is a student performing services for an employer as part of an approved program under IC 20-10.1-6-7 shall be considered a full-time employee for the purpose of computing compensation for permanent impairment under IC 22-3-3-10. The average weekly wages for such a student shall be calculated as provided in subsection (d)(4).

(4) The rights and remedies granted in this subsection to a minor under IC 22-3-2 through IC 22-3-6 on account of personal injury or death by accident shall exclude all rights and remedies of the minor, the minor's parents, or the minor's personal representatives, dependents, or next of kin at common law, statutory or otherwise, on account of the injury or death. This subsection does not apply to minors who have reached seventeen (17) years of age.

(d) "Average weekly wages" means the earnings of the injured employee in the employment in which the employee was working at the time of the injury during the period of fifty-two (52) weeks immediately preceding the date of injury, divided by fifty-two (52), except as follows:

(1) If the injured employee lost seven (7) or more calendar days during this period, although not in the same week, then the earnings for the remainder of the fifty-two (52) weeks shall be divided by the number of weeks and parts thereof remaining after the time lost has been deducted.

(2) Where the employment prior to the injury extended over a period of less than fifty-two (52) weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed, if results just and fair to both parties will be obtained. Where by reason of the shortness of the time during which the employee has been in the employment of the employee's employer or of the casual nature or terms of the employment it is impracticable to compute the average weekly wages, as defined in this subsection, regard shall be had to the average weekly amount which during the fifty-two (52) weeks previous to the injury was being earned by a person in the same grade employed at the same work by the same employer or, if there is no person so employed, by a person in the same grade employed in the same class of employment in the same district.

(3) Wherever allowances of any character made to an employee

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1 in lieu of wages are a specified part of the wage contract, they  
 2 shall be deemed a part of his earnings.  
 3 (4) In computing the average weekly wages to be used in  
 4 calculating an award for permanent impairment under  
 5 IC 22-3-3-10 for a student employee in an approved training  
 6 program under IC 20-10.1-6-7, the following formula shall be  
 7 used. Calculate the product of:  
 8 (A) the student employee's hourly wage rate; multiplied by  
 9 (B) forty (40) hours.  
 10 The result obtained is the amount of the average weekly wages for  
 11 the student employee.  
 12 (e) "Injury" and "personal injury" mean only injury by accident  
 13 arising out of and in the course of the employment and do not include  
 14 a disease in any form except as it results from the injury.  
 15 (f) "Billing review service" refers to a person or an entity that  
 16 reviews a medical service provider's bills or statements for the purpose  
 17 of determining pecuniary liability. The term includes an employer's  
 18 worker's compensation insurance carrier if the insurance carrier  
 19 performs such a review.  
 20 (g) "Billing review standard" means the data used by a billing  
 21 review service to determine pecuniary liability.  
 22 (h) "Community" means a geographic service area based on zip  
 23 code districts defined by the United States Postal Service according to  
 24 the following groupings:  
 25 (1) The geographic service area served by zip codes with the first  
 26 three (3) digits 463 and 464.  
 27 (2) The geographic service area served by zip codes with the first  
 28 three (3) digits 465 and 466.  
 29 (3) The geographic service area served by zip codes with the first  
 30 three (3) digits 467 and 468.  
 31 (4) The geographic service area served by zip codes with the first  
 32 three (3) digits 469 and 479.  
 33 (5) The geographic service area served by zip codes with the first  
 34 three (3) digits 460, 461 (except 46107), and 473.  
 35 (6) The geographic service area served by the 46107 zip code and  
 36 zip codes with the first three (3) digits 462.  
 37 (7) The geographic service area served by zip codes with the first  
 38 three (3) digits 470, 471, 472, 474, and 478.  
 39 (8) The geographic service area served by zip codes with the first  
 40 three (3) digits 475, 476, and 477.  
 41 (i) "Medical service provider" refers to a person or an entity that  
 42 provides medical services, treatment, or supplies to an employee under

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1 IC 22-3-2 through IC 22-3-6.

2 (j) "Pecuniary liability" means the responsibility of an employer or  
3 the employer's insurance carrier for the payment of the charges for each  
4 specific service or product for human medical treatment provided  
5 under IC 22-3-2 through IC 22-3-6 in a defined community, equal to or  
6 less than the charges made by medical service providers at the eightieth  
7 percentile in the same community for like services or products.

8 SECTION 8. IC 22-3-7-9, AS AMENDED BY P.L.258-1997(ss),  
9 SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
10 APRIL 1, 1998]: Sec. 9. (a) As used in this chapter, "employer"  
11 includes the state and any political subdivision, any municipal  
12 corporation within the state, any individual or the legal representative  
13 of a deceased individual, firm, association, limited liability company,  
14 or corporation or the receiver or trustee of the same, using the services  
15 of another for pay. If the employer is insured, the term includes his  
16 insurer so far as applicable. However, the inclusion of an employer's  
17 insurer within this definition does not allow an employer's insurer to  
18 avoid payment for services rendered to an employee with the approval  
19 of the employer.

20 (b) As used in this chapter, "employee" means every person,  
21 including a minor, in the service of another, under any contract of hire  
22 or apprenticeship written or implied, except one whose employment is  
23 both casual and not in the usual course of the trade, business,  
24 occupation, or profession of the employer. For purposes of this chapter  
25 the following apply:

26 (1) Any reference to an employee who has suffered disablement,  
27 when the employee is dead, also includes his legal representative,  
28 dependents, and other persons to whom compensation may be  
29 payable.

30 (2) An owner of a sole proprietorship may elect to include himself  
31 as an employee under this chapter if he is actually engaged in the  
32 proprietorship business. If the owner makes this election, he must  
33 serve upon his insurance carrier and upon the board written notice  
34 of the election. No owner of a sole proprietorship may be  
35 considered an employee under this chapter unless the notice has  
36 been received. ~~If the owner of a sole proprietorship is an~~  
37 ~~independent contractor in the construction trades and does not~~  
38 ~~make the election provided under this subdivision, the owner~~  
39 ~~must obtain an affidavit of exemption under IC 22-3-7-34.5.~~

40 (3) A partner in a partnership may elect to include himself as an  
41 employee under this chapter if he is actually engaged in the  
42 partnership business. If a partner makes this election, he must



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1 serve upon his insurance carrier and upon the board written notice  
 2 of the election. No partner may be considered an employee under  
 3 this chapter until the notice has been received. ~~If a partner in a~~  
 4 ~~partnership is an independent contractor in the construction trades~~  
 5 ~~and does not make the election provided under this subdivision;~~  
 6 ~~the partner must obtain an affidavit of exemption under~~  
 7 ~~IC 22-3-7-34.5.~~

8 (4) Real estate professionals are not employees under this chapter  
 9 if:

10 (A) they are licensed real estate agents;

11 (B) substantially all their remuneration is directly related to  
 12 sales volume and not the number of hours worked; and

13 (C) they have written agreements with real estate brokers  
 14 stating that they are not to be treated as employees for tax  
 15 purposes.

16 ~~(5) A person is an independent contractor in the construction~~  
 17 ~~trades and not an employee under this chapter if the person is an~~  
 18 ~~independent contractor under the guidelines of the United States~~  
 19 ~~Internal Revenue Service.~~

20 ~~(6) (5)~~ An owner-operator that provides a motor vehicle and the  
 21 services of a driver under a written contract that is subject to  
 22 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 1057, to a motor  
 23 carrier is not an employee of the motor carrier for purposes of this  
 24 chapter. The owner-operator may elect to be covered and have the  
 25 owner-operator's drivers covered under a worker's compensation  
 26 insurance policy or authorized self-insurance that insures the  
 27 motor carrier if the owner-operator pays the premiums as  
 28 requested by the motor carrier. An election by an owner-operator  
 29 under this subdivision does not terminate the independent  
 30 contractor status of the owner-operator for any purpose other than  
 31 the purpose of this subdivision.

32 (c) As used in this chapter, "minor" means an individual who has  
 33 not reached seventeen (17) years of age. A minor employee shall be  
 34 considered as being of full age for all purposes of this chapter.  
 35 However, if the employee is a minor who, at the time of the last  
 36 exposure, is employed, required, suffered, or permitted to work in  
 37 violation of the child labor laws of this state, the amount of  
 38 compensation and death benefits, as provided in this chapter, shall be  
 39 double the amount which would otherwise be recoverable. The  
 40 insurance carrier shall be liable on its policy for one-half (1/2) of the  
 41 compensation or benefits that may be payable on account of the  
 42 disability or death of the minor, and the employer shall be wholly liable



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1 for the other one-half (1/2) of the compensation or benefits. If the  
 2 employee is a minor who is not less than sixteen (16) years of age and  
 3 who has not reached seventeen (17) years of age, and who at the time  
 4 of the last exposure is employed, suffered, or permitted to work at any  
 5 occupation which is not prohibited by law, the provisions of this  
 6 subsection prescribing double the amount otherwise recoverable do not  
 7 apply. The rights and remedies granted to a minor under this chapter on  
 8 account of disease shall exclude all rights and remedies of the minor,  
 9 his parents, his personal representatives, dependents, or next of kin at  
 10 common law, statutory or otherwise, on account of any disease.

11 (d) This chapter does not apply to casual laborers as defined in  
 12 subsection (b), nor to farm or agricultural employees, nor to household  
 13 employees, nor to railroad employees engaged in train service as  
 14 engineers, firemen, conductors, brakemen, flagmen, baggagemen, or  
 15 foremen in charge of yard engines and helpers assigned thereto, nor to  
 16 their employers with respect to these employees. Also, this chapter  
 17 does not apply to employees or their employers with respect to  
 18 employments in which the laws of the United States provide for  
 19 compensation or liability for injury to the health, disability, or death by  
 20 reason of diseases suffered by these employees.

21 (e) As used in this chapter, "disablement" means the event of  
 22 becoming disabled from earning full wages at the work in which the  
 23 employee was engaged when last exposed to the hazards of the  
 24 occupational disease by the employer from whom he claims  
 25 compensation or equal wages in other suitable employment, and  
 26 "disability" means the state of being so incapacitated.

27 (f) For the purposes of this chapter, no compensation shall be  
 28 payable for or on account of any occupational diseases unless  
 29 disablement, as defined in subsection (e), occurs within two (2) years  
 30 after the last day of the last exposure to the hazards of the disease  
 31 except for the following:

32 (1) In all cases of occupational diseases caused by the inhalation  
 33 of silica dust or coal dust, no compensation shall be payable  
 34 unless disablement, as defined in subsection (e), occurs within  
 35 three (3) years after the last day of the last exposure to the hazards  
 36 of the disease.

37 (2) In all cases of occupational disease caused by the exposure to  
 38 radiation, no compensation shall be payable unless disablement,  
 39 as defined in subsection (e), occurs within two (2) years from the  
 40 date on which the employee had knowledge of the nature of his  
 41 occupational disease or, by exercise of reasonable diligence,  
 42 should have known of the existence of such disease and its causal



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relationship to his employment.

(3) In all cases of occupational diseases caused by the inhalation of asbestos dust, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within three (3) years after the last day of the last exposure to the hazards of the disease if the last day of the last exposure was before July 1, 1985.

(4) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1985, and before July 1, 1988, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within twenty (20) years after the last day of the last exposure.

(5) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1988, no compensation shall be payable unless disablement (as defined in subsection (e)) occurs within thirty-five (35) years after the last day of the last exposure.

(g) For the purposes of this chapter, no compensation shall be payable for or on account of death resulting from any occupational disease unless death occurs within two (2) years after the date of disablement. However, this subsection does not bar compensation for death:

(1) where death occurs during the pendency of a claim filed by an employee within two (2) years after the date of disablement and which claim has not resulted in a decision or has resulted in a decision which is in process of review or appeal; or

(2) where, by agreement filed or decision rendered, a compensable period of disability has been fixed and death occurs within two (2) years after the end of such fixed period, but in no event later than three hundred (300) weeks after the date of disablement.

(h) As used in this chapter, "billing review service" refers to a person or an entity that reviews a medical service provider's bills or statements for the purpose of determining pecuniary liability. The term includes an employer's worker's compensation insurance carrier if the insurance carrier performs such a review.

(i) As used in this chapter, "billing review standard" means the data used by a billing review service to determine pecuniary liability.

(j) As used in this chapter, "community" means a geographic service area based on zip code districts defined by the United States Postal Service according to the following groupings:

(1) The geographic service area served by zip codes with the first

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- 1 three (3) digits 463 and 464.
- 2 (2) The geographic service area served by zip codes with the first
- 3 three (3) digits 465 and 466.
- 4 (3) The geographic service area served by zip codes with the first
- 5 three (3) digits 467 and 468.
- 6 (4) The geographic service area served by zip codes with the first
- 7 three (3) digits 469 and 479.
- 8 (5) The geographic service area served by zip codes with the first
- 9 three (3) digits 460, 461 (except 46107), and 473.
- 10 (6) The geographic service area served by the 46107 zip code and
- 11 zip codes with the first three (3) digits 462.
- 12 (7) The geographic service area served by zip codes with the first
- 13 three (3) digits 470, 471, 472, 474, and 478.
- 14 (8) The geographic service area served by zip codes with the first
- 15 three (3) digits 475, 476, and 477.

16 (k) As used in this chapter, "medical service provider" refers to a  
 17 person or an entity that provides medical services, treatment, or  
 18 supplies to an employee under this chapter.

19 (l) As used in this chapter, "pecuniary liability" means the  
 20 responsibility of an employer or the employer's insurance carrier for the  
 21 payment of the charges for each specific service or product for human  
 22 medical treatment provided under this chapter in a defined community,  
 23 equal to or less than the charges made by medical service providers at  
 24 the eightieth percentile in the same community for like services or  
 25 products.

26 SECTION 9. IC 27-1-3-15, AS AMENDED BY P.L.116-1994,  
 27 SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 28 JULY 1, 1998]: Sec. 15. (a) **Except as provided in subsection (g)**, the  
 29 commissioner shall collect the following fees when the documents  
 30 described in this subsection are delivered to the commissioner for  
 31 filing:

Document	Fee
Articles of incorporation . . . . .	\$ 350
Amendment of articles of incorporation . . . . .	\$ 10
Filing of annual statement and consolidated statement . . . . .	\$ 100
Annual renewal of company license fee . . . . .	\$ 50
Appointment of commissioner for service of process . . . . .	\$ 10
Withdrawal of certificate	



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1 of authority . . . . . \$ 25  
 2 Certified statement of condition . . . . . \$ 5  
 3 Any other document required to be  
 4 filed by this article . . . . . \$ 25  
 5 (b) The commissioner shall collect a fee of ten dollars (\$10) each  
 6 time process is served on the commissioner under this title.  
 7 (c) The commissioner shall collect the following fees for copying  
 8 and certifying the copy of any filed document relating to a domestic or  
 9 foreign corporation:  
 10 Per page for copying . . . . . As determined by  
 11 the commissioner but not to exceed actual cost  
 12 For the certificate . . . . . \$10  
 13 (d) Each domestic and foreign insurer shall remit annually to the  
 14 commissioner for deposit into the department of insurance fund  
 15 established by IC 27-1-3-28 three hundred fifty dollars (\$350) as an  
 16 internal audit fee. All assessment insurers, farm mutuals, fraternal  
 17 benefit societies, and health maintenance organizations shall remit to  
 18 the commissioner for deposit into the department of insurance fund one  
 19 hundred dollars (\$100) annually as an internal audit fee.  
 20 (e) Beginning July 1, 1994, each insurer shall remit to the  
 21 commissioner for deposit into the department of insurance fund  
 22 established by IC 27-1-3-28 a fee of thirty-five dollars (\$35) for each  
 23 policy, rider, and endorsement filed with the state. However, each  
 24 policy, rider, and endorsement filed as part of a particular product  
 25 filing and associated with that product filing shall be considered to be  
 26 a single filing and subject only to one (1) thirty-five dollar (\$35) fee.  
 27 (f) The commissioner shall pay into the state general fund by the  
 28 end of each calendar month the amounts collected during that month  
 29 under subsections (a), (b), and (c). ~~of this section.~~  
 30 **(g) The commissioner may not collect fees for quarterly**  
 31 **statements filed under IC 27-1-20-33.**  
 32 SECTION 10. IC 27-1-3-20 IS AMENDED TO READ AS  
 33 FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 20. (a) The  
 34 commissioner may issue a certificate of authority to any company when  
 35 it shall have complied with the requirements of the laws of this state so  
 36 as to entitle it to do business herein. The certificate shall be issued  
 37 under the seal of the department authorizing and empowering the  
 38 company to make the kind or kinds of insurance specified in the  
 39 certificate. No certificate of authority shall be issued until the  
 40 commissioner has found that:  
 41 (a) (1) the company has submitted a sound plan of operation; and  
 42 (b) (2) the general character and experience of the incorporators,

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1 directors, and proposed officers is such as to assure reasonable  
 2 promise of a successful operation, based on the fact that such  
 3 persons are of known good character and that there is no good  
 4 reason to believe that they are affiliated, directly or indirectly,  
 5 through ownership, control, management, reinsurance  
 6 transactions, or other insurance or business relations with any  
 7 person or persons known to have been involved in the improper  
 8 manipulation of assets, accounts, or reinsurance.

9 No certificate of authority shall be denied, however, under subdivision  
 10 ~~(a)~~ (1) or ~~(b)~~ (2) until notice, hearing, and right of appeal has been  
 11 given as provided in IC 4-21.5.

12 (b) Every company possessing a certificate of authority shall notify  
 13 the commissioner of the election or appointment of every new director  
 14 or principal officer, within thirty (30) days thereafter. If in the  
 15 commissioner's opinion such a new principal officer or director does  
 16 not meet the standards set forth in this section, he shall request that the  
 17 company effect the removal of such persons from office. If such  
 18 removal is not accomplished as promptly as under the circumstances  
 19 and in the opinion of the commissioner is possible, then upon notice to  
 20 both the company and such principal officer or director and after  
 21 notice, hearing, and right of appeal pursuant to IC 4-21.5, and after a  
 22 finding that such person is incompetent or untrustworthy or of known  
 23 bad character, the commissioner may order the removal of such person  
 24 from office and may, unless such removal is promptly accomplished,  
 25 suspend the company's certificate of authority until there is compliance  
 26 with such order.

27 (c) No company shall transact any business of insurance **under**  
 28 **IC 22 or IC 27, or hold itself out as a company in the business of**  
 29 **insurance in this state Indiana** until it shall have received a certificate  
 30 of authority as prescribed in this section. ~~and~~.

31 (d) No company shall make, **issue, deliver, sell, or advertise** any  
 32 kind or kinds of insurance not specified in ~~such~~ **the company's**  
 33 certificate of authority.

34 SECTION 11. IC 27-1-8-13 IS AMENDED TO READ AS  
 35 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 13. (a) Any domestic  
 36 mutual insurance company may by amendment of its articles of  
 37 incorporation convert to a stock insurance company only upon  
 38 compliance with the requirements of this section and applicable  
 39 requirements of sections 1 through 8 and 11 of this chapter.

40 (b) The board of directors of any such mutual company shall first  
 41 adopt a resolution proposing the amendment to its articles of  
 42 incorporation, as required by section 2 of this chapter, and proposing



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- 1 a plan of conversion of such mutual company into a stock insurance
- 2 company. Such plan of conversion shall set forth the following:
- 3 (1) The terms and conditions of the plan of conversion and the
- 4 manner and basis of carrying the same into effect.
- 5 (2) ~~A formula~~ **Formulas** for:
- 6 (A) the determination of the equity **or share**, if any, of each
- 7 member or policyholder in the entire net worth **or initial issue**
- 8 **of capital stock** of the company; and
- 9 (B) ~~for~~ the determination and preservation of the participation
- 10 rights, if any, in future earnings from each class of existing
- 11 insurance policies.
- 12 (3) ~~A If the procedures of subdivision (5)(A) are applicable, a~~
- 13 statement of the entire net worth of the company attested by two
- 14 (2) independent actuaries, each of whom is a member of the
- 15 American Academy of Actuaries, and **under the procedures of**
- 16 **subdivision (5)(A) or (5)(B)**, written opinions by such actuaries
- 17 that the ~~formula formulas~~ and ~~procedure procedures~~ required in
- 18 subdivision (2) ~~is~~ **are** fair and equitable to the members and
- 19 policyholders of the company.
- 20 (4) ~~That A statement of~~ the members or policyholders entitled to
- 21 participate in the conversion, as provided in the plan, **which** shall
- 22 include all members and policyholders of the company who have
- 23 voting rights as of the effective date of the amendment and the
- 24 plan of conversion **or as of an earlier date as the commissioner**
- 25 **may approve.**
- 26 (5) **A statement** that the members ~~and~~ **or** policyholders of the
- 27 company, as defined in subdivision (4), **shall have the right to**
- 28 **capital stock of the company or to a payment of cash from the**
- 29 **company under one (1) of the following procedures, as**
- 30 **specified by the company in the plan of conversion:**
- 31 (A) **The members and policyholders of the company** shall
- 32 have the first right to acquire all the proposed initial issue of
- 33 capital stock of the company by a fair allocation of the rights
- 34 to acquire such stock among such members or policyholders,
- 35 provided that such right to acquire such shares shall be
- 36 exercised within a designated reasonable period, which period
- 37 shall not be less than thirty (30) days, with the right to apply
- 38 the amount of equity, if any, as determined under the ~~formula~~
- 39 **formulas** in subdivision (2)(A) upon the purchase price of
- 40 such shares; provided, further, that:
- 41 (i) the right shall be exercised by a written election in a form
- 42 provided by the company, and payment for any balance due

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1 upon such shares, after the aforesaid credit, if any, shall be  
 2 made in cash within such time as is fixed in the plan;  
 3 ~~(6) That (ii)~~ any shares not acquired by a member or  
 4 policyholder, as provided in ~~subdivision (5)~~, **the prior**  
 5 **provisions of this clause**, may be offered to others who may  
 6 or may not be members or policyholders at the same or a  
 7 higher price per share than that provided for under  
 8 ~~subdivision (5)~~. **the prior provisions of this clause; and**  
 9 ~~(7) That (iii)~~ at a time specified in the plan, payment to each  
 10 dissenting member or policyholder shall be made in cash of  
 11 the amount, if any, as provided under the plan for payment  
 12 to dissenting members or policyholders, such dissenting  
 13 members or policyholders being those who do not acquire  
 14 shares as provided in ~~subdivision (5)~~. **this clause.**

15 **(B) The members or policyholders of the company shall**  
 16 **receive all of the initial issue of capital stock of the**  
 17 **company, without payment of any consideration to the**  
 18 **company, by a fair allocation of such stock among such**  
 19 **members or policyholders, if the commissioner is satisfied:**

20 (i) that the company will assure that an active public  
 21 trading market for the capital stock of the company will  
 22 develop within a reasonable time after the effective date  
 23 of the plan of conversion or after the delivery of stock  
 24 certificates to the members or policyholders; and

25 (ii) with the terms and conditions of any public offering  
 26 or other stock offerings or sales by the company  
 27 proposed to be made during the three (3) year period  
 28 following the effective date of the plan of conversion,  
 29 including any stock subscription rights of the members  
 30 and policyholders.

31 **(6) The plan of conversion may include procedures for:**

32 **(A) establishment of a noninsurance stock holding**  
 33 **corporation for the company concurrent with or**  
 34 **immediately following the effective date of the plan of**  
 35 **conversion and for the exchange or conversion of the**  
 36 **members' or policyholders' rights to and interests in**  
 37 **capital stock of the company for or into equivalent rights**  
 38 **to and interests in capital stock of the noninsurance stock**  
 39 **holding corporation;**

40 **(B) delayed delivery of stock certificates or cash to the**  
 41 **members or policyholders of the company, or restrictions**  
 42 **on sale or transfer of capital stock by members or**

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- 1            **policyholders of the company, for a reasonable time**  
 2            **following the effective date of the plan of conversion; and**  
 3            **(C) delayed establishment of the formulas required by**  
 4            **subdivision (2)(A) or establishment in the plan of**  
 5            **conversion of specific conditional or alternative formulas.**  
 6            ~~(8)~~ **(7) The plan of conversion may contain** such other terms  
 7            and provisions as the company deems necessary or desirable.
- 8            (c) Any such mutual insurance company shall file with the  
 9            department, following the adoption by its board of directors of such  
 10            resolution proposing the amendment and plan of conversion, and  
 11            before its submission to a vote by its members or policyholders, three  
 12            (3) copies of the proposed amendment to the articles of incorporation,  
 13            together with three (3) copies of the plan of conversion and such other  
 14            supporting documents as the company **or the department** deems  
 15            necessary.
- 16            (d) The insurance commissioner shall hold a hearing upon the  
 17            terms, conditions, and provisions of the plan of conversion, at which  
 18            hearing the policyholders of the company and any other interested party  
 19            shall have the right to appear and become a party to the proceedings.  
 20            The commissioner shall require the company to produce such evidence  
 21            as he shall deem necessary to establish that the plan of conversion  
 22            meets the requirements set forth in this section and further that it is fair  
 23            and equitable to the members and policyholders of the company. Such  
 24            hearing shall be commenced not less than twenty (20) days after the  
 25            date on which the amendment and plan of conversion are presented to  
 26            the department, and shall be held in the city of Indianapolis, Indiana,  
 27            at such place, date, and time as the department shall specify. Notice of  
 28            the hearing shall be published in a newspaper of general circulation in  
 29            the city wherein is located the principal office of the company and in  
 30            the city of Indianapolis once a week for two (2) successive weeks.  
 31            Written notice of the hearing shall be mailed by the company to its  
 32            members and policyholders having voting rights at least ten (10) days  
 33            prior to the hearing. Except as otherwise provided in this section, the  
 34            hearing and the determination made therein shall be subject to  
 35            IC 4-21.5-3.
- 36            (e) The commissioner shall issue an order approving the plan of  
 37            conversion as filed with the department by the company with such  
 38            modifications therein as a majority of the board of directors of the  
 39            company shall approve if the commissioner finds that:
- 40            (1) the plan, including all such modifications, if effected, will  
 41            meet all the requirements set forth in this section;  
 42            (2) such plan is equitable to the members and policyholders of the



- 1 company;
- 2 (3) the terms and conditions of the plan of conversion are fair and
- 3 reasonable;
- 4 (4) upon consummation of the plan of conversion the paid-in
- 5 capital and surplus of the company shall be in an amount not less
- 6 than the minimum paid-in capital and surplus required to organize
- 7 a domestic stock insurance company to transact like kinds of
- 8 insurance; and
- 9 (5) all the rights of every member and policyholder as fixed in any
- 10 policy of insurance of the company, excluding voting rights, if
- 11 any, shall be and remain unaffected by the proposed conversion
- 12 and shall continue in full force in accordance with the terms of the
- 13 policy of each such member and policyholder.
- 14 (f) The order of the commissioner approving or disapproving the
- 15 plan of conversion shall be filed in the department within thirty (30)
- 16 days after the last day of the hearing before the commissioner. The
- 17 department shall promptly give notice of such order to all persons who
- 18 appeared at the hearing and requested to be made parties to the
- 19 proceedings, and the department shall endorse the commissioner's
- 20 approval or disapproval on the plan of conversion in the manner
- 21 provided in IC 27-1-6-8 and shall deliver copies thereof to the
- 22 company. The company or any person who was made a party to such
- 23 proceedings aggrieved by such order shall be entitled to a judicial
- 24 review thereof in accordance with IC 4-21.5-5. Subject only to such
- 25 judicial review, the determination and order of the commissioner (or
- 26 the court upon judicial review) in approving or disapproving the plan
- 27 of conversion shall be binding and conclusive upon all parties to the
- 28 proceedings and all policyholders or members with respect to the
- 29 fairness of the plan and its compliance with this article and with respect
- 30 to the proportionate share, if any, of each policyholder or member in
- 31 the equity **or capital stock** of the company and the value **or**
- 32 **proportionate share, if any**, of his membership interests or rights as
- 33 determined under the ~~formula~~ **formulas** referred to in subsection
- 34 (b)(2).
- 35 (g) The plan of conversion and the proposed amendment to the
- 36 articles of incorporation, as finally approved, shall be submitted to a
- 37 vote of the members or policyholders, as provided in section 3 of this
- 38 chapter, and if the proposed plan of conversion and proposed
- 39 amendment shall be adopted as provided in section 3 of this chapter,
- 40 the company shall proceed to consummate the plan of conversion and
- 41 comply with the applicable provisions of sections 4 through 8 and 11
- 42 of this chapter.

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1 (h) Notwithstanding the adoption of the plan of conversion by the  
2 policyholders and at any time prior to the effective date of the plan of  
3 conversion, the plan and proposed amendment may be abandoned  
4 pursuant to a provision for such abandonment, if any, contained in the  
5 plan of conversion.

6 (i) The plan of conversion and proposed amendment to the articles  
7 of incorporation shall become effective upon the later of:

- 8 (1) the date and time of approval of the articles of amendment by
- 9 the secretary of state as provided in section 8 of this chapter; and
- 10 (2) the date and time of filing with the department a certificate
- 11 setting forth the plan of conversion and the manner of its approval
- 12 by the directors and policyholders of the company, which shall be
- 13 executed on behalf of the company by its president or a vice
- 14 president;

15 unless a later date and time is specified in the plan of conversion, in  
16 which event the plan of conversion and amendment shall become  
17 effective and take place upon such later date and time.

18 (j) When the plan of conversion and proposed amendment to the  
19 articles of incorporation become effective:

- 20 (1) the company shall be converted from a mutual insurance
- 21 company to a stock insurance company and shall have all the
- 22 rights, privileges, immunities, and powers and shall be subject to
- 23 all the duties and liabilities of a stock insurance company existing
- 24 under this article; and
- 25 (2) the rights and interests of every member and policyholder
- 26 existing by virtue of being a member or policyholder of the
- 27 mutual company, of any nature whatsoever, including voting
- 28 rights, shall cease.

29 Provided, however, that rights of every member and policyholder under  
30 any contract of insurance shall continue in force in accordance with the  
31 terms, provisions, and conditions of such contract, including rights, if  
32 any, to policyholder dividends.

33 SECTION 12. IC 27-1-15.5-3, AS AMENDED BY P.L.185-1996,  
34 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
35 JULY 1, 1998]: Sec. 3. (a) A person may not act as or hold himself out  
36 to be an insurance agent, surplus lines insurance agent, limited  
37 insurance representative, or consultant unless he is duly licensed. An  
38 insurance agent, surplus lines insurance agent, or limited insurance  
39 representative may not make application for, procure, negotiate for, or  
40 place for others any policies for any kinds of insurance as to which he  
41 is not then qualified and duly licensed. An insurance agent and a  
42 limited insurance representative may receive qualification for a license

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1 in one (1) or more of the kinds of insurance defined in Class I, Class II,  
2 and Class III of IC 27-1-5-1. A surplus lines insurance agent may  
3 receive qualification for a license in one (1) or more of the kinds of  
4 insurance defined in Class II and Class III of IC 27-1-5-1 from insurers  
5 that are authorized to do business in one (1) or more states of the  
6 United States of America but which insurers are not authorized to do  
7 business in Indiana, whenever, after diligent effort, as determined to  
8 the satisfaction of the insurance department, such licensee is unable to  
9 procure the amount of insurance desired from insurers authorized and  
10 licensed to transact business in Indiana. The commissioner may issue  
11 a limited insurance representative's license to the following without  
12 examination:

13 (1) a person who is a ticket-selling agent of a common carrier who  
14 will act only with reference to the issuance of insurance on  
15 personal effects carried as baggage, in connection with the  
16 transportation provided by such common carrier;

17 (2) a person who will only negotiate or solicit limited travel  
18 accident insurance in transportation terminals;

19 (3) a person who will only negotiate or solicit insurance covered  
20 by IC 27-8-4;

21 (4) a person who will only negotiate or solicit insurance under  
22 Class II(j); or

23 (5) to any person who will negotiate or solicit a kind of insurance  
24 that the commissioner finds does not require an examination to  
25 demonstrate professional competency.

26 (b) A corporation or limited liability company may be licensed as an  
27 insurance agent, surplus lines insurance agent, or limited insurance  
28 representative. Every officer, director, stockholder, or employee of the  
29 corporation or limited liability company personally engaged in Indiana  
30 in soliciting or negotiating policies of insurance shall be registered with  
31 the commissioner as to its license, and each such member, officer,  
32 director, stockholder, or employee shall also qualify as an individual  
33 licensee. However, this section does not apply to a management  
34 association, partnership, or corporation whose operations do not entail  
35 the solicitation of insurance from the public.

36 (c) The commissioner may not grant, renew, continue or permit to  
37 continue any license if he finds that the license is being or will be used  
38 by the applicant or licensee for the purpose of writing controlled  
39 business. "Controlled business" means:

40 (1) insurance written on the interests of the licensee or those of  
41 his immediate family or of his employer; or

42 (2) insurance covering himself or members of his immediate



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1 family or a corporation, limited liability company, association, or  
 2 partnership, or the officers, directors, substantial stockholders,  
 3 partners, members, managers, employees of such a corporation,  
 4 limited liability company, association, or partnership, of which he  
 5 is or a member of his immediate family is an officer, director,  
 6 substantial stockholder, partner, member, manager, associate, or  
 7 employee.

8 However, this section does not apply to insurance written or interests  
 9 insured in connection with or arising out of credit transactions. Such a  
 10 license shall be deemed to have been or intended to be used for the  
 11 purpose of writing controlled business, if the commissioner finds that  
 12 during any twelve (12) month period the aggregate commissions earned  
 13 from such controlled business has exceeded twenty-five percent (25%)  
 14 of the aggregate commission earned on all business written by such  
 15 applicant or licensee during the same period.

16 (d) An insurer, insurance agent, surplus lines insurance agent, or  
 17 limited insurance representative may not pay any commission,  
 18 brokerage, or other valuable consideration to any person for services as  
 19 an insurance agent, surplus lines insurance agent, or limited insurance  
 20 representative within Indiana, unless the person held, at the time the  
 21 services were performed, a valid license for that kind of insurance as  
 22 required by the laws of Indiana for such services. A person, other than  
 23 a person duly licensed by the state of Indiana as an insurance agent,  
 24 surplus lines insurance agent, or limited insurance representative, may  
 25 not, at the time such services were performed, accept any such  
 26 commission, brokerage, or other valuable consideration. However, any  
 27 such person duly licensed under this chapter may:

28 (1) pay or assign his commissions or direct that his commissions  
 29 be paid:

30 (A) to a partnership of which he is a member, an employee, or  
 31 an agent; or

32 (B) to a corporation of which he is an officer, employee, or  
 33 agent; or

34 (2) pay, pledge, assign, or grant a security interest in the person's  
 35 commission to a lending institution as collateral for a loan if the  
 36 payment, pledge, assignment, or grant of a security interest is not,  
 37 directly or indirectly, in exchange for insurance services  
 38 performed.

39 This section shall not prevent payment or receipt of renewal or other  
 40 deferred commissions to or by any person entitled thereto under this  
 41 section.

42 (e) The license shall state the name and resident address of the

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1 licensee, date of issue, the renewal or expiration date, the line or lines  
 2 of insurance covered by the license, and such other information as the  
 3 commissioner considers proper for inclusion in the license.

4 (f) All licenses issued under this chapter shall continue in force not  
 5 longer than twenty-four (24) months. The insurance department shall  
 6 establish procedures for the renewal of licenses. **A license may be  
 7 renewed after it expires as follows:**

8 (1) ~~If~~ A person **who** applies for a **license renewal of his license**  
 9 **not** more than twenty-four (24) months **but no more than sixty**  
 10 ~~(60)~~ months after it **the person's license** expires ~~he~~ must:

11 pay a ~~reinstatement fee of one hundred dollars (\$100)~~ plus  
 12 ~~current fees~~; or

13 **(A) satisfy the requirements of IC 27-1-15.5-7.1(b); and**  
 14 **(B) pass to the department's satisfaction the laws portion of**  
 15 the examination required of an applicant **under**  
 16 **IC 27-1-15.5-4(g)(5)** for the type of license for which the  
 17 person seeks renewal.

18 (2) ~~If~~ A person **who** applies for a **license renewal of his license**  
 19 more than ~~sixty (60)~~ **twenty-four (24)** months after it expires ~~he~~  
 20 must **successfully complete the education requirements of**  
 21 **IC 27-1-15.5-4(e) and** pass to the department's satisfaction the  
 22 examination required of an applicant for the type of license for  
 23 which the person seeks renewal.

24 All license renewals must be accompanied by payment of the renewal  
 25 fee as provided in section 4(d) of this chapter.

26 (g) A license as an insurance agent, surplus lines insurance agent,  
 27 or limited insurance representative may not be required of the  
 28 following:

29 (1) Any regular salaried officer or employee of an insurance  
 30 company, or of a licensed insurance agent, surplus lines insurance  
 31 agent, or limited insurance representative if such officer or  
 32 employee's duties and responsibilities do not include the  
 33 negotiation or solicitation of insurance.

34 (2) Persons who secure and furnish information for the purpose  
 35 of group or wholesale life insurance, or annuities, or group,  
 36 blanket, or franchise health insurance, or for enrolling individuals  
 37 under such plans or issuing certificates thereunder or otherwise  
 38 assisting in administering such plans, where no commission is  
 39 paid for such service.

40 (3) Employers or their officers or employees, or the trustees of  
 41 any employee trust plan, to the extent that such employers,  
 42 officers, employees, or trustees are engaged in the administration



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1 or operation of any program of employee benefits for their own  
2 employees or the employees of their subsidiaries or affiliates  
3 involving the use of insurance issued by a licensed insurance  
4 company, provided that such employers, officers, employees, or  
5 trustees are not in any manner compensated, directly or indirectly,  
6 by the insurance company issuing such insurance.

7 (h) An insurer shall require that a person who, on behalf of the  
8 insurer, makes any oral, written, or electronic communication with an  
9 individual regarding insurance coverage, rates, benefits, or policy  
10 terms, for the purpose of soliciting insurance shall be licensed under  
11 this chapter.

12 (i) A violation of subsection (h) is deemed an unfair method of  
13 competition and an unfair and deceptive act and practice in the  
14 business of insurance subject to the provisions of IC 27-4-1-4.

15 SECTION 13. IC 27-1-15.5-8, AS AMENDED BY  
16 P.L.253-1997(ss), SECTION 27, IS AMENDED TO READ AS  
17 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 8. (a) The  
18 commissioner may suspend, revoke, refuse to continue, renew, or issue  
19 any license issued under this chapter, or impose any of the disciplinary  
20 sanctions under subsection (f) if, after notice to the licensee and to the  
21 insurer represented and a hearing, the commissioner finds as to the  
22 licensee any one (1) or more of the following conditions:

- 23 (1) Any materially untrue statement in the license application.
- 24 (2) Any cause for which issuance of the license could have been  
25 refused had it then existed and been known to the commissioner  
26 at the time of issuance.
- 27 (3) Violation of or noncompliance with any insurance laws,  
28 violation of any provision of IC 28 concerning the sale of a life  
29 insurance policy or an annuity contract, or violation of any lawful  
30 rule, regulation, or order of the commissioner or of a  
31 commissioner of another state.
- 32 (4) Obtaining or attempting to obtain any such license through  
33 misrepresentation or fraud.
- 34 (5) Improperly withholding, misappropriating, or converting to  
35 the licensee's own use any money belonging to policyholders,  
36 insurers, beneficiaries, or others received in the course of the  
37 licensee's insurance business.
- 38 (6) Misrepresentation of the terms of any actual or proposed  
39 insurance contract.
- 40 (7) **A:**
- 41 (A) conviction of; or
- 42 (B) plea of guilty, no contest, or nolo contendere to;

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1 a felony or misdemeanor involving moral turpitude.

2 (8) The licensee has been found guilty of any unfair trade practice  
3 or of fraud.

4 (9) In the conduct of the licensee's affairs under the license, the  
5 licensee has used fraudulent, coercive, or dishonest practices, or  
6 has shown himself to be incompetent, untrustworthy, or  
7 financially irresponsible, or not performing in the best interests of  
8 the insuring public.

9 (10) The licensee's license has been suspended or revoked in any  
10 ~~other~~ state, province, district, or territory.

11 (11) The licensee has forged another's name to an application for  
12 insurance.

13 (12) An applicant has been found to have been cheating on a  
14 examination for an insurance license.

15 (13) The applicant or licensee is on the most recent tax warrant  
16 list supplied to the commissioner by the department of state  
17 revenue.

18 (14) The licensee has failed to satisfy the continuing education  
19 requirements under section 7.1 of this chapter.

20 (b) The commissioner shall refuse to:

21 (1) issue a license; or

22 (2) renew a license issued;

23 under this chapter to any person who is the subject of an order issued  
24 by a court under IC 31-14-12-7 or IC 31-16-12-10 (or  
25 IC 31-1-11.5-13(m) or IC 31-6-6.1-16(m) before their repeal).

26 (c) In the event that the action by the commissioner is to not renew  
27 or to deny an application for a license, the commissioner shall notify  
28 the applicant or licensee and advise, in writing, the applicant or  
29 licensee of the reasons for the denial or nonrenewal of the applicant's  
30 or licensee's license. Not later than sixty (60) days after receiving a  
31 notice from the commissioner under this subsection, the applicant or  
32 licensee may make written demand upon the commissioner for a  
33 hearing to determine the reasonableness of the commissioner's action.  
34 Such hearing shall be held within thirty (30) days from the date of  
35 receipt of the written demand of the applicant.

36 (d) The license of a corporation may be suspended, revoked, or  
37 refused if the commissioner finds, after hearing, that an individual  
38 licensee's violation was known or should have been known by one (1)  
39 or more of the officers or managers acting on behalf of the corporation  
40 and such violation was not reported to the insurance department nor  
41 corrective action taken in relation to the violation.

42 (e) In addition to or in lieu of any applicable denial, suspension, or



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1 revocation of a license, any person violating this chapter may, after a  
2 hearing, be subject to a civil penalty of not less than fifty dollars (\$50)  
3 nor more than ten thousand dollars (\$10,000). Such a penalty may be  
4 enforced in the same manner as civil judgments.

5 (f) The commissioner may impose any of the following sanctions,  
6 singly or in combination, when the commissioner finds that a licensee  
7 is guilty of any offense under subsection (a):

8 (1) Permanently revoke (as defined in subsection (h)) a licensee's  
9 certificate.

10 (2) Revoke a licensee's certificate with a stipulation that the  
11 licensee may not reapply for a certificate for a period fixed by the  
12 commissioner. The fixed period may not exceed ten (10) years.

13 (3) Suspend a licensee's certificate.

14 (4) Censure a licensee.

15 (5) Issue a letter of reprimand.

16 (6) Place a licensee on probation status and require the licensee  
17 to:

18 (A) report regularly to the commissioner upon the matters that  
19 are the basis of probation;

20 (B) limit practice to those areas prescribed by the  
21 commissioner; or

22 (C) continue or renew professional education under a licensee  
23 approved by the commissioner until a satisfactory degree of  
24 skill has been attained in those areas that are the basis of the  
25 probation.

26 The commissioner may withdraw the probation if the  
27 commissioner finds that the deficiency that required disciplinary  
28 action has been remedied.

29 (g) The insurance commissioner shall notify the securities  
30 commissioner when an administrative action or civil proceeding is filed  
31 under this section and when an order is issued under this section  
32 denying, suspending, or revoking a license.

33 (h) For purposes of subsection (f), "permanently revoke" means that  
34 the licensee's certificate shall never be reinstated and the licensee shall  
35 not be eligible to submit an application for a certificate to the  
36 department.

37 SECTION 14. IC 27-1-20-33, AS AMENDED BY P.L.251-1995,  
38 SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
39 JULY 1, 1998]: Sec. 33. (a) As used in this section, "insurer" refers to  
40 each:

41 (1) domestic company;

42 (2) foreign company; and

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- 1 (3) alien company;  
 2 that is authorized to transact business in Indiana.
- 3 (b) As used in this section, "NAIC" means the National Association  
 4 of Insurance Commissioners.
- 5 (c) On or before March 1 of each year, an insurer shall file with the  
 6 National Association of Insurance Commissioners **and with the**  
 7 **department** a copy of the insurer's annual statement convention blank  
 8 and additional filings prescribed by the commissioner for the preceding  
 9 year. An insurer shall also file quarterly statements with the NAIC **and**  
 10 **with the department** on or before May 15, August 15, and November  
 11 15 of each year in a form prescribed by the commissioner. The  
 12 information filed with the NAIC under this subsection:
- 13 (1) must be:
- 14 (A) in the same format; and  
 15 (B) of the same scope;  
 16 as is required by the commissioner under section 21 of this  
 17 chapter;
- 18 (2) to the extent required by the NAIC, must include the signed  
 19 jurat page and the actuarial certification; and
- 20 (3) must be filed on diskette in accordance with NAIC diskette  
 21 filing specifications.
- 22 The commissioner may grant an exemption from the requirement of  
 23 subdivision (3) to domestic companies that operate only in Indiana. If  
 24 an insurer files any amendment or addendum to an insurer's annual  
 25 statement convention blank or quarterly statement with the  
 26 commissioner, the insurer shall also file a copy of the amendment or  
 27 addendum with the NAIC. Annual and quarterly financial statements  
 28 are deemed filed with the NAIC when delivered to the address  
 29 designated by the NAIC for the filings regardless of whether the filing  
 30 is accompanied by any applicable fee.
- 31 (d) The commissioner may, for good cause, grant an insurer an  
 32 extension of time for the filing required by subsection (c).
- 33 (e) A foreign company that:
- 34 (1) is domiciled in a state that has a law substantially similar to  
 35 subsection (c); and  
 36 (2) complies with that law;  
 37 shall be considered to be in compliance with this section.
- 38 (f) In the absence of actual malice:
- 39 (1) members of the NAIC;  
 40 (2) duly authorized committees, subcommittees, and task forces  
 41 of members of the NAIC;  
 42 (3) delegates of members of the NAIC;

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- 1 (4) employees of the NAIC; and
- 2 (5) other persons responsible for collecting, reviewing, analyzing,
- 3 and disseminating information developed from the filing of
- 4 annual statement convention blanks under this section;
- 5 shall be considered to be acting as agents of the commissioner under
- 6 the authority of this section and are not subject to civil liability for
- 7 libel, slander, or any other cause of action by virtue of the collection,
- 8 review, analysis, or dissemination of the data and information collected
- 9 from the filings required by this section.
- 10 (g) The commissioner may suspend, revoke, or refuse to renew the
- 11 certificate of authority of an insurer that fails to file the insurer's annual
- 12 statement convention blank or quarterly statements with the NAIC **or**
- 13 **with the department** within the time allowed by subsection (c) or (d).
- 14 SECTION 15. IC 27-4-5-2, AS AMENDED BY P.L.252-1995,
- 15 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 16 JULY 1, 1998]: Sec. 2. (a) It is a Class A infraction for an insurer to
- 17 transact insurance business in this state, as set forth in subsection (b),
- 18 without a certificate of authority from the commissioner. However, this
- 19 section does not apply to the following:
- 20 (1) The lawful transaction of surplus lines insurance.
- 21 (2) The lawful transaction of reinsurance by insurers.
- 22 (3) Transactions in this state involving a policy lawfully solicited,
- 23 written, and delivered outside of this state covering only subjects
- 24 of insurance not resident, located, or expressly to be performed in
- 25 this state at the time of issuance, and which transactions are
- 26 subsequent to the issuance of such policy.
- 27 (4) Attorneys acting in the ordinary relation of attorney and client
- 28 in the adjustment of claims or losses.
- 29 (5) Transactions in this state involving group life and group
- 30 sickness and accident or blanket sickness and accident insurance
- 31 or group annuities where the master policy of such groups was
- 32 lawfully issued and delivered in and pursuant to the laws of a
- 33 state in which the insurer was authorized to do an insurance
- 34 business, to a group organized for purposes other than the
- 35 procurement of insurance, and where the policyholder is
- 36 domiciled or otherwise has a bona fide situs.
- 37 (6) Transactions in this state relative to a policy issued or to be
- 38 issued outside this state involving insurance on vessels, craft or
- 39 hulls, cargos, marine builder's risk, marine protection and
- 40 indemnity or other risk, including strikes and war risks commonly
- 41 insured under ocean or wet marine forms of policy.
- 42 (7) Transactions in this state involving life insurance, health

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1 insurance, or annuities provided to religious or charitable  
 2 institutions organized and operated without profit to any private  
 3 shareholder or individual for the benefit of such institutions and  
 4 individuals engaged in the service of such institutions.

5 (8) Transactions in this state involving contracts of insurance not  
 6 readily obtainable in the ordinary insurance market and issued to  
 7 one (1) or more industrial insureds. For purposes of this section,  
 8 an "industrial insured" means an insured:

9 (A) who procures the insurance of any risk or risks by use of  
 10 the services of a full-time employee acting as an insurance  
 11 manager or buyer or the services of a regularly retained and  
 12 continuously qualified insurance consultant;

13 (B) whose aggregate annual premium for insurance on all risks  
 14 totals at least twenty-five thousand dollars (\$25,000); and

15 (C) who has at least twenty-five (25) full-time employees.

16 (9) Transactions in Indiana involving the rendering of any service  
 17 by any ambulance service provider and all fees, costs, and  
 18 membership payments charged for the service. To qualify under  
 19 this subdivision, the ambulance service provider:

20 (A) must have its ambulance service program approved by an  
 21 ordinance of the legislative body of the county or city in which  
 22 it operates; and

23 (B) may not offer any membership program that includes  
 24 benefits exceeding one (1) year in duration.

25 (b) Any of the following acts in this state effected by mail or  
 26 otherwise by or on behalf of an unauthorized insurer constitutes the  
 27 transaction of an insurance business in this state. The venue of an act  
 28 committed by mail is at the point where the matter transmitted by mail  
 29 is delivered and takes effect. Unless otherwise indicated, the term  
 30 "insurer" as used in this section includes all persons engaged as  
 31 principals in the business of insurance and also includes interinsurance  
 32 exchanges, ~~and~~ mutual benefit societies, **health maintenance**  
 33 **organizations (as defined in IC 27-13-1-19), and limited service**  
 34 **health maintenance organizations (as defined in IC 27-13-34-4).**

35 (1) The making of or proposing to make, as an insurer, an  
 36 insurance contract.

37 (2) The making of or proposing to make, as guarantor or surety,  
 38 any contract of guaranty or suretyship as a vocation and not  
 39 merely incidental to any other legitimate business or activity of  
 40 the guarantor or surety.

41 (3) The taking or receiving of any application for insurance.

42 (4) The receiving or collection of any premium, commission,

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membership fees, assessments, dues, or other consideration for any insurance or any part thereof.

(5) The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state.

(6) Acting as an agent for or otherwise representing or aiding on behalf of another person or insurer in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or representing or assisting a person or an insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state. This subdivision does not prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of the employer.

(c)(1) The failure of an insurer transacting insurance business in this state to obtain a certificate of authority does not impair the validity of any act or contract of such insurer and does not prevent such insurer from defending any action at law or suit in equity in any court of this state, but no insurer transacting insurance business in this state without a certificate of authority may maintain an action in any court of this state to enforce any right, claim, or demand arising out of the transaction of such business until such insurer obtains a certificate of authority.

(2) In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of such insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of such insurance contract is liable to the insured for the full amount of the claim or loss in the manner provided by the insurance contract.

SECTION 16. IC 27-7-2-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 7. Stock companies and nonstock companies shall be represented in the bureau management and on all committees. **Participation in the bureau management and its committees is restricted to those companies maintaining at least five million dollars (\$5,000,000) in worker's compensation writings in Indiana.** In case of a tie vote in any committee or governing body of said bureau, the insurance commissioner shall decide the matter.

SECTION 17. IC 27-7-2-8 IS AMENDED TO READ AS



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1 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 8. The bureau shall  
 2 admit to membership every company **holding a certificate of**  
 3 **authority and** lawfully engaged in whole or in part in writing worker's  
 4 compensation insurance in Indiana.

5 SECTION 18. IC 27-7-2-20 IS AMENDED TO READ AS  
 6 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 20. (a) Every company  
 7 shall adhere to manual rules, policy forms, a statistical plan, a  
 8 classification system, and experience rating plan filed by the bureau  
 9 and approved by the commissioner.

10 (b) The commissioner shall designate the bureau to assist in  
 11 gathering, compiling, and reporting relevant statistical information.  
 12 Every company shall record and report its worker's compensation  
 13 experience to the bureau according to the statistical plan approved by  
 14 the commissioner. The report shall include any deviation from the filed  
 15 recommended minimum premiums and rates, in total and by  
 16 classification. The bureau shall annually submit data concerning these  
 17 deviations to the department. Upon receipt, the department shall  
 18 evaluate the data and prepare a report concerning the effect of  
 19 competitive rating in Indiana. The department shall ~~submit fifty (50)~~  
 20 ~~copies of~~ **make** the report **available to the legislative services agency**  
 21 **by no not** later than ~~October 31, 1990; and no later than~~ October 31 of  
 22 each year. ~~thereafter. The department shall notify each member of the~~  
 23 ~~general assembly that the report is available from the legislative~~  
 24 ~~services agency and shall briefly summarize the conclusions of the~~  
 25 ~~report for each member.~~

26 (c) Every company shall adhere to the approved manual rules,  
 27 policy forms, statistical plan, classification system, and experience  
 28 rating plan in the recording and reporting of data to the bureau.

29 (d) Copies of all approved classifications, rules, and forms shall be  
 30 provided to the worker's compensation board.

31 SECTION 19. IC 27-7-9-8, AS AMENDED BY P.L.116-1994,  
 32 SECTION 57, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 33 JULY 1, 1998]: Sec. 8. (a) Coverage for damage due to mine  
 34 subsidence must be available as an additional form of coverage under  
 35 any insurance policy providing the type of insurance described in Class  
 36 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located  
 37 in a county identified under section 6 of this chapter. The mine  
 38 subsidence coverage must be available in an amount adequate to  
 39 indemnify the insured to the extent of the loss in actual cash value of  
 40 the covered structure due to mine subsidence, less a deductible equal  
 41 to two percent (2%) of the insured value of the structure under the  
 42 policy. However, the deductible must be no less than two hundred fifty



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1 dollars (\$250) and no more than five hundred dollars (\$500).

2 (b) An insurer proposing to issue ~~or renew~~ a policy providing the  
3 type of insurance described in Class 3(a) of IC 27-1-5-1 to cover one  
4 (1) or more structures located in a county identified under section 6 of  
5 this chapter shall inform the ~~policyholder~~ or prospective policyholder  
6 of the availability of mine subsidence coverage under this section. An  
7 insurer shall inform the ~~policyholder~~ or prospective policyholder of the  
8 availability of mine subsidence coverage under this subsection when  
9 a policy described in this subsection is issued. ~~and each time a policy~~  
10 ~~described in this subsection is renewed.~~ However, an insurer is not  
11 required to inform a ~~policyholder~~ or prospective policyholder of the  
12 availability of mine subsidence coverage if ~~(1) the issuance or renewal~~  
13 ~~of the policy will take place after June 30, 1997; 2000. or (2) the policy~~  
14 ~~to be renewed already includes mine subsidence coverage.~~

15 (c) When an insurer informs a ~~policyholder~~ or prospective  
16 policyholder of the amount of the premium for the mine subsidence  
17 coverage that is available as an additional form of coverage under a  
18 policy as required by subsection (a), the premium for the mine  
19 subsidence coverage must be stated separately from the premium for  
20 the other coverage provided by the policy. The amount of the premium  
21 for mine subsidence coverage provided by an insurer under this section  
22 must be set according to the premium level set by the commissioner  
23 under section 10 of this chapter.

24 (d) Except as provided in subsection (f), an insurance policy  
25 providing the type of insurance described in Class 3(a) of IC 27-1-5-1  
26 to directly cover one (1) or more structures located in a county  
27 identified under section 6 of this chapter must include the mine  
28 subsidence coverage provided for under subsection (a) if the  
29 prospective insured (before issuance of the policy) or the insured  
30 (before renewal of the policy) indicates that the coverage is to be  
31 included in the policy.

32 (e) An insurer is not required to provide mine subsidence coverage  
33 under subsection (a) under any insurance policy in an amount  
34 exceeding the amount that is reimbursable from the fund under section  
35 9(a)(4) of this chapter.

36 (f) An insurer must decline to make the mine subsidence coverage  
37 provided for under subsection (a) available to cover a structure  
38 evidencing unrepaired mine subsidence damage, until necessary repairs  
39 are made. An insurer may also decline to make the mine subsidence  
40 coverage available under an insurance policy if the insurer has:

- 41 (1) declined to issue the policy;  
42 (2) declined to renew the policy; or



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- 1 (3) canceled all coverage under the policy for underwriting  
 2 reasons unrelated to mine subsidence.
- 3 SECTION 20. IC 27-8-5-1 IS AMENDED TO READ AS  
 4 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) The term "policy  
 5 of accident and sickness insurance", as used in this chapter, includes  
 6 any policy or contract covering one (1) or more of the kinds of  
 7 insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies  
 8 may be on the individual basis under this section and sections 2  
 9 through 9 of this chapter, on the group basis under this section and  
 10 sections 16 through 19 of this chapter, on the franchise basis under this  
 11 section and section 11 of this chapter, or on a blanket basis under  
 12 section 15 of this chapter and (except as otherwise expressly provided  
 13 in this chapter) shall be exclusively governed by this chapter.
- 14 (b) No policy of accident and sickness insurance may be issued or  
 15 delivered to any person in this state, nor may any application, rider, or  
 16 endorsement be used in connection with an accident and sickness  
 17 insurance policy until a copy of the form of the policy and of the  
 18 classification of risks and the premium rates, or, in the case of  
 19 assessment companies, the estimated cost pertaining thereto, have been  
 20 filed with the commissioner. This section is applicable also to  
 21 assessment companies and fraternal benefit associations or societies.
- 22 (c) No policy of accident and sickness insurance may be issued, nor  
 23 may any application, rider, or endorsement be used in connection with  
 24 a policy of accident and sickness insurance, until the expiration of  
 25 thirty (30) days after it has been filed under subsection (b), unless the  
 26 commissioner gives his written approval to it before the expiration of  
 27 the thirty (30) day period.
- 28 (d) The commissioner may, within thirty (30) days after the filing of  
 29 any **form policy, application, rider, or endorsement** under subsection  
 30 (b), disapprove the **form filing**:
- 31 (1) if, in the case of an individual accident and sickness **form**;  
 32 **filing**, the benefits provided therein are unreasonable in relation  
 33 to the premium charged; or  
 34 (2) if, in the case of an individual, blanket, or group accident and  
 35 sickness **form filing**, it contains a provision or provisions that are  
 36 unjust, unfair, inequitable, misleading, or deceptive or that  
 37 encourage misrepresentation of the policy.
- 38 (e) If the commissioner notifies the insurer that **filed a form made**  
 39 **a filing** that the **form filing** does not comply with this section, it is  
 40 unlawful thereafter for the insurer to issue **or use the form or use it**  
 41 **filing** in connection with any policy. In the notice given under this  
 42 subsection, the commissioner shall specify the reasons for his

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1 disapproval and state that a hearing will be granted within twenty (20)  
2 days after request in writing by the insurer.

3 (f) The commissioner may at any time, after a hearing of which not  
4 less than twenty (20) days written notice has been given to the insurer,  
5 withdraw his approval of any ~~form filed~~ **filing** under subsection (b) on  
6 any of the grounds stated in this section. It is unlawful for the insurer  
7 to issue ~~the form~~ or use it **the filing** in connection with any policy after  
8 the effective date of the withdrawal of approval. The notice of any  
9 hearing called under this subsection must specify the matters to be  
10 considered at the hearing, and any decision affirming disapproval or  
11 directing withdrawal of approval under this section must be in writing  
12 and must specify the reasons for the decision.

13 (g) Any order or decision of the commissioner under this section is  
14 subject to review under IC 4-21.5.

15 SECTION 21. IC 27-8-5-3, AS AMENDED BY P.L.93-1995,  
16 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
17 APRIL 1, 1998]: Sec. 3. (a) Except as provided in subsection (c), each  
18 policy delivered or issued for delivery to any person in this state shall  
19 contain the provisions specified in this subsection in the words in  
20 which the same appear in this section. However, the insurer may, at its  
21 option, substitute for one (1) or more of the provisions corresponding  
22 provisions of different wording approved by the commissioner that are  
23 in each instance no less favorable in any respect to the insured or the  
24 beneficiary. The provisions shall be preceded individually by the  
25 caption appearing in this subsection or, at the option of the insurer, by  
26 appropriate individual or group captions or subcaptions as the  
27 commissioner may approve.

28 (1) A provision as follows: ENTIRE CONTRACT; CHANGES:  
29 This policy, including the endorsements and the attached papers, if any,  
30 constitutes the entire contract of insurance. No change in this policy  
31 shall be valid until approved by an executive officer of the insurer and  
32 unless such approval be endorsed hereon or attached hereto. No agent  
33 has authority to change this policy or to waive any of its provisions.

34 (2) A provision as follows: TIME LIMIT ON CERTAIN  
35 DEFENSES: (A) After two (2) years from the date of issue of this  
36 policy no misstatements, except fraudulent misstatements, made by the  
37 applicant in the application for such policy shall be used to void the  
38 policy or to deny a claim for loss incurred or disability (as defined in  
39 the policy) commencing after the expiration of such two (2) year  
40 period.

41 The foregoing policy provision shall not be so construed as to affect  
42 any legal requirement for avoidance of a policy of denial of a claim

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1 during such initial two (2) year period, nor to limit the application of  
 2 subsection (b), (1), (2), (3), (4), and (5) in the event of misstatement  
 3 with respect to age or occupation or other insurance.

4 A policy which the insured has the right to continue in force subject  
 5 to its terms by the timely payment of premium:

6 (1) until at least age fifty (50); or

7 (2) in the case of a policy issued after forty-four (44) years of age,  
 8 for at least five (5) years from its date of issue;

9 may contain in lieu of the foregoing the following provision (from  
 10 which the clause in parentheses may be omitted at the insurer's option)  
 11 under the caption "INCONTESTABLE": After this policy has been in  
 12 force for a period of two (2) years during the lifetime of the insured  
 13 (excluding any period during which the insured is disabled), it shall  
 14 become incontestable as to the statements contained in the application.

15 (B) No claim for loss incurred or disability (as defined in the policy)  
 16 commencing after two (2) years from the date of issue of this policy  
 17 shall be reduced or denied on the ground that a disease or physical  
 18 condition, not excluded from coverage by name or specific description  
 19 effective on the date of loss, had existed prior to the effective date of  
 20 coverage of this policy.

21 (3) A provision as follows: GRACE PERIOD: A grace period of  
 22 (insert a number not less than "7" for weekly premium policies, "10"  
 23 for monthly premium policies and "31" for all other policies) days will  
 24 be granted for the payment of each premium falling due after the first  
 25 premium, during which grace period the policy shall continue in force.

26 A policy in which the insurer reserves the right to refuse renewal  
 27 shall have, at the beginning of the above provision: "Unless not less  
 28 than thirty (30) days prior to the premium due date the insurer has  
 29 delivered to the insured or has mailed to the insured's last address as  
 30 shown by the records of the insurer written notice of its intention not  
 31 to renew this policy beyond the period for which the premium has been  
 32 accepted."

33 Each policy in which the insurer reserves the right to refuse renewal  
 34 on an individual basis shall provide, in substance, in a provision of the  
 35 policy, in an endorsement on the policy, or in a rider attached to the  
 36 policy, that subject to the right to terminate the policy upon  
 37 non-payment of premium when due, such right to refuse renewal shall  
 38 not be exercised before the renewal date occurring on, or after and  
 39 nearest, each anniversary, or in the case of lapse and reinstatement at  
 40 the renewal date occurring on, or after and nearest, each anniversary of  
 41 the last reinstatement, and that any refusal or renewal shall be without  
 42 prejudice to any claim originating while the policy is in force. The



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1 preceding sentence shall not apply to accident insurance only policies.

2 (4) A provision as follows: REINSTATEMENT: If any renewal  
3 premium is not paid within the time granted the insured for payment,  
4 a subsequent acceptance of premium by the insurer or by any agent  
5 authorized by the insurer to accept such premium, without requiring in  
6 connection therewith an application for reinstatement, shall reinstate  
7 the policy. Provided, that if the insurer or such agent requires an  
8 application for reinstatement and issues a conditional receipt for the  
9 premium tendered, the policy will be reinstated upon approval of such  
10 application by the insurer or, lacking such approval, upon the forty-fifth  
11 day following the date of such conditional receipt unless the insurer has  
12 previously notified the insured in writing of its disapproval of such  
13 application. The reinstated policy shall cover only loss resulting from  
14 such accidental injury as may be sustained after the date of  
15 reinstatement and loss due to such sickness as may begin more than ten  
16 (10) days after such date. In all other respects the insured and insurer  
17 shall have the same rights as they had under the policy immediately  
18 before the due date of the defaulted premium, subject to any provisions  
19 endorsed hereon or attached hereto in connection with the  
20 reinstatement. Any premium accepted in connection with a  
21 reinstatement shall be applied to a period for which premium has not  
22 been previously paid, but not to any period more than sixty (60) days  
23 prior to the date of reinstatement.

24 The last sentence of the above provision may be omitted from any  
25 policy which the insured has the right to continue in force subject to its  
26 terms by the timely payment of premiums:

- 27 (1) until at least fifty (50) years of age; or  
28 (2) in the case of a policy issued after forty-four (44) years of age,  
29 for at least five (5) years from its date of issue.

30 (5) A provision as follows: NOTICE OF CLAIM: Written notice of  
31 claim must be given to the insurer within twenty (20) days after the  
32 occurrence or commencement of any loss covered by the policy, or as  
33 soon thereafter as is reasonably possible. Notice given by or on behalf  
34 of the insured or the beneficiary to the insurer at \_\_\_\_\_ (insert the  
35 location of such office as the insurer may designate for the purpose), or  
36 to any authorized agent of the insurer, with information sufficient to  
37 identify the insured, shall be deemed notice to the insurer.

38 In a policy providing a loss-of-time benefit which may be payable  
39 for at least two (2) years, an insurer may insert the following between  
40 the first and second sentences of the above provision:

41 Subject to the qualifications set forth below, if the insured suffers  
42 loss of time on account of disability for which indemnity may be

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1 payable for at least two (2) years, the insured shall, at least once in  
2 every six (6) months after having given notice of claim, give to the  
3 insurer notice of continuance of said disability, except in the event of  
4 legal incapacity. The period of six (6) months following any filing of  
5 proof by the insured or any payment by the insurer on account of such  
6 claim or any denial of liability in whole or in part by the insurer shall  
7 be excluded in applying this provision. Delay in the giving of such  
8 notice shall not impair the insurer's right to any indemnity which would  
9 otherwise have accrued during the period of six (6) months preceding  
10 the date on which such notice is actually given.

11 (6) A provision as follows: CLAIM FORMS: The insurer, upon  
12 receipt of a notice of claim, will furnish to the claimant such forms as  
13 are usually furnished by it for filing proofs of loss. If such forms are not  
14 furnished within fifteen (15) days after the giving of such notice, the  
15 claimant shall be deemed to have complied with the requirements of  
16 this policy as to proof of loss upon submitting, within the time fixed in  
17 the policy for filing proofs of loss, written proof covering the  
18 occurrence, the character, and the extent of the loss for which claim is  
19 made.

20 (7) A provision as follows: PROOFS OF LOSS: Written proof of  
21 loss must be furnished to the insurer at its said office in case of claim  
22 for loss for which this policy provides any periodic payment contingent  
23 upon continuing loss within ninety (90) days after the termination of  
24 the period for which the insurer is liable and in case of claim for any  
25 other loss within ninety (90) days after the date of such loss. Failure to  
26 furnish such proof within the time required shall not invalidate nor  
27 reduce any claim if it was not reasonably possible to give proof within  
28 such time, provided such proof is furnished as soon as reasonably  
29 possible and in no event, except in the absence of legal capacity, later  
30 than one (1) year from the time proof is otherwise required.

31 (8) A provision as follows: TIME OF PAYMENT OF CLAIMS:  
32 Indemnities payable under this policy for any loss other than loss for  
33 which this policy provides any periodic payment will be paid  
34 immediately upon receipt of due written proof of such loss. Subject to  
35 due written proof of loss, all accrued indemnities for loss for which this  
36 policy provides periodic payment will be paid \_\_\_\_\_ (insert period  
37 for payment which must not be less frequently than monthly) and any  
38 balance remaining unpaid upon the termination of liability will be paid  
39 immediately upon receipt of due written proof.

40 (9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for  
41 loss of life will be payable in accordance with the beneficiary  
42 designation and the provisions respecting such payment which may be



1 prescribed herein and effective at the time of payment. If no such  
2 designation or provision is then effective, such indemnity shall be  
3 payable to the estate of the insured. Any other accrued indemnities  
4 unpaid at the insured's death may, at the option of the insurer, be paid  
5 either to such beneficiary or to such estate. All other indemnities will  
6 be payable to the insured.

7 The following provisions, or either of them, may be included with  
8 the foregoing provision at the option of the insurer:

9 If any indemnity of this policy shall be payable to the estate of the  
10 insured, or to an insured or beneficiary who is a minor or otherwise not  
11 competent to give a valid release, the insurer may pay such indemnity,  
12 up to an amount not exceeding \$ \_\_\_\_\_ (insert an amount which  
13 shall not exceed \$1,000), to any relative by blood or connection by  
14 marriage of the insured or beneficiary who is deemed by the insurer to  
15 be equitably entitled thereto. Any payment made by the insurer in good  
16 faith pursuant to this provision shall fully discharge the insurer to the  
17 extent of such payment.

18 Subject to any written direction of the insured in the application or  
19 otherwise all or a portion of any indemnities provided by this policy on  
20 account of hospital, nursing, medical, or surgical services may, at the  
21 insurer's option and unless the insured requests otherwise in writing not  
22 later than the time of filing proofs of such loss, be paid directly to the  
23 hospital or person rendering such services; but it is not required that the  
24 service be rendered by a particular hospital or person.

25 For the purposes of this section a "minor" is a person under the age  
26 of eighteen (18) years. A person eighteen (18) years of age or over is  
27 competent, insofar as the person's age is concerned, to sign a valid  
28 release.

29 (10) A provision as follows: **PHYSICAL EXAMINATIONS AND**  
30 **AUTOPSY:** The insurer at its own expense shall have the right and  
31 opportunity to examine the person of the insured when and as often as  
32 it may reasonably require during the pendency of a claim hereunder  
33 and to make an autopsy in case of death where it is not forbidden by  
34 law.

35 (11) A provision as follows: **LEGAL ACTIONS:** No action at law  
36 or in equity shall be brought to recover on this policy prior to the  
37 expiration of sixty (60) days after written proof of loss has been  
38 furnished in accordance with the requirements of this policy. No such  
39 action shall be brought after the expiration of three (3) years after the  
40 time written proof of loss is required to be furnished.

41 (12) A provision as follows: **CHANGE OF BENEFICIARY:** Unless  
42 the insured makes an irrevocable designation of beneficiary, the right

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1 to change of beneficiary is reserved to the insured and the consent of  
 2 the beneficiary or beneficiaries shall not be requisite to surrender or  
 3 assignment of this policy or to any change of beneficiary or  
 4 beneficiaries, or to any other changes in this policy.

5 The first clause of this provision, relating to the irrevocable  
 6 designation of beneficiary, may be omitted at the insurer's option.

7 **(13) A provision as follows: GUARANTEED RENEWABILITY:**  
 8 **In compliance with the federal Health Insurance Portability and**  
 9 **Accountability Act of 1996 (P.L.104-191), renewability is**  
 10 **guaranteed.**

11 (b) Except as provided in subsection (c), no policy delivered or  
 12 issued for delivery to any person in Indiana shall contain provisions  
 13 respecting the matters set forth below unless the provisions are in the  
 14 words in which the provisions appear in this section. However, the  
 15 insurer may use, instead of any provision, a corresponding provision of  
 16 different wording approved by the commissioner which is not less  
 17 favorable in any respect to the insured or the beneficiary. Any  
 18 substitute provision contained in the policy shall be preceded  
 19 individually by the appropriate caption appearing in this subsection or,  
 20 at the option of the insurer, by appropriate individual or group captions  
 21 or subcaptions as the commissioner may approve.

22 (1) A provision as follows: CHANGE OF OCCUPATION: If the  
 23 insured be injured or contract sickness after having changed the  
 24 insured's occupation to one classified by the insurer as more hazardous  
 25 than that stated in this policy or while doing for compensation anything  
 26 pertaining to an occupation so classified, the insurer will pay only such  
 27 portion of the indemnities provided in this policy as the premium paid  
 28 would have purchased at the rates and within the limits fixed by the  
 29 insurer for such more hazardous occupation. If the insured changes the  
 30 insured's occupation to one classified by the insurer as less hazardous  
 31 than that stated in this policy, the insurer, upon receipt of proof of such  
 32 change of occupation, will reduce the premium rate accordingly, and  
 33 will return the excess pro rata unearned premium from the date of  
 34 change of occupation or from the policy anniversary date immediately  
 35 preceding receipt of such proof, whichever is the more recent. In  
 36 applying this provision, the classification of occupational risk and the  
 37 premium rates shall be such as have been last filed by the insurer prior  
 38 to the occurrence of the loss for which the insurer is liable or prior to  
 39 date of proof of change in occupation with the state official having  
 40 supervision of insurance in the state where the insured resided at the  
 41 time this policy was issued; but if such filing was not required, then the  
 42 classification of occupational risk and the premium rates shall be those



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1 last made effective by the insurer in such state prior to the occurrence  
2 of the loss or prior to the date of proof of change in occupation.

3 (2) A provision as follows: MISSTATEMENT OF AGE: If the age  
4 of the insured has been misstated, all amounts payable under this policy  
5 shall be such as the premium paid would have purchased at the correct  
6 age.

7 (3) A provision as follows: OTHER INSURANCE IN THIS  
8 INSURER: If an accident or sickness or accident and sickness policy  
9 or policies previously issued by the insurer to the insured are in force  
10 concurrently herewith, making the aggregate indemnity for \_\_\_\_\_  
11 (insert type of coverage or coverages) in excess of \$ \_\_\_\_\_ (insert  
12 maximum limit of indemnity or indemnities) the excess insurance shall  
13 be void and all premiums paid for such excess shall be returned to the  
14 insured or to the insured's estate. Or, instead of that provision:  
15 Insurance effective at any one (1) time on the insured under a like  
16 policy or policies, in this insurer is limited to the one (1) such policy  
17 elected by the insured, the insured's beneficiary or the insured's estate,  
18 as the case may be, and the insurer will return all premiums paid for all  
19 other such policies.

20 (4) A provision as follows: INSURANCE WITH OTHER  
21 INSURER: If there is other valid coverage, not with this insurer,  
22 providing benefits for the same loss on a provision of service basis or  
23 on an expense incurred basis and of which this insurer has not been  
24 given written notice prior to the occurrence or commencement of loss,  
25 the only liability under any expense incurred coverage of this policy  
26 shall be for such proportion of the loss as the amount which would  
27 otherwise have been payable hereunder plus the total of the like  
28 amounts under all such other valid coverages for the same loss of  
29 which this insurer had notice bears to the total like amounts under all  
30 valid coverages for such loss, and for the return of such portion of the  
31 premiums paid as shall exceed the pro-rata portion of the amount so  
32 determined. For the purpose of applying this provision when other  
33 coverage is on a provision of service basis, the "like amount" of such  
34 other coverage shall be taken as the amount which the services  
35 rendered would have cost in the absence of such coverage.

36 If the foregoing policy provision is included in a policy which also  
37 contains the next following policy provision there shall be added to the  
38 caption of the foregoing provision the phrase "EXPENSE INCURRED  
39 BENEFITS". The insurer may, at its option, include in this provision  
40 a definition of "other valid coverage," approved as to form by the  
41 commissioner, which definition shall be limited in subject matter to  
42 coverage provided by organizations subject to regulation by insurance

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1 law or by insurance authorities of this or any other state of the United  
2 States or any province of Canada, and by hospital or medical service  
3 organizations, and to any other coverage the inclusion of which may be  
4 approved by the commissioner. In the absence of such definition such  
5 term shall not include group insurance, automobile medical payments  
6 insurance, or coverage provided by hospital or medical service  
7 organizations or by union welfare plans or employer or employee  
8 benefit organizations. For the purpose of applying the foregoing policy  
9 provision with respect to any insured, any amount of benefit provided  
10 for such insured pursuant to any compulsory benefit statute (including  
11 any worker's compensation or employer's liability statute) whether  
12 provided by a governmental agency or otherwise shall in all cases be  
13 deemed to be "other valid coverage" of which the insurer has had  
14 notice. In applying the foregoing policy provision no third party  
15 liability coverage shall be included as "other valid coverage".

16 (5) A provision as follows: INSURANCE WITH OTHER  
17 INSURERS: If there is other valid coverage, not with this insurer,  
18 providing benefits for the same loss on other than an expense incurred  
19 basis and of which this insurer has not been given written notice prior  
20 to the occurrence or commencement of loss, the only liability for such  
21 benefits under this policy shall be for such proportion of the  
22 indemnities otherwise provided hereunder for such loss as the like  
23 indemnities of which the insurer had notice (including the indemnities  
24 under this policy) bear to the total amount of all like indemnities for  
25 such loss, and for the return of such portion of the premium paid as  
26 shall exceed the pro-rata portion for the indemnities thus determined.  
27 If the foregoing policy provision is included in a policy which also  
28 contains the next preceding policy provision, there shall be added to the  
29 caption of the foregoing provision the phrase "-OTHER BENEFITS."  
30 The insurer may, at its option, include in this provision a definition of  
31 "other valid coverage," approved as to form by the commissioner,  
32 which definition shall be limited in subject matter to coverage provided  
33 by organizations subject to regulation by insurance law or by insurance  
34 authorities of this or any other state of the United States or any  
35 province of Canada, and to any other coverage to the inclusion of  
36 which may be approved by the commissioner. In the absence of such  
37 definition such term shall not include group insurance or benefits  
38 provided by union welfare plans or by employer or employee benefit  
39 organizations. For the purpose of applying the foregoing policy  
40 provision with respect to any insured, any amount of benefit provided  
41 for such insured pursuant to any compulsory benefit statute (including  
42 any worker's compensation or employer's liability statute) whether



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1 provided by a governmental agency or otherwise shall in all cases be  
 2 deemed to be "other valid coverage" of which the insurer has had  
 3 notice. In applying the foregoing policy provision no third party  
 4 liability coverage shall be included as "other valid coverage".

5 (6) A provision as follows: RELATION OF EARNINGS TO  
 6 INSURANCE: If the total monthly amount of loss of time benefits  
 7 promised for the same loss under all valid loss of time coverage upon  
 8 the insured, whether payable on a weekly or monthly basis, shall  
 9 exceed the monthly earnings of the insured at the time disability  
 10 commenced or the insured's average monthly earnings for the period of  
 11 two (2) years immediately preceding a disability for which claim is  
 12 made, whichever is the greater, the insurer will be liable only for such  
 13 proportionate amount of such benefits under this policy as the amount  
 14 of such monthly earnings or such average monthly earnings of the  
 15 insured bears to the total amount of monthly benefits for the same loss  
 16 under all such coverage upon the insured at the time such disability  
 17 commences and for the return of such part of the premiums paid during  
 18 such two (2) years as shall exceed the pro rata amount of the premiums  
 19 for the benefits actually paid; but this shall not operate to reduce the  
 20 total monthly amount of benefits payable under all such coverage upon  
 21 the insured below the sum of two hundred dollars (\$200) or the sum of  
 22 the monthly benefits specified in such coverages, whichever is the  
 23 lesser, nor shall it operate to reduce benefits other than those payable  
 24 for loss of time.

25 The foregoing policy provision may be inserted only in a policy  
 26 which the insured has the right to continue in force subject to its terms  
 27 by the timely payment of premiums:

- 28 (1) until at least fifty (50) years of age; or
- 29 (2) in the case of a policy issued after forty-four (44) years of age,  
 30 for at least five (5) years from its date of issue.

31 The insurer may, at its option, include in this provision a definition of  
 32 "valid loss of time coverage", approved as to form by the  
 33 commissioner, which definition shall be limited in subject matter to  
 34 coverage provided by governmental agencies or by organizations  
 35 subject to regulation by insurance law or by insurance authorities of  
 36 this or any other state of the United States or any province of Canada,  
 37 or to any other coverage the inclusion of which may be approved by the  
 38 commissioner or any combination of such coverages. In the absence of  
 39 such definition the term shall not include any coverage provided for the  
 40 insured pursuant to any compulsory benefit statute (including any  
 41 worker's compensation or employer's liability statute), or benefits  
 42 provided by union welfare plans or by employer or employee benefit



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1 organizations.

2 (7) A provision as follows: UNPAID PREMIUM: Upon the payment  
3 of a claim under this policy, any premium then due and unpaid or  
4 covered by any note or written order may be deducted therefrom.

5 (8) A provision as follows: CONFORMITY WITH STATE  
6 STATUTES: Any provision of this policy which, on its effective date,  
7 is in conflict with the statutes of the state in which the insured resides  
8 on such date is hereby amended to conform to the minimum  
9 requirements of such statutes.

10 (9) A provision as follows: ILLEGAL OCCUPATION: The insurer  
11 shall not be liable for any loss to which a contributing cause was the  
12 insured's commission of or attempt to commit a felony or to which a  
13 contributing cause was the insured's being engaged in an illegal  
14 occupation.

15 (10) A provision as follows: INTOXICANTS AND NARCOTICS:  
16 The insurer shall not be liable for any loss sustained or contracted in  
17 consequence of the insured's being intoxicated or under the influence  
18 of any narcotic unless administered on the advice of a physician.

19 (c) If any provision of this section is in whole or in part inapplicable  
20 to or inconsistent with the coverage provided by a particular form of  
21 policy the insurer, with the approval of the commissioner, shall omit  
22 from such policy any inapplicable provision or part of a provision, and  
23 shall modify any inconsistent provision or part of the provision in such  
24 manner as to make the provision as contained in the policy consistent  
25 with the coverage provided by the policy.

26 (d) The provisions which are the subject of subsections (a) and (b),  
27 or any corresponding provisions which are used in lieu thereof in  
28 accordance with such subsections, shall be printed in the consecutive  
29 order of the provisions in such subsections or, at the option of the  
30 insurer, any such provision may appear as a unit in any part of the  
31 policy, with other provisions to which it may be logically related,  
32 provided the resulting policy shall not be in whole or in part  
33 unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a  
34 person to whom the policy is offered, delivered, or issued.

35 (e) "Insured", as used in this chapter, shall not be construed as  
36 preventing a person other than the insured with a proper insurable  
37 interest from making application for and owning a policy covering the  
38 insured or from being entitled under such a policy to any indemnities,  
39 benefits, and rights provided therein.

40 (f)(1) Any policy of a foreign or alien insurer, when delivered or  
41 issued for delivery to any person in this state, may contain any  
42 provision which is not less favorable to the insured or the beneficiary



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1 than is provided in this chapter and which is prescribed or required by  
2 the law of the state under which the insurer is organized.

3 (f)(2) Any policy of a domestic insurer may, when issued for  
4 delivery in any other state or country, contain any provision permitted  
5 or required by the laws of such other state or country.

6 (g) The commissioner may make reasonable rules under IC 4-22-2  
7 concerning the procedure for the filing or submission of policies  
8 subject to this chapter as are necessary, proper, or advisable to the  
9 administration of this chapter. This provision shall not abridge any  
10 other authority granted the commissioner by law.

11 SECTION 22. IC 27-8-5-19, AS AMENDED BY P.L.185-1996,  
12 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
13 APRIL 1, 1998]: Sec. 19. (a) **As used in this chapter, "late enrollee"**  
14 **has the meaning set forth in 26 U.S.C. 9801(b)(3).**

15 (b) A policy of group accident and sickness insurance may not be  
16 issued to a group that has a legal situs in Indiana unless it contains in  
17 substance:

18 (1) the provisions described in subsection ~~(b)~~ (c); or

19 (2) provisions that, in the opinion of the commissioner, are:

20 (A) more favorable to the persons insured; or

21 (B) at least as favorable to the persons insured and more  
22 favorable to the policyholder;

23 than the provisions set forth in subsection ~~(b)~~ (c).

24 ~~(b)~~ (c) The provisions referred to in subsection ~~(a)~~(1) (b)(1) are as  
25 follows:

26 (1) A provision that the policyholder is entitled to a grace period  
27 of thirty-one (31) days for the payment of any premium due  
28 except the first, during which grace period the policy will  
29 continue in force, unless the policyholder has given the insurer  
30 written notice of discontinuance in advance of the date of  
31 discontinuance and in accordance with the terms of the policy.  
32 The policy may provide that the policyholder is liable to the  
33 insurer for the payment of a pro rata premium for the time the  
34 policy was in force during the grace period. A provision under  
35 this subdivision may provide that the insurer is not obligated to  
36 pay claims incurred during the grace period until the premium  
37 due is received.

38 (2) A provision that the validity of the policy may not be  
39 contested, except for nonpayment of premiums, after the policy  
40 has been in force for two (2) years after its date of issue, and that  
41 no statement made by a person covered under the policy relating  
42 to the person's insurability may be used in contesting the validity

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- 1 of the insurance with respect to which the statement was made,  
 2 unless:
- 3 (A) the insurance has not been in force for a period of two (2)  
 4 years or longer during the person's lifetime; or
- 5 (B) the statement is contained in a written instrument signed  
 6 by the insured person.
- 7 However, a provision under this subdivision may not preclude the  
 8 assertion at any time of defenses based upon a person's  
 9 ineligibility for coverage under the policy or based upon other  
 10 provisions in the policy.
- 11 (3) A provision that a copy of the application, if there is one, of  
 12 the policyholder must be attached to the policy when issued, that  
 13 all statements made by the policyholder or by the persons insured  
 14 are to be deemed representations and not warranties, and that no  
 15 statement made by any person insured may be used in any contest  
 16 unless a copy of the instrument containing the statement is or has  
 17 been furnished to the insured person or, in the event of death or  
 18 incapacity of the insured person, to the insured person's  
 19 beneficiary or personal representative.
- 20 (4) A provision setting forth the conditions, if any, under which  
 21 the insurer reserves the right to require a person eligible for  
 22 insurance to furnish evidence of individual insurability  
 23 satisfactory to the insurer as a condition to part or all of the  
 24 person's coverage.
- 25 (5) A provision specifying any additional exclusions or limitations  
 26 applicable under the policy with respect to a disease or physical  
 27 condition of a person that existed before the effective date of the  
 28 person's coverage under the policy and that is not otherwise  
 29 excluded from the person's coverage by name or specific  
 30 description effective on the date of the person's loss. An exclusion  
 31 or limitation that must be specified in a provision under this  
 32 subdivision:
- 33 (A) may apply only to a disease or physical condition for  
 34 which medical advice, **diagnosis, care, or treatment** was  
 35 received by the person, **or recommended to the person,**  
 36 during the ~~three hundred sixty-five (365) days~~ **six (6) months**  
 37 before the ~~effective~~ **enrollment** date of the person's coverage;  
 38 and
- 39 (B) may not apply to a loss incurred or disability beginning  
 40 after the earlier of:
- 41 (i) the end of a continuous period of ~~three hundred sixty-five~~  
 42 ~~(365) days,~~ **twelve (12) months** beginning on or after the

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- 1 effective **enrollment** date of the person's coverage; ~~during~~  
 2 ~~all of which the person received no medical advice or~~  
 3 ~~treatment in connection with the disease or physical~~  
 4 ~~condition; or~~  
 5 (ii) the end of ~~the two (2) year~~ a **continuous** period of  
 6 **eighteen (18) months** beginning on the **effective**  
 7 **enrollment** date of the person's coverage **if the person is a**  
 8 **late enrollee.**
- 9 (6) If premiums or benefits under the policy vary according to a  
 10 person's age, a provision specifying an equitable adjustment of:  
 11 (A) premiums;  
 12 (B) benefits; or  
 13 (C) both premiums and benefits;  
 14 to be made if the age of a covered person has been misstated. A  
 15 provision under this subdivision must contain a clear statement of  
 16 the method of adjustment to be used.
- 17 (7) A provision that the insurer will issue to the policyholder, for  
 18 delivery to each person insured, a certificate setting forth a  
 19 statement that:  
 20 (A) explains the insurance protection to which the person  
 21 insured is entitled;  
 22 (B) indicates to whom the insurance benefits are payable; and  
 23 (C) explains any family member's or dependent's coverage  
 24 under the policy.
- 25 (8) A provision stating that written notice of a claim must be  
 26 given to the insurer within twenty (20) days after the occurrence  
 27 or commencement of any loss covered by the policy, but that a  
 28 failure to give notice within the twenty (20) day period does not  
 29 invalidate or reduce any claim if it can be shown that it was not  
 30 reasonably possible to give notice within that period and that  
 31 notice was given as soon as was reasonably possible.
- 32 (9) A provision stating that:  
 33 (A) the insurer will furnish to the person making a claim, or to  
 34 the policyholder for delivery to the person making a claim,  
 35 forms usually furnished by the insurer for filing proof of loss;  
 36 and  
 37 (B) if the forms are not furnished within fifteen (15) days after  
 38 the insurer received notice of a claim, the person making the  
 39 claim will be deemed to have complied with the requirements  
 40 of the policy as to proof of loss upon submitting, within the  
 41 time fixed in the policy for filing proof of loss, written proof  
 42 covering the occurrence, character, and extent of the loss for

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which the claim is made.  
(10) A provision stating that:  
(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;  
(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and  
(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.  
(11) A provision that:  
(A) all benefits payable under the policy (other than benefits for loss of time) will be paid within forty-five (45) days after the insurer receives all information required to determine liability under the terms of the policy; and  
(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.  
(12) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars (\$5,000), to any relative by blood or connection by marriage of the person who is deemed

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by the insurer to be equitably entitled to the benefit.  
(13) A provision that the insurer has the right and must be allowed the opportunity to:  
    (A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and  
    (B) conduct an autopsy in case of death if it is not prohibited by law.  
(14) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy, and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.  
(15) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.  
(16) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:  
    (A) incapable of self-sustaining employment because of mental retardation or a physical disability; and  
    (B) chiefly dependent upon the group member for support and maintenance.  
A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or

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1 exclusion from coverage of the child.

2 **(17) A provision that complies with the group portability and**  
 3 **guaranteed renewability provisions of the federal Health**  
 4 **Insurance Portability and Accountability Act of 1996**  
 5 **(P.L.104-191).**

6 ~~(c)~~ **(d)** Subsection ~~(b)(5), (b)(7), (c)(5), (c)(7), and (b)(12)~~ **(c)(12)**  
 7 do not apply to policies insuring the lives of debtors. The standard  
 8 provisions required under section 3(a) of this chapter for individual  
 9 accident and sickness insurance policies do not apply to group accident  
 10 and sickness insurance policies.

11 ~~(d)~~ **(e)** If any policy provision required under subsection ~~(b)~~ **(c)** is in  
 12 whole or in part inapplicable to or inconsistent with the coverage  
 13 provided by an insurer under a particular form of policy, the insurer,  
 14 with the approval of the commissioner, shall delete the provision from  
 15 the policy or modify the provision in such a manner as to make it  
 16 consistent with the coverage provided by the policy.

17 SECTION 23. IC 27-8-10-1, AS AMENDED BY P.L.188-1995,  
 18 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 19 APRIL 1, 1998]: Sec. 1. (a) The definitions in this section apply  
 20 throughout this chapter.

21 (b) "Association" means the Indiana comprehensive health  
 22 insurance association established under section 2.1 of this chapter.

23 (c) "Association policy" means a policy issued by the association  
 24 that provides coverage specified in section 3 of this chapter. The term  
 25 does not include a Medicare supplement policy that is issued under  
 26 section 9 of this chapter.

27 (d) "Carrier" means an insurer providing medical, hospital, or  
 28 surgical expense incurred health insurance policies.

29 **(e) "Church plan" means a plan defined in the federal Employee**  
 30 **Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).**

31 ~~(e)~~ **(f)** "Commissioner" refers to the insurance commissioner.

32 **(g) "Creditable coverage" has the meaning set forth in the**  
 33 **federal Health Insurance Portability and Accountability Act of**  
 34 **1996 (26 U.S.C. 9801(c)(1)).**

35 ~~(f)~~ **(h)** "Eligible expenses" means those charges for health care  
 36 services and articles provided for in section 3 of this chapter.

37 **(i) "Federally eligible individual" means an individual:**

38 **(1) for whom, as of the date on which the individual seeks**  
 39 **coverage under this chapter, the aggregate period of**  
 40 **creditable coverage is at least eighteen (18) months and whose**  
 41 **most recent prior creditable coverage was under a:**

42 **(A) group health plan;**



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- 1           **(B) governmental plan; or**  
 2           **(C) church plan;**  
 3           **or health insurance coverage in connection with any of these**  
 4           **plans;**  
 5           **(2) who is not eligible for coverage under:**  
 6           **(A) a group health plan;**  
 7           **(B) Part A or Part B of Title XVIII of the federal Social**  
 8           **Security Act; or**  
 9           **(C) a state plan under Title XIX of the federal Social**  
 10           **Security Act (or any successor program);**  
 11           **and does not have other health insurance coverage;**  
 12           **(3) with respect to whom the individual's most recent**  
 13           **coverage was not terminated for factors relating to**  
 14           **nonpayment of premiums or fraud;**  
 15           **(4) who, if after being offered the option of continuation**  
 16           **coverage under the Consolidated Omnibus Budget**  
 17           **Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)),**  
 18           **or under a similar state program, elected such coverage; and**  
 19           **(5) who, if after electing continuation coverage described in**  
 20           **subdivision (4), has exhausted continuation coverage under**  
 21           **the provision or program.**  
 22           **(j) "Governmental plan" means a plan as defined under the**  
 23           **federal Employee Retirement Income Security Act of 1974 (26**  
 24           **U.S.C. 414(d)) and any plan established or maintained for its**  
 25           **employees by the United States government or by any agency or**  
 26           **instrumentality of the United States government.**  
 27           **(k) "Group health plan" means an employee welfare benefit**  
 28           **plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan**  
 29           **provides medical care payments to, or on behalf of, employees or**  
 30           **their dependents, as defined under the terms of the plan, directly**  
 31           **or through insurance, reimbursement, or otherwise.**  
 32           **(g) (l) "Health care facility" means any institution providing health**  
 33           **care services that is licensed in this state, including institutions**  
 34           **engaged principally in providing services for health maintenance**  
 35           **organizations or for the diagnosis or treatment of human disease, pain,**  
 36           **injury, deformity, or physical condition, including a general hospital,**  
 37           **special hospital, mental hospital, public health center, diagnostic**  
 38           **center, treatment center, rehabilitation center, extended care facility,**  
 39           **skilled nursing home, nursing home, intermediate care facility,**  
 40           **tuberculosis hospital, chronic disease hospital, maternity hospital,**  
 41           **outpatient clinic, home health care agency, bioanalytical laboratory, or**  
 42           **central services facility servicing one (1) or more such institutions.**



- 1           (†) (m) "Health care institutions" means skilled nursing facilities,  
2 home health agencies, and hospitals.
- 3           (†) (n) "Health care provider" means any physician, hospital,  
4 pharmacist, or other person who is licensed in Indiana to furnish health  
5 care services.
- 6           (†) (o) "Health care services" means any services or products  
7 included in the furnishing to any individual of medical care, dental  
8 care, or hospitalization, or incident to the furnishing of such care or  
9 hospitalization, as well as the furnishing to any person of any other  
10 services or products for the purpose of preventing, alleviating, curing,  
11 or healing human illness or injury.
- 12           (†) (p) "Health insurance" means hospital, surgical, and medical  
13 expense incurred policies, nonprofit service plan contracts, health  
14 maintenance organizations, limited service health maintenance  
15 organizations, and self-insured plans. However, the term "health  
16 insurance" does not include short term travel accident policies,  
17 accident only policies, fixed indemnity policies, automobile medical  
18 payment, or incidental coverage issued with or as a supplement to  
19 liability insurance.
- 20           (†) (q) "Insured" means all individuals who are provided qualified  
21 comprehensive health insurance coverage under an individual policy,  
22 including all dependents and other insured persons, if any.
- 23           (†) (r) "Medicaid" means medical assistance provided by the state  
24 under the Medicaid program under IC 12-15.
- 25           (s) "Medical care payment" means amounts paid for:  
26           (1) the diagnosis, care, mitigation, treatment, or prevention of  
27 disease or amounts paid for the purpose of affecting any  
28 structure or function of the body;  
29           (2) transportation primarily for and essential to Medicare  
30 services referred to in subdivision (1); and  
31           (3) insurance covering medical care referred to in  
32 subdivisions (1) and (2).
- 33           (†) (t) "Medically necessary" means health care services that the  
34 association has determined:  
35           (1) are recommended by a legally qualified physician;  
36           (2) are commonly and customarily recognized throughout the  
37 physician's profession as appropriate in the treatment of the  
38 patient's diagnosed illness; and  
39           (3) are not primarily for the scholastic education or vocational  
40 training of the provider or patient.
- 41           (†) (u) "Medicare" means Title XVIII of the federal Social Security  
42 Act (42 U.S.C. 1395 et seq.).

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- 1       (¶) (v) "Policy" means a contract, policy, or plan of health  
2 insurance.
- 3       (¶) (w) "Policy year" means a twelve (12) month period during  
4 which a policy provides coverage or obligates the carrier to provide  
5 health care services.
- 6       (x) "**Preexisting condition**" means:  
7       (1) **a condition that manifested itself within a period of six (6)**  
8       **months before the effective date of coverage in such a manner**  
9       **as would cause an ordinarily prudent person to seek**  
10       **diagnosis, care, or treatment; or**  
11       (2) **medical advice or treatment was recommended or received**  
12       **within a period of six (6) months before the effective date of**  
13       **coverage.**
- 14       (¶) (y) "Health maintenance organization" has the meaning set out  
15 in IC 27-13-1-19.
- 16       (¶) (z) "Self-insurer" means an employer who provides services,  
17 payment for, or reimbursement of any part of the cost of health care  
18 services other than payment of insurance premiums or subscriber  
19 charges to a carrier. However, the term "self-insurer" does not include  
20 an employer who is exempt from state insurance regulation by federal  
21 law, or an employer who is a political subdivision of the state of  
22 Indiana.
- 23       (¶) (aa) "Services of a skilled nursing facility" means services that  
24 must commence within fourteen (14) days following a confinement of  
25 at least three (3) consecutive days in a hospital for the same condition.
- 26       (¶) (bb) "Skilled nursing facility", "home health agency", "hospital",  
27 and "home health services" have the meanings assigned to them in 42  
28 U.S.C. 1395x.
- 29       (¶) (cc) "Medicare supplement policy" means an individual policy  
30 of accident and sickness insurance that is designed primarily as a  
31 supplement to reimbursements under Medicare for the hospital,  
32 medical, and surgical expenses of individuals who are eligible for  
33 Medicare benefits.
- 34       (¶) (dd) "Limited service health maintenance organization" has the  
35 meaning set forth in IC 27-13-34-4.
- 36       SECTION 24. IC 27-8-10-2.1, AS AMENDED BY P.L.255-1995,  
37 SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
38 SEPTEMBER 1, 1998]: Sec. 2.1. (a) There is established a nonprofit  
39 legal entity to be referred to as the Indiana comprehensive health  
40 insurance association, which must assure that health insurance is made  
41 available throughout the year to each eligible Indiana resident applying  
42 to the association for coverage. All carriers, health maintenance

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1 organizations, limited service health maintenance organizations, and  
 2 self-insurers providing health insurance or health care services in  
 3 Indiana must be members of the association. The association shall  
 4 operate under a plan of operation established and approved under  
 5 subsection (c) and shall exercise its powers through a board of directors  
 6 established under this section.

7 (b) The board of directors of the association consists of ~~five (5) to~~  
 8 ~~nine (9)~~ **seven (7) members whose principal residence is in Indiana**  
 9 ~~selected by the members of the association, subject to approval by the~~  
 10 ~~commissioner. as follows:~~

11 **(1) Three (3) members to be appointed by the commissioner**  
 12 **from the members of the association, one (1) of which must be**  
 13 **a representative of a health maintenance organization.**

14 **(2) Two (2) members to be appointed by the commissioner**  
 15 **shall be consumers representing policyholders.**

16 **(3) Two (2) members shall be the state budget director or**  
 17 **designee and the commissioner of the department of insurance**  
 18 **or designee.**

19 **The commissioner shall appoint the chairman of the board, and the**  
 20 **board shall elect a secretary from its membership. To select the**  
 21 **initial board of directors and to initially organize the association, the**  
 22 **commissioner shall give notice to all members in Indiana of the time**  
 23 **and place of the organizational meeting. In determining voting rights**  
 24 **at the organizational meeting, each member is entitled to one (1) vote**  
 25 **in person or by proxy. If the board of directors is not selected within**  
 26 **sixty (60) days after the organizational meeting, the commissioner shall**  
 27 **appoint the initial board. In approving or selecting members of the**  
 28 **board, the commissioner shall consider whether all members are fairly**  
 29 **represented. The term of office of each appointed member is three**  
 30 **(3) years, subject to eligibility for reappointment. Members of the**  
 31 **board who are not state employees may be reimbursed from the**  
 32 **money of the association association's funds for expenses incurred by**  
 33 **them as members but shall not be otherwise compensated by the**  
 34 **association for their services. in attending meetings. The board shall**  
 35 **meet at least semiannually, with the first meeting to be held not**  
 36 **later than May 15 of each year.**

37 (c) The association shall submit to the commissioner a plan of  
 38 operation for the association and any amendments to the plan necessary  
 39 or suitable to assure the fair, reasonable, and equitable administration  
 40 of the association. The plan of operation becomes effective upon  
 41 approval in writing by the commissioner consistent with the date on  
 42 which the coverage under this chapter must be made available. The



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1 commissioner shall, after notice and hearing, approve the plan of  
 2 operation if the plan is determined to be suitable to assure the fair,  
 3 reasonable, and equitable administration of the association and  
 4 provides for the sharing of association losses on an equitable,  
 5 proportionate basis among the member carriers, health maintenance  
 6 organizations, limited service health maintenance organizations, and  
 7 self-insurers. If the association fails to submit a suitable plan of  
 8 operation within one hundred eighty (180) days after the appointment  
 9 of the board of directors, or at any time thereafter the association fails  
 10 to submit suitable amendments to the plan, the commissioner shall  
 11 adopt rules under IC 4-22-2 necessary or advisable to implement this  
 12 section. These rules are effective until modified by the commissioner  
 13 or superseded by a plan submitted by the association and approved by  
 14 the commissioner. The plan of operation must:

- 15 (1) establish procedures for the handling and accounting of assets  
 16 and money of the association;
- 17 (2) establish the amount and method of reimbursing members of  
 18 the board;
- 19 (3) establish regular times and places for meetings of the board of  
 20 directors;
- 21 (4) establish procedures for records to be kept of all financial  
 22 transactions, and for the annual fiscal reporting to the  
 23 commissioner;
- 24 (5) establish procedures whereby selections for the board of  
 25 directors will be made and submitted to the commissioner for  
 26 approval;
- 27 (6) contain additional provisions necessary or proper for the  
 28 execution of the powers and duties of the association; and
- 29 (7) establish procedures for the periodic advertising of the general  
 30 availability of the health insurance coverages from the  
 31 association.

32 (d) The plan of operation may provide that any of the powers and  
 33 duties of the association be delegated to a person who will perform  
 34 functions similar to those of this association. A delegation under this  
 35 section takes effect only with the approval of both the board of  
 36 directors and the commissioner. The commissioner may not approve a  
 37 delegation unless the protections afforded to the insured are  
 38 substantially equivalent to or greater than those provided under this  
 39 chapter.

40 (e) The association has the general powers and authority enumerated  
 41 by this subsection in accordance with the plan of operation approved  
 42 by the commissioner under subsection (c). The association has the

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- 1 general powers and authority granted under the laws of Indiana to
- 2 carriers licensed to transact the kinds of health care services or health
- 3 insurance described in section 1 of this chapter and also has the
- 4 specific authority to do the following:
- 5 (1) Enter into contracts as are necessary or proper to carry out this
- 6 chapter, **subject to the approval of the commissioner.**
- 7 (2) Sue or be sued, including taking any legal actions necessary
- 8 or proper for recovery of any assessments for, on behalf of, or
- 9 against participating carriers.
- 10 (3) Take legal action necessary to avoid the payment of improper
- 11 claims against the association or the coverage provided by or
- 12 through the association.
- 13 (4) Establish a medical review committee to determine the
- 14 reasonably appropriate level and extent of health care services in
- 15 each instance.
- 16 (5) Establish appropriate rates, scales of rates, rate classifications
- 17 and rating adjustments, such rates not to be unreasonable in
- 18 relation to the coverage provided and the reasonable operational
- 19 expenses of the association.
- 20 (6) Pool risks among members.
- 21 (7) Issue policies of insurance on an indemnity or provision of
- 22 service basis providing the coverage required by this chapter.
- 23 (8) Administer separate pools, separate accounts, or other plans
- 24 or arrangements considered appropriate for separate members or
- 25 groups of members.
- 26 (9) Operate and administer any combination of plans, pools, or
- 27 other mechanisms considered appropriate to best accomplish the
- 28 fair and equitable operation of the association.
- 29 (10) Appoint from among members appropriate legal, actuarial,
- 30 and other committees as necessary to provide technical assistance
- 31 in the operation of the association, policy and other contract
- 32 design, and any other function within the authority of the
- 33 association.
- 34 (11) Hire an independent consultant.
- 35 (12) Develop a method of advising applicants of the availability
- 36 of other coverages outside the association and may promulgate a
- 37 list of health conditions the existence of which would deem an
- 38 applicant eligible without demonstrating a rejection of coverage
- 39 by one (1) carrier.
- 40 (13) Provide for the use of managed care plans for insureds,
- 41 including the use of:
- 42 (A) health maintenance organizations; and

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(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. **Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by**

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1 **the commissioner.**

2 (h) The association shall conduct periodic audits to assure the  
3 general accuracy of the financial data submitted to the association, and  
4 the association shall have an annual audit of its operations by an  
5 independent certified public accountant.

6 (i) The association is subject to examination by the department of  
7 insurance under IC 27-1-3.1. The board of directors shall submit, not  
8 later than March 30 of each year, a financial report for the preceding  
9 calendar year in a form approved by the commissioner.

10 (j) All policy forms issued by the association must conform in  
11 substance to prototype forms developed by the association, must in all  
12 other respects conform to the requirements of this chapter, and must be  
13 filed with and approved by the commissioner before their use.

14 (k) The association may not issue an association policy to any  
15 individual who, on the effective date of the coverage applied for, does  
16 not meet the eligibility requirements of section 5.1 of this chapter.

17 (l) The association shall pay an agent's referral fee of twenty-five  
18 dollars (\$25) to each insurance agent who refers an applicant to the  
19 association if that applicant is accepted.

20 (m) The association and the premium collected by the association  
21 shall be exempt from the premium tax, the gross income tax, the  
22 adjusted gross income tax, supplemental corporate net income, or any  
23 combination of these, or similar taxes upon revenues or income that  
24 may be imposed by the state.

25 (n) Members who after July 1, 1983, during any calendar year, have  
26 paid one (1) or more assessments levied under this chapter may either:

27 (1) take a credit against premium taxes, gross income taxes,  
28 adjusted gross income taxes, supplemental corporate net income  
29 taxes, or any combination of these, or similar taxes upon revenues  
30 or income of member insurers that may be imposed by the state,  
31 up to the amount of the taxes due for each calendar year in which  
32 the assessments were paid and for succeeding years until the  
33 aggregate of those assessments have been offset by either credits  
34 against those taxes or refunds from the association; or

35 (2) any member insurer may include in the rates for premiums  
36 charged for insurance policies to which this chapter applies  
37 amounts sufficient to recoup a sum equal to the amounts paid to  
38 the association by the member less any amounts returned to the  
39 member insurer by the association, and the rates shall not be  
40 deemed excessive by virtue of including an amount reasonably  
41 calculated to recoup assessments paid by the member.

42 (o) The association shall provide for the option of monthly



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1 collection of premiums.

2 SECTION 25. IC 27-8-10-5.1, AS AMENDED BY P.L.2-1995,  
3 SECTION 109, IS AMENDED TO READ AS FOLLOWS  
4 [EFFECTIVE APRIL 1, 1998]: Sec. 5.1. (a) Except as provided in  
5 subsections (b) and (c), a person is not eligible for an association policy  
6 ~~who, if,~~ at the effective date of coverage, **the person** has or is eligible  
7 for coverage under any insurance plan that equals or exceeds the  
8 minimum requirements for accident and sickness insurance policies  
9 issued in Indiana as set forth in IC 27. Coverage under any association  
10 policy is in excess of, and may not duplicate, coverage under any other  
11 form of health insurance.

12 (b) Except as provided in IC 27-13-16-4, a person is eligible for an  
13 association policy upon a showing that:

14 **(1) the person has been rejected by one (1) carrier for coverage**  
15 **under any insurance plan that equals or exceeds the minimum**  
16 **requirements for accident and sickness insurance policies issued**  
17 **in Indiana, as set forth in IC 27, without material underwriting**  
18 **restriction at a rate equal to or less than the association plan rate-**  
19 **restrictions;**

20 **(2) an insurer has refused to issue insurance except at a rate**  
21 **exceeding the association plan rate; or**

22 **(3) the person is a federally eligible individual.**

23 For the purposes of this subsection, eligibility for Medicare coverage  
24 does not disqualify a person who is less than sixty-five (65) years of  
25 age from eligibility for an association policy.

26 (c) The board of directors may establish procedures that would  
27 permit ~~(†)~~ an association policy to be issued to persons who are  
28 covered by a group insurance arrangement when that person or a  
29 dependent's health condition is such that the group's coverage is in  
30 jeopardy of termination or material rate increases because of that  
31 person's or dependent's medical claims experience ~~and~~.

32 ~~(2) an association policy to be issued without any limitation on~~  
33 ~~preexisting conditions to a person who is covered by a health~~  
34 ~~insurance arrangement when that person's coverage is scheduled~~  
35 ~~to terminate for any reason beyond the person's control.~~

36 (d) An association policy must provide that coverage of a dependent  
37 unmarried child terminates when the child becomes nineteen (19) years  
38 of age (or twenty-five (25) years of age if the child is enrolled full-time  
39 in an accredited educational institution). The policy must also provide  
40 in substance that attainment of the limiting age does not operate to  
41 terminate a dependent unmarried child's coverage while the dependent  
42 is and continues to be both:



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- 1 (1) incapable of self-sustaining employment by reason of mental  
 2 retardation or physical disability; and  
 3 (2) chiefly dependent upon the person in whose name the contract  
 4 is issued for support and maintenance.

5 However, proof of such incapacity and dependency must be furnished  
 6 to the carrier within one hundred twenty (120) days of the child's  
 7 attainment of the limiting age, and subsequently as may be required by  
 8 the carrier, but not more frequently than annually after the two (2) year  
 9 period following the child's attainment of the limiting age.

10 (e) An association policy that provides coverage for a family  
 11 member of the person in whose name the contract is issued must, as to  
 12 the family member's coverage, also provide that the health insurance  
 13 benefits applicable for children are payable with respect to a newly  
 14 born child of the person in whose name the contract is issued from the  
 15 moment of birth. The coverage for newly born children must consist of  
 16 coverage of injury or illness, including the necessary care and treatment  
 17 of medically diagnosed congenital defects and birth abnormalities. If  
 18 payment of a specific premium is required to provide coverage for the  
 19 child, the contract may require that notification of the birth of a child  
 20 and payment of the required premium must be furnished to the carrier  
 21 within thirty-one (31) days after the date of birth in order to have the  
 22 coverage continued beyond the thirty-one (31) day period.

23 (f) Except as provided in subsection (g); an association policy may  
 24 contain provisions under which coverage is excluded during a period  
 25 of six (6) months following the effective date of coverage as to a given  
 26 covered individual for preexisting conditions; as long as:

- 27 (1) the condition manifested itself within a period of six (6)  
 28 months before the effective date of coverage in such a manner as  
 29 would cause an ordinarily prudent person to seek diagnosis; care;  
 30 or treatment; or  
 31 (2) medical advice or treatment was recommended or received  
 32 within a period of six (6) months before the effective date of  
 33 coverage.

34 This subsection may not be construed to prohibit preexisting condition  
 35 provisions in an insurance policy that are more favorable to the insured:

36 (g) (f) If a person applies for an association policy within six (6)  
 37 months after termination of the person's coverage under a health  
 38 insurance arrangement and the person meets the eligibility  
 39 requirements of subsection (b), then an association policy may not  
 40 contain provisions under which:

- 41 (1) coverage as to a given individual is delayed to a date after the  
 42 effective date or excluded from the policy; or

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1 (2) coverage as to a given condition is denied;  
 2 on the basis of a preexisting health condition. This subsection may not  
 3 be construed to prohibit preexisting condition provisions in an  
 4 insurance policy that are more favorable to the insured.

5 **(g) Subsection (f) does not apply to a person, other than a**  
 6 **federally eligible individual, who had previous coverage under an**  
 7 **association policy and terminated the coverage or allowed the**  
 8 **coverage to terminate for a period exceeding ninety (90) days.**

9 **(h) Coverage for a preexisting condition of a person described**  
 10 **in subsection (g) may not be delayed or restricted to a date later**  
 11 **than six (6) months after the effective date. However, the six (6)**  
 12 **months must be reduced by one (1) month for each thirty (30) day**  
 13 **period of continuous coverage under a health insurance plan, as**  
 14 **defined in IC 27-8-15-28(a), that the person had during the twelve**  
 15 **(12) months immediately preceding enrollment.**

16 ~~(h)~~ (i) For purposes of this section, coverage under a health  
 17 insurance arrangement includes, but is not limited to, coverage  
 18 pursuant to the Consolidated Omnibus Budget Reconciliation Act of  
 19 1985.

20 SECTION 26. IC 27-8-14-6 IS AMENDED TO READ AS  
 21 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. (a) An insurer must  
 22 offer to provide coverage for breast cancer screening mammography in  
 23 any accident and sickness insurance policy that the insurer issues in  
 24 Indiana.

25 (b) The coverage that an insurer must offer to provide under this  
 26 section must include the following:

27 (1) If the insured is at least thirty-five (35) but less than forty (40)  
 28 years of age, coverage for at least one (1) baseline breast cancer  
 29 screening mammography performed upon the insured before she  
 30 becomes forty (40) years of age.

31 (2) If the insured is:

32 (A) at least forty (40) but less than fifty (50) years of age; and

33 (B) not a woman at risk;

34 coverage for one (1) breast cancer screening mammography  
 35 performed upon the insured in every two (2) year period:

36 (3) If the insured is:

37 (A) at least forty (40) but less than fifty (50) years of age; and

38 (B) a woman at risk;

39 one (1) breast cancer screening mammography performed upon  
 40 the insured every year:

41 ~~(4)~~ If the insured is at least ~~fifty (50)~~ **forty (40)** years of age,  
 42 ~~whether or not at risk~~; one (1) breast cancer screening

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1 mammography performed upon the insured every year.

2 **(3) Any additional views that are required for proper**  
3 **evaluation.**

4 **(4) Ultrasound services, if determined medically necessary by**  
5 **the physician treating the insured.**

6 (c) The coverage that an insurer must offer to provide under this  
7 section must provide reimbursement for breast cancer screening  
8 mammography at a level at least as high as:

9 (1) the limitation on payment for screening mammography  
10 services established in 42 CFR 405.534(b)(3) according to the  
11 Medicare Economic Index at the time the breast cancer screening  
12 mammography is performed; or

13 (2) the rate negotiated by a contract provider according to the  
14 provisions of the insurance policy;

15 whichever is lower.

16 (d) The coverage that an insurer must offer to provide under this  
17 section may not be subject to dollar limits, deductibles, or coinsurance  
18 provisions that are less favorable to the insured than the dollar limits,  
19 deductibles, or coinsurance provisions applying to physical illness  
20 generally under the accident and sickness insurance policy.

21 (e) The coverage that an insurer must offer is in addition to any  
22 benefits specifically provided for x-rays, laboratory testing, or wellness  
23 examinations.

24 SECTION 27. IC 27-8-15-10.5, AS AMENDED BY P.L. 190-1996,  
25 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
26 APRIL 1, 1998]: Sec. 10.5. (a) As used in this chapter, "late enrollee"  
27 means an eligible employee or a dependent of an eligible employee  
28 who did not request enrollment in a health insurance plan of a small  
29 employer during the initial enrollment period during which the  
30 individual was entitled to enroll under the health insurance plan.

31 (b) The term "**late enrollee**" does not include an eligible employee  
32 **or the dependent of an eligible employee: who meets any of the**  
33 **following conditions:**

34 (1) ~~The eligible employee~~ (A) **who** was covered under a health  
35 insurance plan at the time of the initial enrollment;

36 ~~(B) lost coverage under a health insurance plan as a result of:~~

37 ~~(i) the termination of employment or eligibility;~~

38 ~~(ii) the involuntary termination of the health insurance plan;~~

39 ~~(iii) the death of a spouse; or~~

40 ~~(iv) the dissolution of marriage; and~~

41 ~~(C) requests enrollment not later than thirty (30) days after~~  
42 ~~losing coverage under a health insurance plan.~~



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1 or had health insurance coverage at the time coverage was  
 2 previously offered to the employee or to the dependent of the  
 3 employee;

4 (2) who stated in writing at the time coverage was offered that  
 5 coverage under another health insurance plan was the reason  
 6 for declining the enrollment, but only if the insurer required  
 7 such a statement at the time and provided the employee with  
 8 notice of the requirement (and the consequences of the  
 9 requirement) at the time;

10 (3) whose coverage under this subsection:

11 (A) was under a COBRA continuation provision and the  
 12 coverage under the provision was exhausted; or

13 (B) was not under a COBRA continuation provision and  
 14 either the coverage was terminated as a result of loss of  
 15 eligibility for the coverage (including as a result of legal  
 16 separation, divorce, death, termination of employment, or  
 17 reduction in the number of hours of employment) or  
 18 employer contributions toward the coverage were  
 19 terminated; and

20 (4) who requests enrollment under the terms of the plan not  
 21 later than thirty (30) days after the date of exhaustion of  
 22 coverage as described in subdivision (3)(A) or the termination  
 23 of coverage or employer contributions as described in  
 24 subdivision (3)(B).

25 (⇒) (c) The term "late enrollee" does not include an eligible  
 26 employee who is employed by a small employer that offers multiple  
 27 health insurance plans and the eligible employee who elects a different  
 28 plan during an open enrollment period.

29 (⇒) (d) The term "late enrollee" does not include an eligible  
 30 employee or the eligible employee's spouse or minor or dependent  
 31 child where:

32 (1) a court has ordered that health insurance coverage be provided  
 33 for a the spouse or a minor or dependent child of an eligible  
 34 employee under the eligible employee's insurance plan; and

35 (2) the request for enrollment is made not more than thirty (30)  
 36 days after the issuance of the court order.

37 SECTION 28. IC 27-8-15-14, AS AMENDED BY P.L.190-1996,  
 38 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 39 APRIL 1, 1998]: Sec. 14. As used in this chapter, "small employer"  
 40 means any person, firm, corporation, limited liability company,  
 41 partnership, or association actively engaged in business who, on at least  
 42 fifty percent (50%) of the working days of the employer during the



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1 preceding calendar year, employed at least ~~three (3)~~ **two (2)** but not  
 2 more than fifty (50) eligible employees, the majority of whom work in  
 3 Indiana. In determining the number of eligible employees, companies  
 4 that are affiliated companies or that are eligible to file a combined tax  
 5 return for purposes of state taxation are considered one (1) employer.

6 SECTION 29. IC 27-8-15-19, AS AMENDED BY P.L.93-1995,  
 7 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 8 APRIL 1, 1998]: Sec. 19. Except as provided in section 20 of this  
 9 chapter, a small employer insurer may only cancel or refuse to renew  
 10 a health insurance plan for the following reasons:

11 (1) Nonpayment of required premiums.

12 (2) Fraud or misrepresentation of the small employer, or with  
 13 respect to coverage of an insured individual, fraud or  
 14 misrepresentation by the insured individual or the individual's  
 15 representative.

16 ~~(3) Noncompliance with the plan's provisions.~~

17 ~~(4) The number of individuals covered under the plan is less than  
 18 the number of percentage of eligible individuals required by  
 19 percentage requirements under the plan.~~

20 ~~(5) The small employer is no longer actively engaged in the  
 21 business in which the small employer was engaged on the  
 22 effective date of the plan.~~

23 **(3) The small employer has failed to comply with a material  
 24 plan provision relating to employer contribution or group  
 25 participation rules.**

26 **(4) In the case of a small employer insurer that offers  
 27 coverage in a market through a network plan, there is no  
 28 longer any insured individual in connection with the plan who  
 29 lives, resides, or works:**

30 **(A) in the service area of the small employer insurer; or**

31 **(B) in the area for which the issuer is authorized to do  
 32 business.**

33 **(5) In the case of coverage that is made available through one  
 34 (1) or more bona fide associations, the membership of the  
 35 small employer in the association ceases, but only if the  
 36 coverage is terminated under this subdivision uniformly  
 37 without regard to any health status related factor relating to  
 38 an insured individual.**

39 **(6) In a case in which an insurer decides to discontinue  
 40 offering a particular type of group health insurance coverage  
 41 offered in the small employer market, that coverage may be  
 42 discontinued by the insurer only if:**



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- 1 (A) the insurer provides notice of the insurer's intent to
- 2 discontinue the coverage to each small employer provided
- 3 with the coverage;
- 4 (B) the insurer offers the option to purchase all other
- 5 health insurance coverage currently being offered by the
- 6 insurer to the small employer to each small employer that
- 7 is provided with the coverage; and
- 8 (C) in exercising the option to discontinue the coverage in
- 9 offering the option of coverage under clause (B), the
- 10 insurer acts uniformly without regard to:
- 11 (i) the claims experience of the small employer groups;
- 12 or
- 13 (ii) any health status related factor relating to any
- 14 eligible employee or dependent of an eligible employee
- 15 who is covered or who may become eligible for the
- 16 coverage.

17 SECTION 30. IC 27-8-15-27, AS ADDED BY P.L.93-1995,  
 18 SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 19 APRIL 1, 1998]: Sec. 27. A health insurance plan provided by a small  
 20 employer insurer to a small employer must comply with the following:

- 21 (1) The benefits provided by a plan to an eligible employee
- 22 enrolled in the plan may not be excluded, limited, or denied for
- 23 more than nine (9) months after the effective date of the coverage
- 24 because of a preexisting condition of the eligible employee, the
- 25 eligible employee's spouse, or the eligible employee's dependent.
- 26 (2) The plan may not define a preexisting condition, rider, or
- 27 endorsement more restrictively than as ~~(A) a condition that would~~
- 28 ~~have caused an ordinarily prudent person to seek medical advice;~~
- 29 ~~diagnosis, care, or treatment during the nine (9) months~~
- 30 ~~immediately preceding the effective date of enrollment in the~~
- 31 ~~plan;~~ (B) a condition for which medical advice, diagnosis, care,
- 32 or treatment was recommended or received during the ~~nine (9)~~ six
- 33 (6) months immediately preceding the effective date of
- 34 enrollment in the plan. ~~or~~
- 35 ~~(C) a pregnancy existing on the effective date of enrollment in~~
- 36 ~~the plan.~~

37 SECTION 31. IC 27-8-15-28, AS AMENDED BY P.L.190-1996,  
 38 SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 39 APRIL 1, 1998]: Sec. 28. (a) As used in this section, "health insurance  
 40 plan" means coverage provided under any of the following:

- 41 (1) A hospital or medical expense incurred policy or certificate.
- 42 (2) A hospital or medical service plan contract.



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- 1 (3) A health maintenance organization subscriber contract.  
 2 (4) Medicare or Medicaid.  
 3 (5) An employer based health insurance arrangement.  
 4 (6) An individual health insurance policy.  
 5 (7) A policy issued by the Indiana comprehensive health  
 6 insurance association under IC 27-8-10.  
 7 (8) An employee welfare benefit plan (as defined in 29 U.S.C.  
 8 1002) that is self-funded.  
 9 (9) A conversion policy issued under section 31 or 31.1 of this  
 10 chapter.

11 (b) Except as provided in section 29 of this chapter, a small  
 12 employer insurer shall waive the exclusion period described in section  
 13 27 of this chapter applicable to a preexisting condition or the limitation  
 14 period with respect to a particular service in a health insurance plan for  
 15 the time an eligible employee or a dependent of an eligible employee  
 16 was previously covered by a health insurance plan if the following  
 17 conditions are met:

- 18 (1) The eligible employee or a dependent of the eligible employee  
 19 was previously covered by a health insurance plan that provided  
 20 benefits with respect to the particular service.  
 21 (2) Coverage under the health insurance plan was continuous to  
 22 a date not more than ~~thirty (30)~~ **sixty-three (63)** days before the  
 23 effective date of enrollment by:  
 24 (A) the eligible employee; or  
 25 (B) a dependent of the eligible employee.

26 (c) In determining whether an eligible employee or a dependent of  
 27 the eligible employee meets the requirements of subsection (b)(2), a  
 28 waiting period imposed by a small employer insurer or small employer  
 29 before new coverage may become effective must be excluded from the  
 30 calculation.

31 (d) This section does not preclude the application of any waiting  
 32 period applicable to all new enrollees under a plan.

33 SECTION 32. IC 27-8-15-31, AS ADDED BY P.L.93-1995,  
 34 SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 35 JULY 1, 1998]: Sec. 31. (a) If an eligible employee **or a dependent of**  
 36 **an eligible employee** who has been continuously covered under a  
 37 health insurance plan for at least ninety (90) days:

- 38 (1) loses coverage under the plan as the result of:  
 39 (A) termination of **the eligible employee's** employment;  
 40 (B) reduction of **the eligible employee's** hours;  
 41 (C) ~~marriage~~ **dissolution of the eligible employee's marriage;**  
 42 or



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1 (D) attainment of any age specified in the plan; and  
 2 (2) requests a conversion policy from the small employer insurer  
 3 that insured the health insurance plan;  
 4 the individual is entitled to receive a conversion policy from the small  
 5 employer insurer.

6 (b) A request under subsection (a)(2) must be made within thirty  
 7 (30) days after the individual loses coverage under the health insurance  
 8 plan.

9 (c) The premium for a conversion policy issued under this section  
 10 shall not exceed one hundred fifty percent (150%) of the rate that  
 11 would have been charged under the small employer health insurance  
 12 plan with respect to the individual if the individual had been covered  
 13 as an eligible employee **or a dependent of an eligible employee** under  
 14 the plan during the same period. If the health insurance plan under  
 15 which the individual was covered is canceled or is not renewed, the  
 16 rates shall be based on the rate that would have been charged with  
 17 respect to the individual if the plan had continued in force, as  
 18 determined by the small employer insurer in accordance with standard  
 19 actuarial principles.

20 (d) A conversion policy issued under this section must be approved  
 21 by the insurance commissioner as described in IC 27-8-5-1. The  
 22 commissioner may not approve a conversion policy unless the policy  
 23 and its benefits are:

- 24 (1) comparable to those required under IC 27-13-1-4(a)(2)  
 25 through IC 27-13-1-4(a)(5);  
 26 (2) reasonable in relation to the premium charged; and  
 27 (3) in compliance with IC 27-8-6-1.

28 If the benefit limits of the conversion policy are not more than the  
 29 benefit limits of the small employer's health insurance plan, the small  
 30 employer insurer shall credit the individual with any waiting period,  
 31 deductible, or coinsurance credited to the individual under the small  
 32 employer's health insurance plan.

33 (e) This section expires on the effective date of a mechanism  
 34 enacted by the general assembly to offset the potential fiscal impact on  
 35 small employers and small employer insurers that results from the  
 36 establishment of a continuation policy under section 31.1 of this  
 37 chapter.

38 SECTION 33. IC 27-8-15-34.1 IS ADDED TO THE INDIANA  
 39 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 40 [EFFECTIVE APRIL 1, 1998]: **Sec. 34.1. Except as provided in 29**  
 41 **U.S.C. 1191a and 42 U.S.C. 300gg, a small employer insurer must:**

- 42 (1) offer to any small employer all products that are approved



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1           **for sale in the small group market and that the insurer is**  
 2           **actively marketing; and**

3           **(2) accept any employer that applies for any of those products.**

4           SECTION 34. IC 27-8-23-4, AS ADDED BY P.L.133-1995,  
 5           SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 6           JULY 1, 1998]: Sec. 4. As used in this chapter, "insurer" has the  
 7           meaning set forth in IC 12-7-2-120. **The term includes a limited**  
 8           **service health maintenance organization (as defined in**  
 9           **IC 27-13-34-4).**

10          SECTION 35. IC 27-12-3-5 IS AMENDED TO READ AS  
 11          FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 5. **(a) Except as**  
 12          **provided in subsection (b),** the receipt of proof of financial  
 13          responsibility and the surcharge constitutes compliance with section 2  
 14          of this chapter:

15               (1) as of the date on which they are received; or

16               (2) as of the effective date of the policy;

17          if this proof is filed with and the surcharge paid to the department of  
 18          insurance not later than ninety (90) days after the effective date of the  
 19          insurance policy. ~~If proof of financial responsibility and the payment~~  
 20          ~~of the surcharge is not made within ninety (90) days after the policy~~  
 21          ~~effective date, compliance occurs on the date when proof is filed and~~  
 22          ~~the surcharge is paid.~~

23          **(b) If an insurer files proof of financial responsibility and makes**  
 24          **payment of the surcharge to the department of insurance at least**  
 25          **ninety-one (91) days but not more than one hundred eighty (180)**  
 26          **days after the policy effective date, the health care provider is in**  
 27          **compliance with section 2 of this chapter, if the insurer**  
 28          **demonstrates to the satisfaction of the commissioner that the**  
 29          **insurer:**

30               (1) received the premium and surcharge in a timely manner;  
 31               and

32               (2) failed to transmit the surcharge in a timely manner.

33          **(c) If the commissioner accepts a filing as timely under**  
 34          **subsection (b), the filing must be accompanied by a penalty amount**  
 35          **as follows:**

36               (1) Ten percent (10%) of the surcharge, if the proof of  
 37               financial responsibility and surcharge are received by the  
 38               commissioner at least ninety-one (91) days and not more than  
 39               one hundred twenty (120) days after the original effective date  
 40               of the policy.

41               (2) Twenty percent (20%) of the surcharge, if the proof of  
 42               financial responsibility and surcharge are received by the



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1 commissioner at least one hundred twenty-one (121) days and  
 2 not more than one hundred fifty (150) days after the original  
 3 effective date of the policy.

4 **(3) Fifty percent (50%) of the surcharge, if the proof of**  
 5 **financial responsibility and surcharge are received by the**  
 6 **commissioner at least one hundred fifty-one (151) days and**  
 7 **not more than one hundred eighty (180) days after the**  
 8 **original effective date of the policy.**

9 SECTION 36. IC 27-13-7-3, AS ADDED BY P.L.26-1994,  
 10 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 11 JULY 1, 1998]: Sec. 3. (a) A contract referred to in section 1 of this  
 12 chapter must clearly state the following:

- 13 (1) The name and address of the health maintenance organization.  
 14 (2) Eligibility requirements.  
 15 (3) Benefits and services within the service area.  
 16 (4) Emergency care benefits and services.  
 17 (5) Any out-of-area benefits and services.  
 18 (6) Copayments, deductibles, and other out-of-pocket costs.  
 19 (7) Limitations and exclusions.  
 20 (8) Enrollee termination provisions.  
 21 (9) Any enrollee reinstatement provisions.  
 22 (10) Claims procedures.  
 23 (11) Enrollee grievance procedures.  
 24 (12) Continuation of coverage provisions.  
 25 (13) Conversion provisions.  
 26 (14) Extension of benefit provisions.  
 27 (15) Coordination of benefit provisions.  
 28 (16) Any subrogation provisions.  
 29 (17) A description of the service area.  
 30 (18) The entire contract provisions.  
 31 (19) The term of the coverage provided by the contract.  
 32 (20) Any right of cancellation of the group or individual contract  
 33 holder.  
 34 (21) Right of renewal provisions.  
 35 (22) Provisions regarding reinstatement of a group or an  
 36 individual contract holder.  
 37 (23) Grace period provisions.  
 38 (24) A provision on conformity with state law.  
 39 **(25) A provision or provisions that comply with the:**  
 40 **(A) guaranteed renewability; and**  
 41 **(B) group portability;**  
 42 **requirements of the federal Health Insurance Portability and**

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1           **Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).**

2           (b) For purposes of subsection (a), an evidence of coverage which  
3 is filed with a contract may be considered part of the contract.

4           SECTION 37. IC 27-13-7-15 IS ADDED TO THE INDIANA  
5 CODE AS A NEW SECTION TO READ AS FOLLOWS  
6 [EFFECTIVE JULY 1, 1998]: **Sec. 15. (a) A contract under this**  
7 **chapter that provides coverage for an individual enrollee or**  
8 **subscriber or a family member of an enrollee or subscriber must**  
9 **also provide that the coverage applicable to the individual enrollee**  
10 **or subscriber or a family member of the enrollee or subscriber is**  
11 **applicable, from the moment of birth, to a newly born child of the**  
12 **enrollee or subscriber.**

13           (b) The coverage for a newly born child required by subsection  
14 (a) must include the following:

15           (1) Coverage for injury or sickness, including the necessary  
16 care and treatment of medically diagnosed congenital defects  
17 and birth abnormalities.

18           (2) Coverage for inpatient or outpatient services for medical  
19 and dental treatment (including orthodontic and oral surgery  
20 treatment) involved in the management of the birth defects  
21 known as cleft lip and cleft palate.

22           (c) If payment of a specific premium or contract fee is required  
23 to provide coverage for a newly born child, the contract may  
24 require that:

25           (1) notification of birth of a newly born child; and

26           (2) payment of the required premium or fees;

27 **must be furnished to the insurer within thirty-one (31) days after**  
28 **the date of birth in order to have the coverage continue beyond the**  
29 **thirty-one (31) day period.**

30           SECTION 38. IC 27-13-7-16 IS ADDED TO THE INDIANA  
31 CODE AS A NEW SECTION TO READ AS FOLLOWS  
32 [EFFECTIVE JULY 1, 1998]: **Sec. 16. (a) As used in this section,**  
33 **"breast cancer screening mammography" has the meaning set**  
34 **forth in IC 27-8-14-2.**

35           (b) A health maintenance organization issued a certificate of  
36 authority in Indiana must offer to provide coverage for breast  
37 cancer screening mammography.

38           (c) The coverage that a health maintenance organization must  
39 offer to provide under this section must include the following:

40           (1) If an enrollee is at least thirty-five (35) years of age but  
41 less than forty (40) years of age, coverage for at least one (1)  
42 baseline breast cancer screening mammography performed

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- 1           **upon the enrollee before the enrollee becomes forty (40) years**  
 2           **of age.**  
 3           **(2) If the enrollee is at least forty (40) years of age, one (1)**  
 4           **breast cancer screening mammography performed upon the**  
 5           **enrollee every year.**  
 6           **(3) Any additional views that are required for proper**  
 7           **evaluation.**  
 8           **(4) Ultrasound services, if determined medically necessary by**  
 9           **the provider treating the enrollee.**  
 10          **(d) A health maintenance organization must offer to provide**  
 11          **breast cancer screening mammography as a covered service under**  
 12          **a group contract with the health maintenance organization.**  
 13          **(e) The coverage that a health maintenance organization must**  
 14          **offer to provide under this section may not be subject to a contract**  
 15          **provision that is less favorable to an enrollee or a subscriber than**  
 16          **a contract provision applying to physical illness generally under**  
 17          **the health maintenance organization contract.**  
 18          **(f) The coverage that a health maintenance organization must**  
 19          **offer under this section is in addition to services specifically**  
 20          **provided for x-rays, laboratory testing, or wellness examinations.**  
 21          SECTION 39. IC 27-13-29-1, AS AMENDED BY P.L.255-1995,  
 22          SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 23          JULY 1, 1998]: Sec. 1. (a) Except as provided in subsection (b) or as  
 24          otherwise provided in this article or IC 27:  
 25                  (1) IC 27; and  
 26                  (2) the provisions of IC 16 regulating hospitals;  
 27          do not apply to any health maintenance organization or limited service  
 28          health maintenance organization **(as defined in IC 27-13-34-4)** that is  
 29          granted a certificate of authority under this article. However, this  
 30          section does not apply to an insurer or a hospital that is licensed under  
 31          Indiana law, except with respect to the health maintenance organization  
 32          activities of the hospital or insurer that are authorized and regulated  
 33          under this article.  
 34          (b) Every:  
 35                  **(1) health maintenance organization; and**  
 36                  **(2) limited service health maintenance organization (as**  
 37                  **defined in IC 27-13-34-4);**  
 38          authorized to do business in Indiana is subject to IC 27-4-1 relating to  
 39          unfair methods of competition and unfair or deceptive acts or practices  
 40          to the extent that IC 27-4-1 does not conflict with this article. If a  
 41          provision in IC 27-4-1 conflicts with this article, this article governs  
 42          and controls.



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1 SECTION 40. IC 34-4-12.6-1, AS AMENDED BY P.L.147-1997,  
 2 SECTION 74, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 3 JANUARY 1, 1999]: Sec. 1. (a) As used in this chapter, "professional  
 4 health care provider" means:

- 5 (1) a physician licensed under IC 25-22.5;
- 6 (2) a dentist licensed under IC 25-14;
- 7 (3) a hospital licensed under IC 16-21;
- 8 (4) a podiatrist licensed under IC 25-29;
- 9 (5) a chiropractor licensed under IC 25-10;
- 10 (6) an optometrist licensed under IC 25-24;
- 11 (7) a psychologist licensed under IC 25-33;
- 12 (8) a pharmacist licensed under IC 25-26;
- 13 (9) a health facility licensed under IC 16-28-2;
- 14 (10) a registered or licensed practical nurse licensed under  
 15 IC 25-23;
- 16 (11) a physical therapist licensed under IC 25-27;
- 17 (12) a home health agency licensed under IC 16-27-1;
- 18 (13) a community mental health center (as defined in  
 19 IC 12-7-2-38);
- 20 (14) a health care organization whose members, shareholders, or  
 21 partners are:
  - 22 (A) professional health care providers described in  
 23 subdivisions (1) through (13);
  - 24 (B) professional corporations comprised of health care  
 25 professionals (as defined in IC 23-1.5-1-8); or
  - 26 (C) professional health care providers described in  
 27 subdivisions (1) through (13) and professional corporations  
 28 comprised of persons described in subdivisions (1) through  
 29 (13);
- 30 (15) a private psychiatric hospital licensed under IC 12-25;
- 31 (16) a preferred provider organization (including a preferred  
 32 provider arrangement or reimbursement agreement under  
 33 IC 27-8-11);
- 34 (17) a health maintenance organization (as defined in  
 35 IC 27-13-1-19) or a limited service health maintenance  
 36 organization (as defined in IC 27-13-34-4);
- 37 (18) a respiratory care practitioner certified under IC 25-34.5;
- 38 (19) an occupational therapist certified under IC 25-23.5;
- 39 (20) a state institution (as defined in IC 12-7-2-184);
- 40 (21) a clinical social worker who is licensed under  
 41 IC 25-23.6-5-2;
- 42 (22) a managed care provider (as defined in IC 12-7-2-127(b)); or



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- 1 (23) a nonprofit health care organization affiliated with a hospital  
 2 that is owned or operated by a religious order, whose members are  
 3 members of that religious order.
- 4 (b) As used in this chapter, "evaluation of patient care" relates to:  
 5 (1) the accuracy of diagnosis;  
 6 (2) the propriety, appropriateness, quality, or necessity of care  
 7 rendered by a professional health care provider; and  
 8 (3) the reasonableness of the utilization of services, procedures,  
 9 and facilities in the treatment of individual patients.
- 10 As used in this chapter, the term does not relate to charges for services  
 11 or to methods used in arriving at diagnoses.
- 12 (c) As used in this chapter, "peer review committee" means a  
 13 committee that:
- 14 (1) has the responsibility of evaluation of:  
 15 (A) qualifications of professional health care providers;  
 16 (B) patient care rendered by professional health care  
 17 providers; or  
 18 (C) the merits of a complaint against a professional health care  
 19 provider that includes a determination or recommendation  
 20 concerning the complaint, and the complaint is based on the  
 21 competence or professional conduct of an individual health  
 22 care provider which competence or conduct affects or could  
 23 affect adversely the health or welfare of a patient or patients;  
 24 and
- 25 (2) meets the following criteria:  
 26 (A) The committee is organized:  
 27 (i) by a state, regional, or local organization of professional  
 28 health care providers or by a nonprofit foundation created by  
 29 the professional organization for purposes of improvement  
 30 of patient care;  
 31 (ii) by the professional staff of a hospital, another health care  
 32 facility, a nonprofit health care organization (under  
 33 subsection (a)(23)), or a professional health care  
 34 organization;  
 35 (iii) by state or federal law or regulation;  
 36 (iv) by a governing board of a hospital, a nonprofit health  
 37 care organization (under subsection (a)(23)), or professional  
 38 health care organization;  
 39 (v) as a governing board or committee of the board of a  
 40 hospital, a nonprofit health care organization (under  
 41 subsection (a)(23)), or professional health care organization;  
 42 (vi) by an organization, a plan, or a program described in

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- 1 subsection (a)(16) through (a)(17);  
 2 (vii) as a hospital or a nonprofit health care organization  
 3 (under subsection (a)(23)) medical staff or a section of that  
 4 staff; or  
 5 (viii) as a governing board or committee of the board of a  
 6 professional health care provider (as defined in subsection  
 7 (a)(16) through (a)(17)).  
 8 (B) At least fifty percent (50%) of the committee members are:  
 9 (i) individual professional health care providers, the  
 10 governing board of a hospital, the governing board of a  
 11 nonprofit health care organization (under subsection  
 12 (a)(23)), or professional health care organization, or the  
 13 governing board or a committee of the board of a  
 14 professional health care provider (as defined in subsection  
 15 (a)(16) through (a)(17)); or  
 16 (ii) individual professional health care providers and the  
 17 committee is organized as an interdisciplinary committee to  
 18 conduct evaluation of patient care services.  
 19 However, "peer review committee" does not include a medical review  
 20 panel created under IC 27-12-10.  
 21 (d) As used in this chapter, "professional staff" means:  
 22 (1) all individual professional health care providers authorized to  
 23 provide health care in a hospital or other health care facility; or  
 24 (2) the multidisciplinary staff of a community mental health  
 25 center (as defined in IC 12-7-2-38).  
 26 (e) As used in this chapter, "personnel of a peer review committee"  
 27 means not only members of the committee but also all of the  
 28 committee's employees, representatives, agents, attorneys,  
 29 investigators, assistants, clerks, staff, and any other person or  
 30 organization who serves a peer review committee in any capacity.  
 31 (f) As used in this chapter, "in good faith" refers to an act taken  
 32 without malice after a reasonable effort to obtain the facts of the matter  
 33 and in the reasonable belief that the action taken is warranted by the  
 34 facts known. In all actions to which this chapter applies, good faith  
 35 shall be presumed, and malice shall be required to be proven by the  
 36 person aggrieved.  
 37 (g) As used in this chapter, "professional health care organization"  
 38 refers to an organization described in subsection (a)(14).  
 39 **(h) As used in this chapter, "professional review activity" means**  
 40 **an activity of a peer review committee of a hospital licensed under**  
 41 **IC 16-21 with respect to a professional health care provider to:**  
 42 **(1) determine whether the professional health care provider**



- 1           **may have privileges with respect to the hospital;**  
 2           **(2) determine the scope or conditions of the privileges; or**  
 3           **(3) change or modify the privileges.**

4           **The term includes the establishment and enforcement of standards**  
 5           **and rules by the governing board of a hospital concerning practice**  
 6           **in the hospital and the granting and retention of privileges within**  
 7           **the hospital.**

8           SECTION 41. IC 34-4-12.6-3 IS AMENDED TO READ AS  
 9           FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 3. (a) There shall  
 10          be no liability on the part of, and no action of any nature shall arise  
 11          against, **an organization, a peer review committee, or** the personnel  
 12          of a peer review committee for any act, statement made in the confines  
 13          of the **organization or** committee, or proceeding **thereof of the**  
 14          **organization or committee** made in good faith in regard to:

- 15           **(1) evaluation of patient care as that term is defined and limited**  
 16           **in section 1(b) of this chapter; or**  
 17           **(2) professional review activity as defined and limited in**  
 18           **section 1(h) of this chapter.**

19          (b) Notwithstanding any other law, a peer review committee, an  
 20          organization, or any other person who, in good faith and as a witness  
 21          or in some other capacity, furnishes records, information, or assistance  
 22          to a peer review committee that is engaged in:

- 23           (1) the evaluation of the qualifications, competence, or  
 24           professional conduct of a professional health care provider; or  
 25           (2) the evaluation of patient care;

26          is immune from any civil action arising from the furnishing of the  
 27          records, information, or assistance, unless the person knowingly  
 28          furnishes false records or information.

29          (c) The personnel of a peer review committee shall be immune from  
 30          any civil action arising from any determination made in good faith in  
 31          regard to evaluation of patient care as that term is defined and limited  
 32          in section 1(b) of this chapter.

33          (d) No restraining order or injunction shall be issued against a peer  
 34          review committee or any of the personnel **thereof of the committee** to  
 35          interfere with the proper functions of the committee acting in good  
 36          faith in regard to evaluation of patient care as that term is defined and  
 37          limited in section 1(b) of this chapter.

38          (e) If the action of the peer review committee meets the standards  
 39          specified by this chapter and the federal Health Care Quality  
 40          Improvement Act of 1986, P.L.99-660, the following persons are not  
 41          liable for damages under any federal, state, or local law with respect to  
 42          the action:



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- 1 (1) The peer review committee.
- 2 (2) Any person acting as a member or staff to the peer review
- 3 committee.
- 4 (3) Any person under a contract or other formal agreement with
- 5 the peer review committee.
- 6 (4) Any person who participates with or assists the peer review
- 7 committee with respect to the action.
- 8 (f) Subsection (e) does not apply to damages under any federal or
- 9 state law relating to the civil rights of a person including:
- 10 (1) the federal Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq.;
- 11 and
- 12 (2) the federal Civil Rights Act, 42 U.S.C. 1981, et seq.
- 13 SECTION 42. THE FOLLOWING ARE REPEALED [EFFECTIVE
- 14 APRIL 1, 1998]: IC 6-3-7-5; IC 22-3-2-14.5; IC 22-3-7-34.5;
- 15 IC 27-8-15-34.
- 16 SECTION 43. [EFFECTIVE JULY 1, 1998] (a) **Notwithstanding**
- 17 **IC 27-8-10-2.1, the terms of the members of the Indiana**
- 18 **Comprehensive Health Insurance Association board of directors**
- 19 **-serving on August 31, 1998, expire August 31, 1998.**
- 20 (b) **The commissioner shall appoint, not later than September**
- 21 **1, 1998, the members of the Indiana Comprehensive Health**
- 22 **Insurance Association board of directors as required under**
- 23 **IC 27-8-10-2.1(b), as amended by this act, for terms commencing**
- 24 **on September 1, 1998.**
- 25 (c) **This SECTION expires January 1, 2000.**
- 26 SECTION 44. [EFFECTIVE APRIL 1, 1998] (a) **IC 27-8-5-3 and**
- 27 **IC 27-8-5-19, both as amended by this act, apply to all accident and**
- 28 **sickness policies in force on April 1, 1998.**
- 29 (b) **IC 27-8-15-10.5, IC 27-8-15-14, IC 27-8-15-19, IC 27-8-15-27,**
- 30 **IC 27-8-15-28, all as amended by this act, and IC 27-8-15-34.1, as**
- 31 **added by this act, apply to all small employer health insurance**
- 32 **plans in force under IC 27-8-15 on April 1, 1998.**
- 33 SECTION 45. **An emergency is declared for this act.**

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SENATE MOTION

Mr. President: I move that Senator Randolph be added as coauthor of Senate Bill 292.

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Environmental Affairs, to which was referred Senate Bill 292, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to Senate Bill 292 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 7, Nays 0.

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## SENATE MOTION

Mr. President: I move that Senate Bill 292 be amended to read as follows:

Page 8, delete lines 26 through 27.

Page 8, line 28, delete "(c)" and insert "**(b)**".

Page 8, line 31, delete "(d)" and insert "(c)".

Page 8, line 33, delete "insured" and insert "**enrollee**".

Page 8, line 36, delete "insured before the insured" and insert "**enrollee before the enrollee**".

Page 8, delete lines 38 through 42.

Page 9, delete lines 1 through 7.

Page 9, line 8, delete "(4)" and insert "**(2)**".

Page 9, line 8, delete "insured" and insert "**enrollee**".

Page 9, line 8, delete "fifty (50)" and insert "**forty (40)**".

Page 9, line 10, before "every" delete "insured" and insert "**enrollee**".

Page 9, line 10, delete ", regardless of whether the insured is a" and insert ".".

Page 9, delete line 11, begin a new line block indented and insert:

**"(3) Any additional views that are required for proper evaluation.**

**(4) Ultrasound services, if determined medically necessary by the provider treating the enrollee."**

Page 9, line 12, delete "(e)" and insert "**(d)**".

Page 9, line 14, after "a" insert "**group**".

Page 9, line 15, delete "(f)" and insert "**(e)**".

Page 9, line 17, after "or" insert "**a**".

Page 9, line 20, delete "(g)" and insert "**(f)**".

Page 9, line 21, delete "any".

(Reference is to Senate Bill 292 as printed January 30, 1998.)

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred Senate Bill 292, 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 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 2-5-23-8, AS ADDED BY P.L.11-1995, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 8. Beginning May 1, 1997, the health policy advisory committee is established. At the request of the chairman, the health policy advisory committee shall provide information and otherwise assist the commission to perform the duties of the commission under this chapter. The health policy advisory committee members are ex officio and may not vote. The health policy advisory committee members shall be appointed from the general public and must include one (1) individual who represents each of the following:

- (1) The interests of public hospitals.
- (2) The interests of community mental health centers.
- (3) The interests of community health centers.
- (4) The interests of the long term care industry.
- (5) The interests of health care professionals licensed under IC 25, but not licensed under IC 25-22.5.
- (6) The interests of rural hospitals. An individual appointed under this subdivision must be licensed under IC 25-22.5.
- (7) The interests of health maintenance organizations (as defined in IC 27-13-1-19).
- (8) The interests of for-profit health care facilities (as defined in ~~IC 27-8-10-1(g)~~: **IC 27-8-10-1(l)**).
- (9) A statewide consumer organization.
- (10) A statewide senior citizen organization.
- (11) A statewide organization representing people with disabilities.
- (12) Organized labor.
- (13) The interests of businesses that purchase health insurance policies.
- (14) The interests of businesses that provide employee welfare benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.
- (15) A minority community.
- (16) The uninsured. An individual appointed under this subdivision must be and must have been chronically uninsured.
- (17) An individual who is not associated with any organization,

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business, or profession represented in this subsection other than as a consumer.

SECTION 2. IC 10-1-2-2, AS AMENDED BY P.L.40-1997, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. (a) Authority is granted to the department to establish and operate an actuarially sound pension plan governed by a pension trust and to make the necessary annual contribution in order to prevent any deterioration in the actuarial status of the trust fund.

(b) Contributions shall be made to the trust fund by the department and by each employee beneficiary through authorized monthly deductions from wages.

(c) The trust fund may not be commingled with any other funds and shall be invested only in accordance with Indiana laws for the investment of trust funds, together with such other investments as are specifically designated in the pension trust. Subject to the terms of the pension trust, the trustee, with the approval of the Department and the Pension Advisory Board, may establish investment guidelines and limits on all types of investments (including, but not limited to, stocks and bonds) and take other action necessary to fulfill its duty as a fiduciary for the trust fund. However, the trustee shall invest the trust fund assets with the same care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims. The trustee shall also diversify such investments in accordance with prudent investment standards. The investment of trust funds is subject to section 2.5 of this chapter.

(d) The trustee shall receive and hold as trustee for the uses and purposes set forth in the pension trust any and all funds paid by the department, the employee beneficiaries, or by any other person or persons.

(e) The trustee shall engage pension consultants to supervise and assist in the technical operation of the pension plan in order that there may be no deterioration in the actuarial status of the plan.

(f) Before October 1 of each year, the trustee, with the aid of the pension consultants, shall prepare and file a report with the department and the ~~insurance commissioner~~ **state board of accounts**. The report must include the following with respect to the fiscal year ending on the preceding June 30:

SCHEDULE I. Receipts and disbursements.

SCHEDULE II. Assets of the pension trust, listing investments as to book value and current market value at the end of the fiscal year.



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SCHEDULE III. List of terminations, showing cause and amount of refund.

SCHEDULE IV. The application of actuarially computed "reserve factors" to the payroll data, properly classified for the purpose of computing the reserve liability of the trust fund as of the end of the fiscal year.

SCHEDULE V. The application of actuarially computed "current liability factors" to the payroll data, properly classified for the purpose of computing the liability of the trust fund for the end of the fiscal year.

SCHEDULE VI. An actuarial computation of the pension liability for all employees retired before the close of the fiscal year.

(g) The minimum annual contribution by the department must be of sufficient amount, as determined by the pension consultants, to prevent any deterioration in the actuarial status of the pension plan during that year. If the department fails to make the minimum contribution for five (5) successive years, the pension trust terminates and the trust fund shall be liquidated.

(h) In the event of liquidation, all expenses of the pension trust shall be paid, adequate provision shall be made for continuing pension payments to retired persons, and each employee beneficiary shall receive the net amount paid into the trust fund from wages. Any remaining sum shall be equitably divided among employee beneficiaries in proportion to the net amount paid from their wages into the trust fund.

SECTION 3. IC 16-18-2-163, AS AMENDED BY P.L.188-1995, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 163. (a) "Health care provider", for purposes of IC 16-21 and IC 16-41, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), a dentist, a registered or licensed practical nurse, a midwife, an optometrist, a pharmacist, a podiatrist, a chiropractor, a physical therapist, a respiratory care practitioner, an occupational therapist, a psychologist, a paramedic, an emergency medical technician, or an advanced emergency technician, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.



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(2) A college, university, or junior college that provides health care to a student, a faculty member, or an employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment.

(3) A blood bank, community mental health center, community mental retardation center, community health center, or migrant health center.

(4) A home health agency (as defined in IC 16-27-1-2).

(5) A health maintenance organization (as defined in IC 27-13-1-19).

(6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(7) A corporation, partnership, or professional corporation not otherwise qualified under this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under IC 27-12 for the corporation's, partnership's, or professional corporation's health care function.

Coverage for a health care provider qualified under this subdivision is limited to the health care provider's health care functions and does not extend to other causes of action.

**(b) "Health care provider", for purposes of IC 16-22-3-9.5 and IC 16-22-8-39.5, means an individual who holds a valid license under Indiana law to practice:**

**(1) chiropractic;**

**(2) optometry; or**

**(3) podiatry.**

~~(b)~~ (c) "Health care provider", for purposes of IC 16-35:

(1) has the meaning set forth in subsection (a); ~~However, for purposes of IC 16-35, the term also and~~

(2) includes a health facility (as defined in section 167 of this chapter).

SECTION 4. IC 16-22-3-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: **Sec. 9.5. (a) The governing board may delineate privileges for the provision of patient care services by a health care provider.**

**(b) A health care provider is eligible for privileges to provide patient care services, but the board shall establish and enforce**



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reasonable standards and rules concerning a health care provider's qualifications for the following:

- (1) Practice in the hospital.
- (2) The granting of privileges to a provider.
- (3) The retention of privileges.

(c) The fact that an applicant for privileges to provide patient care services is a health care provider may not serve as a basis for denying the applicant privileges to provide patient care services that are allowed under the professional license held by the applicant.

(d) The board may determine the kinds of health care procedures and treatments that are appropriate for an inpatient or outpatient hospital setting.

(e) The standards and rules described in subsection (b) may, in the interest of good patient care, allow the board to do the following:

- (1) Consider a health care provider's postgraduate education, training, experience, and other facts concerning the provider that may affect the provider's professional competence.
- (2) Consider the scope of practice allowed under the professional license held by a health care provider.
- (3) Limit privileges for admitting patients to the hospital to physicians licensed under IC 25-22.5.
- (4) Limit responsibility for the management of a patient's care to physicians licensed under IC 25-22.5.
- (5) Limit or preclude a health care provider's performance of x-rays or other imaging procedures in an inpatient or outpatient hospital setting. However, this subdivision does not affect the ability of a health care provider to order x-rays under that provider's scope of practice.

(f) The standards and rules described in subsection (b) may include a requirement for the following:

- (1) Submitting proof that a health care provider is qualified under IC 27-12-3-2.
- (2) Performing patient care and related duties in a manner that is not disruptive to the delivery of quality care in the hospital setting.
- (3) Maintaining standards of quality care that recognize the efficient and effective utilization of hospital resources as developed by the hospital's medical staff.

(g) The standards and rules described in subsection (b) must allow a health care provider who applies for privileges an



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opportunity to appear before a peer review committee that is established by the board to make recommendations regarding applications for privileges by health care providers before the peer review committee makes its recommendations regarding the applicant's request for privileges.

(h) The board must provide for a hearing before a peer review committee for a health care provider whose privileges have been recommended for termination.

SECTION 5. IC 16-22-8-39.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: **Sec. 39.5. (a) The governing board may delineate privileges for the provision of patient care services by a health care provider.**

(b) A health care provider is eligible for privileges to provide patient care services, but the board shall establish and enforce reasonable standards and rules concerning a health care provider's qualifications for the following:

- (1) Practice in the hospital.
- (2) The granting of privileges to a provider.
- (3) The retention of privileges.

(c) The fact that an applicant for privileges to provide patient care services is a health care provider may not serve as a basis for denying the applicant privileges to provide patient care services that are allowed under the professional license held by the applicant.

(d) The board may determine the kinds of health care procedures and treatments that are appropriate for an inpatient or outpatient hospital setting.

(e) The standards and rules described in subsection (b) may, in the interest of good patient care, allow the board to do the following:

- (1) Consider a health care provider's postgraduate education, training, experience, and other facts concerning the provider that may affect the provider's professional competence.
- (2) Consider the scope of practice allowed under the professional license held by a health care provider.
- (3) Limit privileges for admitting patients to the hospital to physicians licensed under IC 25-22.5.
- (4) Limit responsibility for the management of a patient's care to physicians licensed under IC 25-22.5.
- (5) Limit or preclude a health care provider's performance of x-rays or other imaging procedures in an inpatient or



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outpatient hospital setting. However, this subdivision does not affect the ability of a health care provider to order x-rays under that provider's scope of practice.

(f) The standards and rules described in subsection (b) may include a requirement for the following:

(1) Submitting proof that a health care provider is qualified under IC 27-12-3-2.

(2) Performing patient care and related duties in a manner that is not disruptive to the delivery of quality care in the hospital setting.

(3) Maintaining standards of quality care that recognize the efficient and effective utilization of hospital resources as developed by the hospital's medical staff.

(g) The standards and rules described in subsection (b) must allow a health care provider who applies for privileges an opportunity to appear before a peer review committee that is established by the board to make recommendations regarding applications for privileges by health care providers before the peer review committee makes its recommendations regarding the applicant's request for privileges.

(h) The board must provide for a hearing before a peer review committee for a health care provider whose privileges have been recommended for termination.

SECTION 6. IC 22-3-5-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 6. (a) The worker's compensation supplemental administrative fund is established for the purpose of carrying out the administrative purposes and functions of the worker's compensation board. The fund consists of fees collected from employers under sections 1 through 2 of this chapter. ~~and from fees collected under IC 22-3-2-14.5 and IC 22-3-7-34.5.~~ The fund shall be administered by the worker's compensation board. ~~Money in the fund is annually appropriated to the worker's compensation board for its use in carrying out the administrative purposes and functions of the worker's compensation board.~~

(b) The money in the fund is not to be used to replace funds otherwise appropriated to the board. Money in the fund at the end of the state fiscal year does not revert to the state general fund.

SECTION 7. IC 22-3-6-1, AS AMENDED BY P.L.258-1997(ss), SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 1. In IC 22-3-2 through IC 22-3-6, unless the context otherwise requires:

(a) "Employer" includes the state and any political subdivision, any

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municipal corporation within the state, any individual or the legal representative of a deceased individual, firm, association, limited liability company, or corporation or the receiver or trustee of the same, using the services of another for pay. If the employer is insured, the term includes the employer's insurer so far as applicable. However, the inclusion of an employer's insurer within this definition does not allow an employer's insurer to avoid payment for services rendered to an employee with the approval of the employer.

(b) "Employee" means every person, including a minor, in the service of another, under any contract of hire or apprenticeship, written or implied, except one whose employment is both casual and not in the usual course of the trade, business, occupation, or profession of the employer.

(1) An executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation, other than a municipal corporation or governmental subdivision or a charitable, religious, educational, or other nonprofit corporation, is an employee of the corporation under IC 22-3-2 through IC 22-3-6.

(2) An executive officer of a municipal corporation or other governmental subdivision or of a charitable, religious, educational, or other nonprofit corporation may, notwithstanding any other provision of IC 22-3-2 through IC 22-3-6, be brought within the coverage of its insurance contract by the corporation by specifically including the executive officer in the contract of insurance. The election to bring the executive officer within the coverage shall continue for the period the contract of insurance is in effect, and during this period, the executive officers thus brought within the coverage of the insurance contract are employees of the corporation under IC 22-3-2 through IC 22-3-6.

(3) Any reference to an employee who has been injured, when the employee is dead, also includes the employee's legal representatives, dependents, and other persons to whom compensation may be payable.

(4) An owner of a sole proprietorship may elect to include the owner as an employee under IC 22-3-2 through IC 22-3-6 if the owner is actually engaged in the proprietorship business. If the owner makes this election, the owner must serve upon the owner's insurance carrier and upon the board written notice of the election. No owner of a sole proprietorship may be considered an employee under IC 22-3-2 through IC 22-3-6 until the notice has been received. ~~If the owner of a sole proprietorship is an~~

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~~independent contractor in the construction trades and does not make the election provided under this subdivision; the owner must obtain an affidavit of exemption under IC 22-3-2-14.5.~~

(5) A partner in a partnership may elect to include the partner as an employee under IC 22-3-2 through IC 22-3-6 if the partner is actually engaged in the partnership business. If a partner makes this election, the partner must serve upon the partner's insurance carrier and upon the board written notice of the election. No partner may be considered an employee under IC 22-3-2 through IC 22-3-6 until the notice has been received. ~~If a partner in a partnership is an independent contractor in the construction trades and does not make the election provided under this subdivision; the partner must obtain an affidavit of exemption under IC 22-3-2-14.5.~~

(6) Real estate professionals are not employees under IC 22-3-2 through IC 22-3-6 if:

- (A) they are licensed real estate agents;
- (B) substantially all their remuneration is directly related to sales volume and not the number of hours worked; and
- (C) they have written agreements with real estate brokers stating that they are not to be treated as employees for tax purposes.

~~(7) A person is an independent contractor in the construction trades and not an employee under IC 22-3-2 through IC 22-3-6 if the person is an independent contractor under the guidelines of the United States Internal Revenue Service.~~

~~(8) (7)~~ An owner-operator that provides a motor vehicle and the services of a driver under a written contract that is subject to IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 1057, to a motor carrier is not an employee of the motor carrier for purposes of IC 22-3-2 through IC 22-3-6. The owner-operator may elect to be covered and have the owner-operator's drivers covered under a worker's compensation insurance policy or authorized self-insurance that insures the motor carrier if the owner-operator pays the premiums as requested by the motor carrier. An election by an owner-operator under this subdivision does not terminate the independent contractor status of the owner-operator for any purpose other than the purpose of this subdivision.

~~(9) (8)~~ A member or manager in a limited liability company may elect to include the member or manager as an employee under IC 22-3-2 through IC 22-3-6 if the member or manager is actually engaged in the limited liability company business. If a member or

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manager makes this election, the member or manager must serve upon the member's or manager's insurance carrier and upon the board written notice of the election. A member or manager may not be considered an employee under IC 22-3-2 through IC 22-3-6 until the notice has been received.

(c) "Minor" means an individual who has not reached seventeen (17) years of age.

(1) Unless otherwise provided in this subsection, a minor employee shall be considered as being of full age for all purposes of IC 22-3-2 through IC 22-3-6.

(2) If the employee is a minor who, at the time of the accident, is employed, required, suffered, or permitted to work in violation of IC 20-8.1-4-25, the amount of compensation and death benefits, as provided in IC 22-3-2 through IC 22-3-6, shall be double the amount which would otherwise be recoverable. The insurance carrier shall be liable on its policy for one-half (1/2) of the compensation or benefits that may be payable on account of the injury or death of the minor, and the employer shall be liable for the other one-half (1/2) of the compensation or benefits. If the employee is a minor who is not less than sixteen (16) years of age and who has not reached seventeen (17) years of age and who at the time of the accident is employed, suffered, or permitted to work at any occupation which is not prohibited by law, this subdivision does not apply.

(3) A minor employee who, at the time of the accident, is a student performing services for an employer as part of an approved program under IC 20-10.1-6-7 shall be considered a full-time employee for the purpose of computing compensation for permanent impairment under IC 22-3-3-10. The average weekly wages for such a student shall be calculated as provided in subsection (d)(4).

(4) The rights and remedies granted in this subsection to a minor under IC 22-3-2 through IC 22-3-6 on account of personal injury or death by accident shall exclude all rights and remedies of the minor, the minor's parents, or the minor's personal representatives, dependents, or next of kin at common law, statutory or otherwise, on account of the injury or death. This subsection does not apply to minors who have reached seventeen (17) years of age.

(d) "Average weekly wages" means the earnings of the injured employee in the employment in which the employee was working at the time of the injury during the period of fifty-two (52) weeks



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immediately preceding the date of injury, divided by fifty-two (52), except as follows:

(1) If the injured employee lost seven (7) or more calendar days during this period, although not in the same week, then the earnings for the remainder of the fifty-two (52) weeks shall be divided by the number of weeks and parts thereof remaining after the time lost has been deducted.

(2) Where the employment prior to the injury extended over a period of less than fifty-two (52) weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed, if results just and fair to both parties will be obtained. Where by reason of the shortness of the time during which the employee has been in the employment of the employee's employer or of the casual nature or terms of the employment it is impracticable to compute the average weekly wages, as defined in this subsection, regard shall be had to the average weekly amount which during the fifty-two (52) weeks previous to the injury was being earned by a person in the same grade employed at the same work by the same employer or, if there is no person so employed, by a person in the same grade employed in the same class of employment in the same district.

(3) Wherever allowances of any character made to an employee in lieu of wages are a specified part of the wage contract, they shall be deemed a part of his earnings.

(4) In computing the average weekly wages to be used in calculating an award for permanent impairment under IC 22-3-3-10 for a student employee in an approved training program under IC 20-10.1-6-7, the following formula shall be used. Calculate the product of:

- (A) the student employee's hourly wage rate; multiplied by
- (B) forty (40) hours.

The result obtained is the amount of the average weekly wages for the student employee.

(e) "Injury" and "personal injury" mean only injury by accident arising out of and in the course of the employment and do not include a disease in any form except as it results from the injury.

(f) "Billing review service" refers to a person or an entity that reviews a medical service provider's bills or statements for the purpose of determining pecuniary liability. The term includes an employer's worker's compensation insurance carrier if the insurance carrier performs such a review.



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(g) "Billing review standard" means the data used by a billing review service to determine pecuniary liability.

(h) "Community" means a geographic service area based on zip code districts defined by the United States Postal Service according to the following groupings:

- (1) The geographic service area served by zip codes with the first three (3) digits 463 and 464.
- (2) The geographic service area served by zip codes with the first three (3) digits 465 and 466.
- (3) The geographic service area served by zip codes with the first three (3) digits 467 and 468.
- (4) The geographic service area served by zip codes with the first three (3) digits 469 and 479.
- (5) The geographic service area served by zip codes with the first three (3) digits 460, 461 (except 46107), and 473.
- (6) The geographic service area served by the 46107 zip code and zip codes with the first three (3) digits 462.
- (7) The geographic service area served by zip codes with the first three (3) digits 470, 471, 472, 474, and 478.
- (8) The geographic service area served by zip codes with the first three (3) digits 475, 476, and 477.

(i) "Medical service provider" refers to a person or an entity that provides medical services, treatment, or supplies to an employee under IC 22-3-2 through IC 22-3-6.

(j) "Pecuniary liability" means the responsibility of an employer or the employer's insurance carrier for the payment of the charges for each specific service or product for human medical treatment provided under IC 22-3-2 through IC 22-3-6 in a defined community, equal to or less than the charges made by medical service providers at the eightieth percentile in the same community for like services or products.

SECTION 8. IC 22-3-7-9, AS AMENDED BY P.L.258-1997(ss), SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 9. (a) As used in this chapter, "employer" includes the state and any political subdivision, any municipal corporation within the state, any individual or the legal representative of a deceased individual, firm, association, limited liability company, or corporation or the receiver or trustee of the same, using the services of another for pay. If the employer is insured, the term includes his insurer so far as applicable. However, the inclusion of an employer's insurer within this definition does not allow an employer's insurer to avoid payment for services rendered to an employee with the approval of the employer.

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(b) As used in this chapter, "employee" means every person, including a minor, in the service of another, under any contract of hire or apprenticeship written or implied, except one whose employment is both casual and not in the usual course of the trade, business, occupation, or profession of the employer. For purposes of this chapter the following apply:

(1) Any reference to an employee who has suffered disablement, when the employee is dead, also includes his legal representative, dependents, and other persons to whom compensation may be payable.

(2) An owner of a sole proprietorship may elect to include himself as an employee under this chapter if he is actually engaged in the proprietorship business. If the owner makes this election, he must serve upon his insurance carrier and upon the board written notice of the election. No owner of a sole proprietorship may be considered an employee under this chapter unless the notice has been received. ~~If the owner of a sole proprietorship is an independent contractor in the construction trades and does not make the election provided under this subdivision, the owner must obtain an affidavit of exemption under IC 22-3-7-34.5.~~

(3) A partner in a partnership may elect to include himself as an employee under this chapter if he is actually engaged in the partnership business. If a partner makes this election, he must serve upon his insurance carrier and upon the board written notice of the election. No partner may be considered an employee under this chapter until the notice has been received. ~~If a partner in a partnership is an independent contractor in the construction trades and does not make the election provided under this subdivision, the partner must obtain an affidavit of exemption under IC 22-3-7-34.5.~~

(4) Real estate professionals are not employees under this chapter if:

- (A) they are licensed real estate agents;
- (B) substantially all their remuneration is directly related to sales volume and not the number of hours worked; and
- (C) they have written agreements with real estate brokers stating that they are not to be treated as employees for tax purposes.

(5) ~~A person is an independent contractor in the construction trades and not an employee under this chapter if the person is an independent contractor under the guidelines of the United States Internal Revenue Service.~~

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~~(6)~~ (5) An owner-operator that provides a motor vehicle and the services of a driver under a written contract that is subject to IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 1057, to a motor carrier is not an employee of the motor carrier for purposes of this chapter. The owner-operator may elect to be covered and have the owner-operator's drivers covered under a worker's compensation insurance policy or authorized self-insurance that insures the motor carrier if the owner-operator pays the premiums as requested by the motor carrier. An election by an owner-operator under this subdivision does not terminate the independent contractor status of the owner-operator for any purpose other than the purpose of this subdivision.

(c) As used in this chapter, "minor" means an individual who has not reached seventeen (17) years of age. A minor employee shall be considered as being of full age for all purposes of this chapter. However, if the employee is a minor who, at the time of the last exposure, is employed, required, suffered, or permitted to work in violation of the child labor laws of this state, the amount of compensation and death benefits, as provided in this chapter, shall be double the amount which would otherwise be recoverable. The insurance carrier shall be liable on its policy for one-half (1/2) of the compensation or benefits that may be payable on account of the disability or death of the minor, and the employer shall be wholly liable for the other one-half (1/2) of the compensation or benefits. If the employee is a minor who is not less than sixteen (16) years of age and who has not reached seventeen (17) years of age, and who at the time of the last exposure is employed, suffered, or permitted to work at any occupation which is not prohibited by law, the provisions of this subsection prescribing double the amount otherwise recoverable do not apply. The rights and remedies granted to a minor under this chapter on account of disease shall exclude all rights and remedies of the minor, his parents, his personal representatives, dependents, or next of kin at common law, statutory or otherwise, on account of any disease.

(d) This chapter does not apply to casual laborers as defined in subsection (b), nor to farm or agricultural employees, nor to household employees, nor to railroad employees engaged in train service as engineers, firemen, conductors, brakemen, flagmen, baggagemen, or foremen in charge of yard engines and helpers assigned thereto, nor to their employers with respect to these employees. Also, this chapter does not apply to employees or their employers with respect to employments in which the laws of the United States provide for compensation or liability for injury to the health, disability, or death by

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reason of diseases suffered by these employees.

(e) As used in this chapter, "disablement" means the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he claims compensation or equal wages in other suitable employment, and "disability" means the state of being so incapacitated.

(f) For the purposes of this chapter, no compensation shall be payable for or on account of any occupational diseases unless disablement, as defined in subsection (e), occurs within two (2) years after the last day of the last exposure to the hazards of the disease except for the following:

(1) In all cases of occupational diseases caused by the inhalation of silica dust or coal dust, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within three (3) years after the last day of the last exposure to the hazards of the disease.

(2) In all cases of occupational disease caused by the exposure to radiation, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within two (2) years from the date on which the employee had knowledge of the nature of his occupational disease or, by exercise of reasonable diligence, should have known of the existence of such disease and its causal relationship to his employment.

(3) In all cases of occupational diseases caused by the inhalation of asbestos dust, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within three (3) years after the last day of the last exposure to the hazards of the disease if the last day of the last exposure was before July 1, 1985.

(4) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1985, and before July 1, 1988, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within twenty (20) years after the last day of the last exposure.

(5) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1988, no compensation shall be payable unless disablement (as defined in subsection (e)) occurs within thirty-five (35) years after the last day of the last exposure.

(g) For the purposes of this chapter, no compensation shall be payable for or on account of death resulting from any occupational

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disease unless death occurs within two (2) years after the date of disablement. However, this subsection does not bar compensation for death:

- (1) where death occurs during the pendency of a claim filed by an employee within two (2) years after the date of disablement and which claim has not resulted in a decision or has resulted in a decision which is in process of review or appeal; or
- (2) where, by agreement filed or decision rendered, a compensable period of disability has been fixed and death occurs within two (2) years after the end of such fixed period, but in no event later than three hundred (300) weeks after the date of disablement.

(h) As used in this chapter, "billing review service" refers to a person or an entity that reviews a medical service provider's bills or statements for the purpose of determining pecuniary liability. The term includes an employer's worker's compensation insurance carrier if the insurance carrier performs such a review.

(i) As used in this chapter, "billing review standard" means the data used by a billing review service to determine pecuniary liability.

(j) As used in this chapter, "community" means a geographic service area based on zip code districts defined by the United States Postal Service according to the following groupings:

- (1) The geographic service area served by zip codes with the first three (3) digits 463 and 464.
- (2) The geographic service area served by zip codes with the first three (3) digits 465 and 466.
- (3) The geographic service area served by zip codes with the first three (3) digits 467 and 468.
- (4) The geographic service area served by zip codes with the first three (3) digits 469 and 479.
- (5) The geographic service area served by zip codes with the first three (3) digits 460, 461 (except 46107), and 473.
- (6) The geographic service area served by the 46107 zip code and zip codes with the first three (3) digits 462.
- (7) The geographic service area served by zip codes with the first three (3) digits 470, 471, 472, 474, and 478.
- (8) The geographic service area served by zip codes with the first three (3) digits 475, 476, and 477.

(k) As used in this chapter, "medical service provider" refers to a person or an entity that provides medical services, treatment, or supplies to an employee under this chapter.

(l) As used in this chapter, "pecuniary liability" means the



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responsibility of an employer or the employer's insurance carrier for the payment of the charges for each specific service or product for human medical treatment provided under this chapter in a defined community, equal to or less than the charges made by medical service providers at the eightieth percentile in the same community for like services or products.

SECTION 9. IC 27-1-3-15, AS AMENDED BY P.L.116-1994, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 15. (a) **Except as provided in subsection (g)**, the commissioner shall collect the following fees when the documents described in this subsection are delivered to the commissioner for filing:

Document	Fee
Articles of incorporation . . . . .	\$ 350
Amendment of articles of incorporation . . . . .	\$ 10
Filing of annual statement and consolidated statement . . . . .	\$ 100
Annual renewal of company license fee . . . . .	\$ 50
Appointment of commissioner for service of process . . . . .	\$ 10
Withdrawal of certificate of authority . . . . .	\$ 25
Certified statement of condition . . . . .	\$ 5
Any other document required to be filed by this article . . . . .	\$ 25

(b) The commissioner shall collect a fee of ten dollars (\$10) each time process is served on the commissioner under this title.

(c) The commissioner shall collect the following fees for copying and certifying the copy of any filed document relating to a domestic or foreign corporation:

Per page for copying . . . . .	As determined by the commissioner but not to exceed actual cost
For the certificate . . . . .	\$10

(d) Each domestic and foreign insurer shall remit annually to the commissioner for deposit into the department of insurance fund established by IC 27-1-3-28 three hundred fifty dollars (\$350) as an internal audit fee. All assessment insurers, farm mutuals, fraternal benefit societies, and health maintenance organizations shall remit to the commissioner for deposit into the department of insurance fund one hundred dollars (\$100) annually as an internal audit fee.

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(e) Beginning July 1, 1994, each insurer shall remit to the commissioner for deposit into the department of insurance fund established by IC 27-1-3-28 a fee of thirty-five dollars (\$35) for each policy, rider, and endorsement filed with the state. However, each policy, rider, and endorsement filed as part of a particular product filing and associated with that product filing shall be considered to be a single filing and subject only to one (1) thirty-five dollar (\$35) fee.

(f) The commissioner shall pay into the state general fund by the end of each calendar month the amounts collected during that month under subsections (a), (b), and (c). ~~of this section.~~

**(g) The commissioner may not collect fees for quarterly statements filed under IC 27-1-20-33.**

SECTION 10. IC 27-1-3-20 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 20. (a) The commissioner may issue a certificate of authority to any company when it shall have complied with the requirements of the laws of this state so as to entitle it to do business herein. The certificate shall be issued under the seal of the department authorizing and empowering the company to make the kind or kinds of insurance specified in the certificate. No certificate of authority shall be issued until the commissioner has found that:

- ~~(a)~~ (1) the company has submitted a sound plan of operation; and
- ~~(b)~~ (2) the general character and experience of the incorporators, directors, and proposed officers is such as to assure reasonable promise of a successful operation, based on the fact that such persons are of known good character and that there is no good reason to believe that they are affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions, or other insurance or business relations with any person or persons known to have been involved in the improper manipulation of assets, accounts, or reinsurance.

No certificate of authority shall be denied, however, under subdivision ~~(a)~~ (1) or ~~(b)~~ (2) until notice, hearing, and right of appeal has been given as provided in IC 4-21.5.

(b) Every company possessing a certificate of authority shall notify the commissioner of the election or appointment of every new director or principal officer, within thirty (30) days thereafter. If in the commissioner's opinion such a new principal officer or director does not meet the standards set forth in this section, he shall request that the company effect the removal of such persons from office. If such removal is not accomplished as promptly as under the circumstances and in the opinion of the commissioner is possible, then upon notice to



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both the company and such principal officer or director and after notice, hearing, and right of appeal pursuant to IC 4-21.5, and after a finding that such person is incompetent or untrustworthy or of known bad character, the commissioner may order the removal of such person from office and may, unless such removal is promptly accomplished, suspend the company's certificate of authority until there is compliance with such order.

(c) No company shall transact any business of insurance **under IC 22 or IC 27, or hold itself out as a company in the business of insurance in this state Indiana** until it shall have received a certificate of authority as prescribed in this section. ~~and:~~

(d) No company shall make, **issue, deliver, sell, or advertise** any kind or kinds of insurance not specified in ~~such the company's~~ certificate of authority.

SECTION 11. IC 27-1-8-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 13. (a) Any domestic mutual insurance company may by amendment of its articles of incorporation convert to a stock insurance company only upon compliance with the requirements of this section and applicable requirements of sections 1 through 8 and 11 of this chapter.

(b) The board of directors of any such mutual company shall first adopt a resolution proposing the amendment to its articles of incorporation, as required by section 2 of this chapter, and proposing a plan of conversion of such mutual company into a stock insurance company. Such plan of conversion shall set forth the following:

(1) The terms and conditions of the plan of conversion and the manner and basis of carrying the same into effect.

(2) ~~A formula~~ **Formulas** for:

(A) the determination of the equity **or share**, if any, of each member or policyholder in the entire net worth **or initial issue of capital stock** of the company; and

(B) ~~for~~ the determination and preservation of the participation rights, if any, in future earnings from each class of existing insurance policies.

(3) ~~A If the procedures of subdivision (5)(A) are applicable, a~~ statement of the entire net worth of the company attested by two (2) independent actuaries, each of whom is a member of the American Academy of Actuaries, and **under the procedures of subdivision (5)(A) or (5)(B)**, written opinions by such actuaries that the ~~formula formulas~~ and ~~procedure procedures~~ required in subdivision (2) ~~is~~ **are** fair and equitable to the members and policyholders of the company.



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(4) ~~That~~ **A statement of** the members or policyholders entitled to participate in the conversion, as provided in the plan, **which** shall include all members and policyholders of the company who have voting rights as of the effective date of the amendment and the plan of conversion **or as of an earlier date as the commissioner may approve.**

(5) **A statement** that the members ~~and~~ **or** policyholders of the company, as defined in subdivision (4), **shall have the right to capital stock of the company or to a payment of cash from the company under one (1) of the following procedures, as specified by the company in the plan of conversion:**

**(A) The members and policyholders of the company** shall have the first right to acquire all the proposed initial issue of capital stock of the company by a fair allocation of the rights to acquire such stock among such members or policyholders, provided that such right to acquire such shares shall be exercised within a designated reasonable period, which period shall not be less than thirty (30) days, with the right to apply the amount of equity, if any, as determined under the ~~formula~~ **formulas** in subdivision (2)(A) upon the purchase price of such shares; provided, further, that:

**(i)** the right shall be exercised by a written election in a form provided by the company, and payment for any balance due upon such shares, after the aforesaid credit, if any, shall be made in cash within such time as is fixed in the plan;

~~(6) That~~ **(ii)** any shares not acquired by a member or policyholder, as provided in ~~subdivision (5); the prior provisions of this clause,~~ may be offered to others who may or may not be members or policyholders at the same or a higher price per share than that provided for under ~~subdivision (5); the prior provisions of this clause; and~~

~~(7) That~~ **(iii)** at a time specified in the plan, payment to each dissenting member or policyholder shall be made in cash of the amount, if any, as provided under the plan for payment to dissenting members or policyholders, such dissenting members or policyholders being those who do not acquire shares as provided in ~~subdivision (5); this clause.~~

**(B) The members or policyholders of the company shall receive all of the initial issue of capital stock of the company, without payment of any consideration to the company, by a fair allocation of such stock among such members or policyholders, if the commissioner is satisfied:**

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(i) that the company will assure that an active public trading market for the capital stock of the company will develop within a reasonable time after the effective date of the plan of conversion or after the delivery of stock certificates to the members or policyholders; and

(ii) with the terms and conditions of any public offering or other stock offerings or sales by the company proposed to be made during the three (3) year period following the effective date of the plan of conversion, including any stock subscription rights of the members and policyholders.

(6) The plan of conversion may include procedures for:

(A) establishment of a noninsurance stock holding corporation for the company concurrent with or immediately following the effective date of the plan of conversion and for the exchange or conversion of the members' or policyholders' rights to and interests in capital stock of the company for or into equivalent rights to and interests in capital stock of the noninsurance stock holding corporation;

(B) delayed delivery of stock certificates or cash to the members or policyholders of the company, or restrictions on sale or transfer of capital stock by members or policyholders of the company, for a reasonable time following the effective date of the plan of conversion; and

(C) delayed establishment of the formulas required by subdivision (2)(A) or establishment in the plan of conversion of specific conditional or alternative formulas.

~~(8)~~ (7) The plan of conversion may contain such other terms and provisions as the company deems necessary or desirable.

(c) Any such mutual insurance company shall file with the department, following the adoption by its board of directors of such resolution proposing the amendment and plan of conversion, and before its submission to a vote by its members or policyholders, three (3) copies of the proposed amendment to the articles of incorporation, together with three (3) copies of the plan of conversion and such other supporting documents as the company or the department deems necessary.

(d) The insurance commissioner shall hold a hearing upon the terms, conditions, and provisions of the plan of conversion, at which hearing the policyholders of the company and any other interested party shall have the right to appear and become a party to the proceedings.



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The commissioner shall require the company to produce such evidence as he shall deem necessary to establish that the plan of conversion meets the requirements set forth in this section and further that it is fair and equitable to the members and policyholders of the company. Such hearing shall be commenced not less than twenty (20) days after the date on which the amendment and plan of conversion are presented to the department, and shall be held in the city of Indianapolis, Indiana, at such place, date, and time as the department shall specify. Notice of the hearing shall be published in a newspaper of general circulation in the city wherein is located the principal office of the company and in the city of Indianapolis once a week for two (2) successive weeks. Written notice of the hearing shall be mailed by the company to its members and policyholders having voting rights at least ten (10) days prior to the hearing. Except as otherwise provided in this section, the hearing and the determination made therein shall be subject to IC 4-21.5-3.

(e) The commissioner shall issue an order approving the plan of conversion as filed with the department by the company with such modifications therein as a majority of the board of directors of the company shall approve if the commissioner finds that:

- (1) the plan, including all such modifications, if effected, will meet all the requirements set forth in this section;
- (2) such plan is equitable to the members and policyholders of the company;
- (3) the terms and conditions of the plan of conversion are fair and reasonable;
- (4) upon consummation of the plan of conversion the paid-in capital and surplus of the company shall be in an amount not less than the minimum paid-in capital and surplus required to organize a domestic stock insurance company to transact like kinds of insurance; and
- (5) all the rights of every member and policyholder as fixed in any policy of insurance of the company, excluding voting rights, if any, shall be and remain unaffected by the proposed conversion and shall continue in full force in accordance with the terms of the policy of each such member and policyholder.

(f) The order of the commissioner approving or disapproving the plan of conversion shall be filed in the department within thirty (30) days after the last day of the hearing before the commissioner. The department shall promptly give notice of such order to all persons who appeared at the hearing and requested to be made parties to the proceedings, and the department shall endorse the commissioner's



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approval or disapproval on the plan of conversion in the manner provided in IC 27-1-6-8 and shall deliver copies thereof to the company. The company or any person who was made a party to such proceedings aggrieved by such order shall be entitled to a judicial review thereof in accordance with IC 4-21.5-5. Subject only to such judicial review, the determination and order of the commissioner (or the court upon judicial review) in approving or disapproving the plan of conversion shall be binding and conclusive upon all parties to the proceedings and all policyholders or members with respect to the fairness of the plan and its compliance with this article and with respect to the proportionate share, if any, of each policyholder or member in the equity **or capital stock** of the company and the value **or proportionate share, if any**, of his membership interests or rights as determined under the ~~formula~~ **formulas** referred to in subsection (b)(2).

(g) The plan of conversion and the proposed amendment to the articles of incorporation, as finally approved, shall be submitted to a vote of the members or policyholders, as provided in section 3 of this chapter, and if the proposed plan of conversion and proposed amendment shall be adopted as provided in section 3 of this chapter, the company shall proceed to consummate the plan of conversion and comply with the applicable provisions of sections 4 through 8 and 11 of this chapter.

(h) Notwithstanding the adoption of the plan of conversion by the policyholders and at any time prior to the effective date of the plan of conversion, the plan and proposed amendment may be abandoned pursuant to a provision for such abandonment, if any, contained in the plan of conversion.

(i) The plan of conversion and proposed amendment to the articles of incorporation shall become effective upon the later of:

- (1) the date and time of approval of the articles of amendment by the secretary of state as provided in section 8 of this chapter; and
- (2) the date and time of filing with the department a certificate setting forth the plan of conversion and the manner of its approval by the directors and policyholders of the company, which shall be executed on behalf of the company by its president or a vice president;

unless a later date and time is specified in the plan of conversion, in which event the plan of conversion and amendment shall become effective and take place upon such later date and time.

(j) When the plan of conversion and proposed amendment to the articles of incorporation become effective:

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(1) the company shall be converted from a mutual insurance company to a stock insurance company and shall have all the rights, privileges, immunities, and powers and shall be subject to all the duties and liabilities of a stock insurance company existing under this article; and

(2) the rights and interests of every member and policyholder existing by virtue of being a member or policyholder of the mutual company, of any nature whatsoever, including voting rights, shall cease.

Provided, however, that rights of every member and policyholder under any contract of insurance shall continue in force in accordance with the terms, provisions, and conditions of such contract, including rights, if any, to policyholder dividends.

SECTION 12. IC 27-1-15.5-3, AS AMENDED BY P.L.185-1996, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 3. (a) A person may not act as or hold himself out to be an insurance agent, surplus lines insurance agent, limited insurance representative, or consultant unless he is duly licensed. An insurance agent, surplus lines insurance agent, or limited insurance representative may not make application for, procure, negotiate for, or place for others any policies for any kinds of insurance as to which he is not then qualified and duly licensed. An insurance agent and a limited insurance representative may receive qualification for a license in one (1) or more of the kinds of insurance defined in Class I, Class II, and Class III of IC 27-1-5-1. A surplus lines insurance agent may receive qualification for a license in one (1) or more of the kinds of insurance defined in Class II and Class III of IC 27-1-5-1 from insurers that are authorized to do business in one (1) or more states of the United States of America but which insurers are not authorized to do business in Indiana, whenever, after diligent effort, as determined to the satisfaction of the insurance department, such licensee is unable to procure the amount of insurance desired from insurers authorized and licensed to transact business in Indiana. The commissioner may issue a limited insurance representative's license to the following without examination:

- (1) a person who is a ticket-selling agent of a common carrier who will act only with reference to the issuance of insurance on personal effects carried as baggage, in connection with the transportation provided by such common carrier;
- (2) a person who will only negotiate or solicit limited travel accident insurance in transportation terminals;
- (3) a person who will only negotiate or solicit insurance covered



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by IC 27-8-4;

(4) a person who will only negotiate or solicit insurance under Class II(j); or

(5) to any person who will negotiate or solicit a kind of insurance that the commissioner finds does not require an examination to demonstrate professional competency.

(b) A corporation or limited liability company may be licensed as an insurance agent, surplus lines insurance agent, or limited insurance representative. Every officer, director, stockholder, or employee of the corporation or limited liability company personally engaged in Indiana in soliciting or negotiating policies of insurance shall be registered with the commissioner as to its license, and each such member, officer, director, stockholder, or employee shall also qualify as an individual licensee. However, this section does not apply to a management association, partnership, or corporation whose operations do not entail the solicitation of insurance from the public.

(c) The commissioner may not grant, renew, continue or permit to continue any license if he finds that the license is being or will be used by the applicant or licensee for the purpose of writing controlled business. "Controlled business" means:

(1) insurance written on the interests of the licensee or those of his immediate family or of his employer; or

(2) insurance covering himself or members of his immediate family or a corporation, limited liability company, association, or partnership, or the officers, directors, substantial stockholders, partners, members, managers, employees of such a corporation, limited liability company, association, or partnership, of which he is or a member of his immediate family is an officer, director, substantial stockholder, partner, member, manager, associate, or employee.

However, this section does not apply to insurance written or interests insured in connection with or arising out of credit transactions. Such a license shall be deemed to have been or intended to be used for the purpose of writing controlled business, if the commissioner finds that during any twelve (12) month period the aggregate commissions earned from such controlled business has exceeded twenty-five percent (25%) of the aggregate commission earned on all business written by such applicant or licensee during the same period.

(d) An insurer, insurance agent, surplus lines insurance agent, or limited insurance representative may not pay any commission, brokerage, or other valuable consideration to any person for services as an insurance agent, surplus lines insurance agent, or limited insurance



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representative within Indiana, unless the person held, at the time the services were performed, a valid license for that kind of insurance as required by the laws of Indiana for such services. A person, other than a person duly licensed by the state of Indiana as an insurance agent, surplus lines insurance agent, or limited insurance representative, may not, at the time such services were performed, accept any such commission, brokerage, or other valuable consideration. However, any such person duly licensed under this chapter may:

(1) pay or assign his commissions or direct that his commissions be paid:

(A) to a partnership of which he is a member, an employee, or an agent; or

(B) to a corporation of which he is an officer, employee, or agent; or

(2) pay, pledge, assign, or grant a security interest in the person's commission to a lending institution as collateral for a loan if the payment, pledge, assignment, or grant of a security interest is not, directly or indirectly, in exchange for insurance services performed.

This section shall not prevent payment or receipt of renewal or other deferred commissions to or by any person entitled thereto under this section.

(e) The license shall state the name and resident address of the licensee, date of issue, the renewal or expiration date, the line or lines of insurance covered by the license, and such other information as the commissioner considers proper for inclusion in the license.

(f) All licenses issued under this chapter shall continue in force not longer than twenty-four (24) months. The insurance department shall establish procedures for the renewal of licenses. **A license may be renewed after it expires as follows:**

(1) ~~If~~ A person **who** applies for a **license** renewal ~~of his license~~ **not** more than twenty-four (24) months ~~but no more than sixty (60) months~~ after it ~~the person's license~~ expires ~~he~~ must:

pay a reinstatement fee of one hundred dollars (\$100) plus current fees; or

(A) **satisfy the requirements of IC 27-1-15.5-7.1(b); and**  
 (B) pass to the department's satisfaction **the laws portion of** the examination required of an applicant **under IC 27-1-15.5-4(g)(5)** for the type of license for which the person seeks renewal.

(2) ~~If~~ A person **who** applies for a **license** renewal ~~of his license~~ more than ~~sixty (60)~~ **twenty-four (24)** months after it expires ~~he~~

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must **successfully complete the education requirements of IC 27-1-15.5-4(e)** and pass to the department's satisfaction the examination required of an applicant for the type of license for which the person seeks renewal.

All license renewals must be accompanied by payment of the renewal fee as provided in section 4(d) of this chapter.

(g) A license as an insurance agent, surplus lines insurance agent, or limited insurance representative may not be required of the following:

(1) Any regular salaried officer or employee of an insurance company, or of a licensed insurance agent, surplus lines insurance agent, or limited insurance representative if such officer or employee's duties and responsibilities do not include the negotiation or solicitation of insurance.

(2) Persons who secure and furnish information for the purpose of group or wholesale life insurance, or annuities, or group, blanket, or franchise health insurance, or for enrolling individuals under such plans or issuing certificates thereunder or otherwise assisting in administering such plans, where no commission is paid for such service.

(3) Employers or their officers or employees, or the trustees of any employee trust plan, to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company, provided that such employers, officers, employees, or trustees are not in any manner compensated, directly or indirectly, by the insurance company issuing such insurance.

(h) An insurer shall require that a person who, on behalf of the insurer, makes any oral, written, or electronic communication with an individual regarding insurance coverage, rates, benefits, or policy terms, for the purpose of soliciting insurance shall be licensed under this chapter.

(i) A violation of subsection (h) is deemed an unfair method of competition and an unfair and deceptive act and practice in the business of insurance subject to the provisions of IC 27-4-1-4."

Page 2, delete lines 11 through 12, begin a new line block indented and insert:

(7) **A:**

(A) conviction of; or

(B) **plea of guilty, no contest, or nolo contendere to;**

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a felony or misdemeanor involving moral turpitude."

Page 4, between lines 5 and 6, begin a new paragraph and insert:

"SECTION 14. IC 27-1-20-33, AS AMENDED BY P.L.251-1995, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 33. (a) As used in this section, "insurer" refers to each:

- (1) domestic company;
- (2) foreign company; and
- (3) alien company;

that is authorized to transact business in Indiana.

(b) As used in this section, "NAIC" means the National Association of Insurance Commissioners.

(c) On or before March 1 of each year, an insurer shall file with the National Association of Insurance Commissioners **and with the department** a copy of the insurer's annual statement convention blank and additional filings prescribed by the commissioner for the preceding year. An insurer shall also file quarterly statements with the NAIC **and with the department** on or before May 15, August 15, and November 15 of each year in a form prescribed by the commissioner. The information filed with the NAIC under this subsection:

- (1) must be:
  - (A) in the same format; and
  - (B) of the same scope;
 as is required by the commissioner under section 21 of this chapter;
- (2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and
- (3) must be filed on diskette in accordance with NAIC diskette filing specifications.

The commissioner may grant an exemption from the requirement of subdivision (3) to domestic companies that operate only in Indiana. If an insurer files any amendment or addendum to an insurer's annual statement convention blank or quarterly statement with the commissioner, the insurer shall also file a copy of the amendment or addendum with the NAIC. Annual and quarterly financial statements are deemed filed with the NAIC when delivered to the address designated by the NAIC for the filings regardless of whether the filing is accompanied by any applicable fee.

(d) The commissioner may, for good cause, grant an insurer an extension of time for the filing required by subsection (c).

(e) A foreign company that:

- (1) is domiciled in a state that has a law substantially similar to

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subsection (c); and

(2) complies with that law;

shall be considered to be in compliance with this section.

(f) In the absence of actual malice:

(1) members of the NAIC;

(2) duly authorized committees, subcommittees, and task forces of members of the NAIC;

(3) delegates of members of the NAIC;

(4) employees of the NAIC; and

(5) other persons responsible for collecting, reviewing, analyzing, and disseminating information developed from the filing of annual statement convention blanks under this section;

shall be considered to be acting as agents of the commissioner under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of the collection, review, analysis, or dissemination of the data and information collected from the filings required by this section.

(g) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of an insurer that fails to file the insurer's annual statement convention blank or quarterly statements with the NAIC **or with the department** within the time allowed by subsection (c) or (d)."

Page 6, between lines 25 and 26, begin a new paragraph and insert:

"SECTION 16. IC 27-7-2-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 7. Stock companies and nonstock companies shall be represented in the bureau management and on all committees. **Participation in the bureau management and its committees is restricted to those companies maintaining at least five million dollars (\$5,000,000) in worker's compensation writings in Indiana.** In case of a tie vote in any committee or governing body of said bureau, the insurance commissioner shall decide the matter.

SECTION 17. IC 27-7-2-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 8. The bureau shall admit to membership every company **holding a certificate of authority and** lawfully engaged in whole or in part in writing worker's compensation insurance in Indiana.

SECTION 18. IC 27-7-2-20 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 20. (a) Every company shall adhere to manual rules, policy forms, a statistical plan, a classification system, and experience rating plan filed by the bureau and approved by the commissioner.

(b) The commissioner shall designate the bureau to assist in



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gathering, compiling, and reporting relevant statistical information. Every company shall record and report its worker's compensation experience to the bureau according to the statistical plan approved by the commissioner. The report shall include any deviation from the filed recommended minimum premiums and rates, in total and by classification. The bureau shall annually submit data concerning these deviations to the department. Upon receipt, the department shall evaluate the data and prepare a report concerning the effect of competitive rating in Indiana. The department shall ~~submit fifty (50) copies of~~ **make** the report **available** to the legislative services agency ~~by no not later than October 31, 1990; and no later than October 31 of each year thereafter. The department shall notify each member of the general assembly that the report is available from the legislative services agency and shall briefly summarize the conclusions of the report for each member.~~

(c) Every company shall adhere to the approved manual rules, policy forms, statistical plan, classification system, and experience rating plan in the recording and reporting of data to the bureau.

(d) Copies of all approved classifications, rules, and forms shall be provided to the worker's compensation board.

SECTION 19. IC 27-7-9-8, AS AMENDED BY P.L.116-1994, SECTION 57, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 8. (a) Coverage for damage due to mine subsidence must be available as an additional form of coverage under any insurance policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located in a county identified under section 6 of this chapter. The mine subsidence coverage must be available in an amount adequate to indemnify the insured to the extent of the loss in actual cash value of the covered structure due to mine subsidence, less a deductible equal to two percent (2%) of the insured value of the structure under the policy. However, the deductible must be no less than two hundred fifty dollars (\$250) and no more than five hundred dollars (\$500).

(b) An insurer proposing to issue ~~or renew~~ a policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to cover one (1) or more structures located in a county identified under section 6 of this chapter shall inform the ~~policyholder~~ or prospective policyholder of the availability of mine subsidence coverage under this section. An insurer shall inform the ~~policyholder~~ or prospective policyholder of the availability of mine subsidence coverage under this subsection when a policy described in this subsection is issued. ~~and each time a policy described in this subsection is renewed.~~ However, an insurer is not



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required to inform a ~~policyholder or~~ prospective policyholder of the availability of mine subsidence coverage if ~~(1) the issuance or renewal of the policy will take place after June 30, 1997; 2000. or (2) the policy to be renewed already includes mine subsidence coverage.~~

(c) When an insurer informs a ~~policyholder or~~ prospective policyholder of the amount of the premium for the mine subsidence coverage that is available as an additional form of coverage under a policy as required by subsection (a), the premium for the mine subsidence coverage must be stated separately from the premium for the other coverage provided by the policy. The amount of the premium for mine subsidence coverage provided by an insurer under this section must be set according to the premium level set by the commissioner under section 10 of this chapter.

(d) Except as provided in subsection (f), an insurance policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located in a county identified under section 6 of this chapter must include the mine subsidence coverage provided for under subsection (a) if the prospective insured (before issuance of the policy) or the insured (before renewal of the policy) indicates that the coverage is to be included in the policy.

(e) An insurer is not required to provide mine subsidence coverage under subsection (a) under any insurance policy in an amount exceeding the amount that is reimbursable from the fund under section 9(a)(4) of this chapter.

(f) An insurer must decline to make the mine subsidence coverage provided for under subsection (a) available to cover a structure evidencing unrepaired mine subsidence damage, until necessary repairs are made. An insurer may also decline to make the mine subsidence coverage available under an insurance policy if the insurer has:

- (1) declined to issue the policy;
- (2) declined to renew the policy; or
- (3) canceled all coverage under the policy for underwriting reasons unrelated to mine subsidence.

SECTION 20. IC 27-8-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this



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section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with the commissioner. This section is applicable also to assessment companies and fraternal benefit associations or societies.

(c) No policy of accident and sickness insurance may be issued, nor may any application, rider, or endorsement be used in connection with a policy of accident and sickness insurance, until the expiration of thirty (30) days after it has been filed under subsection (b), unless the commissioner gives his written approval to it before the expiration of the thirty (30) day period.

(d) The commissioner may, within thirty (30) days after the filing of any ~~form policy, application, rider, or endorsement~~ under subsection (b), disapprove the ~~form~~: **filing**:

- (1) if, in the case of an individual accident and sickness ~~form~~: **filing**, the benefits provided therein are unreasonable in relation to the premium charged; or
- (2) if, in the case of an individual, blanket, or group accident and sickness ~~form~~: **filing**, it contains a provision or provisions that are unjust, unfair, inequitable, misleading, or deceptive or that encourage misrepresentation of the policy.

(e) If the commissioner notifies the insurer that ~~filed a form made a filing~~ that the ~~form filing~~ does not comply with this section, it is unlawful thereafter for the insurer to issue ~~or use the form or use it filing~~ in connection with any policy. In the notice given under this subsection, the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer.

(f) The commissioner may at any time, after a hearing of which not less than twenty (20) days written notice has been given to the insurer, withdraw his approval of any ~~form filed filing~~ under subsection (b) on any of the grounds stated in this section. It is unlawful for the insurer to issue ~~the form~~ or use ~~it~~ **the filing** in connection with any policy after the effective date of the withdrawal of approval. The notice of any hearing called under this subsection must specify the matters to be considered at the hearing, and any decision affirming disapproval or



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directing withdrawal of approval under this section must be in writing and must specify the reasons for the decision.

(g) Any order or decision of the commissioner under this section is subject to review under IC 4-21.5.

SECTION 21. IC 27-8-5-3, AS AMENDED BY P.L.93-1995, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 3. (a) Except as provided in subsection (c), each policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one (1) or more of the provisions corresponding provisions of different wording approved by the commissioner that are in each instance no less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows: TIME LIMIT ON CERTAIN DEFENSES: (A) After two (2) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two (2) year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy of denial of a claim during such initial two (2) year period, nor to limit the application of subsection (b), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

(1) until at least age fifty (50); or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue;

may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option)

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under the caption "INCONTESTABLE": After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(B) No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.

(3) A provision as follows: GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision: "Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

Each policy in which the insurer reserves the right to refuse renewal on an individual basis shall provide, in substance, in a provision of the policy, in an endorsement on the policy, or in a rider attached to the policy, that subject to the right to terminate the policy upon non-payment of premium when due, such right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary, or in the case of lapse and reinstatement at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement, and that any refusal or renewal shall be without prejudice to any claim originating while the policy is in force. The preceding sentence shall not apply to accident insurance only policies.

(4) A provision as follows: REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. Provided, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth



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day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

- (1) until at least fifty (50) years of age; or
- (2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

(5) A provision as follows: **NOTICE OF CLAIM:** Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at \_\_\_\_\_ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, the insured shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insurer's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.



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(6) A provision as follows: CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(7) A provision as follows: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

(8) A provision as follows: TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid \_\_\_\_\_ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not

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competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$ \_\_\_\_\_ (insert an amount which shall not exceed \$1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

For the purposes of this section a "minor" is a person under the age of eighteen (18) years. A person eighteen (18) years of age or over is competent, insofar as the person's age is concerned, to sign a valid release.

(10) A provision as follows: **PHYSICAL EXAMINATIONS AND AUTOPSY:** The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows: **LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(12) A provision as follows: **CHANGE OF BENEFICIARY:** Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

**(13) A provision as follows: GUARANTEED RENEWABILITY: In compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), renewability is guaranteed.**



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(b) Except as provided in subsection (c), no policy delivered or issued for delivery to any person in Indiana shall contain provisions respecting the matters set forth below unless the provisions are in the words in which the provisions appear in this section. However, the insurer may use, instead of any provision, a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any substitute provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: **CHANGE OF OCCUPATION:** If the insured be injured or contract sickness after having changed the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision as follows: **MISSTATEMENT OF AGE:** If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision as follows: **OTHER INSURANCE IN THIS INSURER:** If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for \_\_\_\_\_



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(insert type of coverage or coverages) in excess of \$ \_\_\_\_\_ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate. Or, instead of that provision: Insurance effective at any one (1) time on the insured under a like policy or policies, in this insurer is limited to the one (1) such policy elected by the insured, the insured's beneficiary or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows: **INSURANCE WITH OTHER INSURER:** If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including

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any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(5) A provision as follows: **INSURANCE WITH OTHER INSURERS:** If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "-OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage to the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(6) A provision as follows: **RELATION OF EARNINGS TO INSURANCE:** If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of

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two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars (\$200) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

- (1) until at least fifty (50) years of age; or
- (2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(7) A provision as follows: **UNPAID PREMIUM:** Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) A provision as follows: **CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(9) A provision as follows: **ILLEGAL OCCUPATION:** The insurer



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shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(10) A provision as follows: INTOXICANTS AND NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(c) If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(d) The provisions which are the subject of subsections (a) and (b), or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

(e) "Insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

(f)(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than is provided in this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(f)(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(g) The commissioner may make reasonable rules under IC 4-22-2 concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper, or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.



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SECTION 22. IC 27-8-5-19, AS AMENDED BY P.L.185-1996, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 19. (a) **As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).**

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

- (1) the provisions described in subsection ~~(b)~~ (c); or
- (2) provisions that, in the opinion of the commissioner, are:
  - (A) more favorable to the persons insured; or
  - (B) at least as favorable to the persons insured and more favorable to the policyholder;
 than the provisions set forth in subsection ~~(b)~~ (c).

~~(b)~~ (c) The provisions referred to in subsection ~~(a)(1)~~ (b)(1) are as follows:

- (1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.
- (2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:
  - (A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or
  - (B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.



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(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, **diagnosis, care,** or treatment was received by the person, **or recommended to the person,** during the ~~three hundred sixty-five (365) days~~ **six (6) months** before the **effective enrollment** date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of ~~three hundred sixty-five (365) days,~~ **twelve (12) months** beginning on or after the **effective enrollment** date of the person's coverage; ~~during all of which the person received no medical advice or treatment in connection with the disease or physical condition;~~ or

(ii) the end of ~~the two (2) year~~ **a continuous period of eighteen (18) months** beginning on the **effective enrollment** date of the person's coverage **if the person is a late enrollee.**

(6) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

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- (A) premiums;
- (B) benefits; or
- (C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(7) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement that:

- (A) explains the insurance protection to which the person insured is entitled;
- (B) indicates to whom the insurance benefits are payable; and
- (C) explains any family member's or dependent's coverage under the policy.

(8) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(9) A provision stating that:

- (A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and
- (B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(10) A provision stating that:

- (A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;
- (B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90)

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days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(11) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid within forty-five (45) days after the insurer receives all information required to determine liability under the terms of the policy; and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(12) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars (\$5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(13) A provision that the insurer has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(14) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of

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loss is filed in accordance with the requirements of the policy, and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(15) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(16) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

- (A) incapable of self-sustaining employment because of mental retardation or a physical disability; and
- (B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

**(17) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).**

~~(c)~~ **(d)** Subsection ~~(b)(5)~~, ~~(b)(7)~~, **(c)(5)**, **(c)(7)**, and ~~(b)(12)~~ **(c)(12)** do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.



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(d) (e) If any policy provision required under subsection (b) (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

SECTION 23. IC 27-8-10-1, AS AMENDED BY P.L.188-1995, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) **"Church plan" means a plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).**

(f) (f) "Commissioner" refers to the insurance commissioner.

(g) **"Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).**

(h) (h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) **"Federally eligible individual" means an individual:**

**(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:**

- (A) group health plan;**
- (B) governmental plan; or**
- (C) church plan;**

**or health insurance coverage in connection with any of these plans;**

**(2) who is not eligible for coverage under:**

- (A) a group health plan;**
- (B) Part A or Part B of Title XVIII of the federal Social Security Act; or**
- (C) a state plan under Title XIX of the federal Social Security Act (or any successor program);**



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and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(j) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(k) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(g) (l) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(h) (m) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(i) (n) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(j) (o) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing,



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or healing human illness or injury.

(~~t~~) (p) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(~~t~~) (q) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(~~m~~) (r) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(s) "**Medical care payment**" means amounts paid for:

- (1) **the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;**
- (2) **transportation primarily for and essential to Medicare services referred to in subdivision (1); and**
- (3) **insurance covering medical care referred to in subdivisions (1) and (2).**

(~~m~~) (t) "Medically necessary" means health care services that the association has determined:

- (1) are recommended by a legally qualified physician;
- (2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and
- (3) are not primarily for the scholastic education or vocational training of the provider or patient.

(~~t~~) (u) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(~~p~~) (v) "Policy" means a contract, policy, or plan of health insurance.

(~~t~~) (w) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(x) "**Preexisting condition**" means:

- (1) **a condition that manifested itself within a period of six (6) months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or**



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**(2) medical advice or treatment was recommended or received within a period of six (6) months before the effective date of coverage.**

(†) (y) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(‡) (z) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

(†) (aa) "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

(†) (bb) "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

(†) (cc) "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

(†) (dd) "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 24. IC 27-8-10-2.1, AS AMENDED BY P.L.255-1995, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 1, 1998]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of ~~five (5) to nine (9)~~ **seven (7) members whose principal residence is in Indiana selected by the members of the association, subject to approval by the commissioner, as follows:**

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**(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.**

**(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.**

**(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.**

**The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. To select the initial board of directors and to initially organize the association, the commissioner shall give notice to all members in Indiana of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member is entitled to one (1) vote in person or by proxy. If the board of directors is not selected within sixty (60) days after the organizational meeting, the commissioner shall appoint the initial board. In approving or selecting members of the board, the commissioner shall consider whether all members are fairly represented. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the money of the association association's funds for expenses incurred by them as members but shall not be otherwise compensated by the association for their services. in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.**

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall



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adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

- (1) establish procedures for the handling and accounting of assets and money of the association;
- (2) establish the amount and method of reimbursing members of the board;
- (3) establish regular times and places for meetings of the board of directors;
- (4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;
- (5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;
- (6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and
- (7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

- (1) Enter into contracts as are necessary or proper to carry out this chapter, **subject to the approval of the commissioner.**
- (2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.
- (3) Take legal action necessary to avoid the payment of improper



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claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than one hundred fifty

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percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. **Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.**

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in

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substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

(l) The association shall pay an agent's referral fee of twenty-five dollars (\$25) to each insurance agent who refers an applicant to the association if that applicant is accepted.

(m) The association and the premium collected by the association shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate net income, or any combination of these, or similar taxes upon revenues or income that may be imposed by the state.

(n) Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or

(2) any member insurer may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

(o) The association shall provide for the option of monthly collection of premiums.

SECTION 25. IC 27-8-10-5.1, AS AMENDED BY P.L.2-1995, SECTION 109, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy ~~who; if,~~ at the effective date of coverage, **the person** has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other

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form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an association policy upon a showing that:

- (1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restriction at a rate equal to or less than the association plan rate restrictions;
- (2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or
- (3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit ~~(1)~~ an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience ~~and~~.

- ~~(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.~~

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

- (1) incapable of self-sustaining employment by reason of mental retardation or physical disability; and
- (2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family

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member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of six (6) months following the effective date of coverage as to a given covered individual for preexisting conditions; as long as:

- (1) the condition manifested itself within a period of six (6) months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or
- (2) medical advice or treatment was recommended or received within a period of six (6) months before the effective date of coverage.

This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured:

(g) (f) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

- (1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or
- (2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

**(g) Subsection (f) does not apply to a person, other than a federally eligible individual, who had previous coverage under an association policy and terminated the coverage or allowed the coverage to terminate for a period exceeding ninety (90) days.**

**(h) Coverage for a preexisting condition of a person described in subsection (g) may not be delayed or restricted to a date later**



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than six (6) months after the effective date. However, the six (6) months must be reduced by one (1) month for each thirty (30) day period of continuous coverage under a health insurance plan, as defined in IC 27-8-15-28(a), that the person had during the twelve (12) months immediately preceding enrollment.

~~(h)~~ (i) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 26. IC 27-8-14-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. (a) An insurer must offer to provide coverage for breast cancer screening mammography in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) The coverage that an insurer must offer to provide under this section must include the following:

(1) If the insured is at least thirty-five (35) but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the insured before she becomes forty (40) years of age.

(2) If the insured is:

(A) at least forty (40) but less than fifty (50) years of age; and

(B) not a woman at risk;

coverage for one (1) breast cancer screening mammography performed upon the insured in every two (2) year period:

(3) If the insured is:

(A) at least forty (40) but less than fifty (50) years of age; and

(B) a woman at risk;

one (1) breast cancer screening mammography performed upon the insured every year:

~~(4)~~ If the insured is at least ~~fifty (50)~~ **forty (40)** years of age, ~~whether or not at risk~~; one (1) breast cancer screening mammography performed upon the insured every year.

**(3) Any additional views that are required for proper evaluation.**

**(4) Ultrasound services, if determined medically necessary by the physician treating the insured.**

(c) The coverage that an insurer must offer to provide under this section must provide reimbursement for breast cancer screening mammography at a level at least as high as:

(1) the limitation on payment for screening mammography services established in 42 CFR 405.534(b)(3) according to the

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Medicare Economic Index at the time the breast cancer screening mammography is performed; or

(2) the rate negotiated by a contract provider according to the provisions of the insurance policy;

whichever is lower.

(d) The coverage that an insurer must offer to provide under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.

(e) The coverage that an insurer must offer is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

SECTION 27. IC 27-8-15-10.5, AS AMENDED BY P.L. 190-1996, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 10.5. (a) As used in this chapter, "late enrollee" means an eligible employee or a dependent of an eligible employee who did not request enrollment in a health insurance plan of a small employer during the initial enrollment period during which the individual was entitled to enroll under the health insurance plan.

(b) The term "**late enrollee**" does not include an eligible employee **or the dependent of an eligible employee: who meets any of the following conditions:**

(1) ~~The eligible employee (A) who~~ was covered under a health insurance plan at the time of the initial enrollment;

~~(B) lost coverage under a health insurance plan as a result of:~~

~~(i) the termination of employment or eligibility;~~

~~(ii) the involuntary termination of the health insurance plan;~~

~~(iii) the death of a spouse; or~~

~~(iv) the dissolution of marriage; and~~

~~(C) requests enrollment not later than thirty (30) days after losing coverage under a health insurance plan:~~

**or had health insurance coverage at the time coverage was previously offered to the employee or to the dependent of the employee;**

**(2) who stated in writing at the time coverage was offered that coverage under another health insurance plan was the reason for declining the enrollment, but only if the insurer required such a statement at the time and provided the employee with notice of the requirement (and the consequences of the requirement) at the time;**

**(3) whose coverage under this subsection:**

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(A) was under a COBRA continuation provision and the coverage under the provision was exhausted; or  
 (B) was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and

(4) who requests enrollment under the terms of the plan not later than thirty (30) days after the date of exhaustion of coverage as described in subdivision (3)(A) or the termination of coverage or employer contributions as described in subdivision (3)(B).

(⇒) (c) The term "late enrollee" does not include an eligible employee who is employed by a small employer that offers multiple health insurance plans and the eligible employee who elects a different plan during an open enrollment period.

(⇒) (d) The term "late enrollee" does not include an eligible employee or the eligible employee's spouse or minor or dependent child where:

(1) a court has ordered that health insurance coverage be provided for a the spouse or a minor or dependent child of an eligible employee under the eligible employee's insurance plan; and

(2) the request for enrollment is made not more than thirty (30) days after the issuance of the court order.

SECTION 28. IC 27-8-15-14, AS AMENDED BY P.L.190-1996, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 14. As used in this chapter, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least ~~three~~ (⇒) **two (2)** but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

SECTION 29. IC 27-8-15-19, AS AMENDED BY P.L.93-1995, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 19. Except as provided in section 20 of this chapter, a small employer insurer may only cancel or refuse to renew a health insurance plan for the following reasons:

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- (1) Nonpayment of required premiums.
- (2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative.
- (3) Noncompliance with the plan's provisions:
- (4) The number of individuals covered under the plan is less than the number of percentage of eligible individuals required by percentage requirements under the plan.
- (5) The small employer is no longer actively engaged in the business in which the small employer was engaged on the effective date of the plan.
- (3) The small employer has failed to comply with a material plan provision relating to employer contribution or group participation rules.**
- (4) In the case of a small employer insurer that offers coverage in a market through a network plan, there is no longer any insured individual in connection with the plan who lives, resides, or works:**
- (A) in the service area of the small employer insurer; or**
- (B) in the area for which the issuer is authorized to do business.**
- (5) In the case of coverage that is made available through one (1) or more bona fide associations, the membership of the small employer in the association ceases, but only if the coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to an insured individual.**
- (6) In a case in which an insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small employer market, that coverage may be discontinued by the insurer only if:**
- (A) the insurer provides notice of the insurer's intent to discontinue the coverage to each small employer provided with the coverage;**
- (B) the insurer offers the option to purchase all other health insurance coverage currently being offered by the insurer to the small employer to each small employer that is provided with the coverage; and**
- (C) in exercising the option to discontinue the coverage in offering the option of coverage under clause (B), the insurer acts uniformly without regard to:**



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- (i) the claims experience of the small employer groups;  
or  
(ii) any health status related factor relating to any eligible employee or dependent of an eligible employee who is covered or who may become eligible for the coverage.

SECTION 30. IC 27-8-15-27, AS ADDED BY P.L.93-1995, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 27. A health insurance plan provided by a small employer insurer to a small employer must comply with the following:

- (1) The benefits provided by a plan to an eligible employee enrolled in the plan may not be excluded, limited, or denied for more than nine (9) months after the effective date of the coverage because of a preexisting condition of the eligible employee, the eligible employee's spouse, or the eligible employee's dependent.
- (2) The plan may not define a preexisting condition, rider, or endorsement more restrictively than as ~~(A) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the nine (9) months immediately preceding the effective date of enrollment in the plan;~~ ~~(B) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the ~~nine (9)~~ six (6) months immediately preceding the effective date of enrollment in the plan. or~~

~~(C) a pregnancy existing on the effective date of enrollment in the plan.~~

SECTION 31. IC 27-8-15-28, AS AMENDED BY P.L.190-1996, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 28. (a) As used in this section, "health insurance plan" means coverage provided under any of the following:

- (1) A hospital or medical expense incurred policy or certificate.
- (2) A hospital or medical service plan contract.
- (3) A health maintenance organization subscriber contract.
- (4) Medicare or Medicaid.
- (5) An employer based health insurance arrangement.
- (6) An individual health insurance policy.
- (7) A policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.
- (8) An employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.
- (9) A conversion policy issued under section 31 or 31.1 of this chapter.



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(b) Except as provided in section 29 of this chapter, a small employer insurer shall waive the exclusion period described in section 27 of this chapter applicable to a preexisting condition or the limitation period with respect to a particular service in a health insurance plan for the time an eligible employee or a dependent of an eligible employee was previously covered by a health insurance plan if the following conditions are met:

- (1) The eligible employee or a dependent of the eligible employee was previously covered by a health insurance plan that provided benefits with respect to the particular service.
- (2) Coverage under the health insurance plan was continuous to a date not more than ~~thirty (30)~~ **sixty-three (63)** days before the effective date of enrollment by:
  - (A) the eligible employee; or
  - (B) a dependent of the eligible employee.

(c) In determining whether an eligible employee or a dependent of the eligible employee meets the requirements of subsection (b)(2), a waiting period imposed by a small employer insurer or small employer before new coverage may become effective must be excluded from the calculation.

(d) This section does not preclude the application of any waiting period applicable to all new enrollees under a plan."

Page 7, between lines 30 and 31, begin a new paragraph and insert:  
 "SECTION 33. IC 27-8-15-34.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: **Sec. 34.1. Except as provided in 29 U.S.C. 1191a and 42 U.S.C. 300gg, a small employer insurer must:**

- (1) offer to any small employer all products that are approved for sale in the small group market and that the insurer is actively marketing; and**
- (2) accept any employer that applies for any of those products."**

Page 7, between lines 36 and 37, begin a new paragraph and and insert:

"SECTION 35. IC 27-12-3-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 5. **(a) Except as provided in subsection (b)**, the receipt of proof of financial responsibility and the surcharge constitutes compliance with section 2 of this chapter:

- (1) as of the date on which they are received; or
- (2) as of the effective date of the policy;

if this proof is filed with and the surcharge paid to the department of



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insurance not later than ninety (90) days after the effective date of the insurance policy. If proof of financial responsibility and the payment of the surcharge is not made within ninety (90) days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid:

**(b) If an insurer files proof of financial responsibility and makes payment of the surcharge to the department of insurance at least ninety-one (91) days but not more than one hundred eighty (180) days after the policy effective date, the health care provider is in compliance with section 2 of this chapter, if the insurer demonstrates to the satisfaction of the commissioner that the insurer:**

- (1) received the premium and surcharge in a timely manner; and**
- (2) failed to transmit the surcharge in a timely manner.**

**(c) If the commissioner accepts a filing as timely under subsection (b), the filing must be accompanied by a penalty amount as follows:**

- (1) Ten percent (10%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least ninety-one (91) days and not more than one hundred twenty (120) days after the original effective date of the policy.**
- (2) Twenty percent (20%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least one hundred twenty-one (121) days and not more than one hundred fifty (150) days after the original effective date of the policy.**
- (3) Fifty percent (50%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least one hundred fifty-one (151) days and not more than one hundred eighty (180) days after the original effective date of the policy.**

SECTION 36. IC 27-13-7-3, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

- (1) The name and address of the health maintenance organization.
- (2) Eligibility requirements.
- (3) Benefits and services within the service area.
- (4) Emergency care benefits and services.
- (5) Any out-of-area benefits and services.



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- (6) Copayments, deductibles, and other out-of-pocket costs.
- (7) Limitations and exclusions.
- (8) Enrollee termination provisions.
- (9) Any enrollee reinstatement provisions.
- (10) Claims procedures.
- (11) Enrollee grievance procedures.
- (12) Continuation of coverage provisions.
- (13) Conversion provisions.
- (14) Extension of benefit provisions.
- (15) Coordination of benefit provisions.
- (16) Any subrogation provisions.
- (17) A description of the service area.
- (18) The entire contract provisions.
- (19) The term of the coverage provided by the contract.
- (20) Any right of cancellation of the group or individual contract holder.
- (21) Right of renewal provisions.
- (22) Provisions regarding reinstatement of a group or an individual contract holder.
- (23) Grace period provisions.
- (24) A provision on conformity with state law.
- (25) A provision or provisions that comply with the:**
  - (A) guaranteed renewability; and**
  - (B) group portability;****requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).**

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract."

Page 9, after line 11, begin a new paragraph and insert:

"SECTION 39. IC 27-13-29-1, AS AMENDED BY P.L.255-1995, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) Except as provided in subsection (b) or as otherwise provided in this article or IC 27:

(1) IC 27; and

(2) the provisions of IC 16 regulating hospitals;

do not apply to any health maintenance organization or limited service health maintenance organization **(as defined in IC 27-13-34-4)** that is granted a certificate of authority under this article. However, this section does not apply to an insurer or a hospital that is licensed under Indiana law, except with respect to the health maintenance organization activities of the hospital or insurer that are authorized and regulated under this article.



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(b) Every:

- (1) health maintenance organization; **and**
- (2) **limited service health maintenance organization (as defined in IC 27-13-34-4);**

authorized to do business in Indiana is subject to IC 27-4-1 relating to unfair methods of competition and unfair or deceptive acts or practices to the extent that IC 27-4-1 does not conflict with this article. If a provision in IC 27-4-1 conflicts with this article, this article governs and controls.

SECTION 40. IC 34-4-12.6-1, AS AMENDED BY P.L.147-1997, SECTION 74, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 1. (a) As used in this chapter, "professional health care provider" means:

- (1) a physician licensed under IC 25-22.5;
- (2) a dentist licensed under IC 25-14;
- (3) a hospital licensed under IC 16-21;
- (4) a podiatrist licensed under IC 25-29;
- (5) a chiropractor licensed under IC 25-10;
- (6) an optometrist licensed under IC 25-24;
- (7) a psychologist licensed under IC 25-33;
- (8) a pharmacist licensed under IC 25-26;
- (9) a health facility licensed under IC 16-28-2;
- (10) a registered or licensed practical nurse licensed under IC 25-23;
- (11) a physical therapist licensed under IC 25-27;
- (12) a home health agency licensed under IC 16-27-1;
- (13) a community mental health center (as defined in IC 12-7-2-38);
- (14) a health care organization whose members, shareholders, or partners are:
  - (A) professional health care providers described in subdivisions (1) through (13);
  - (B) professional corporations comprised of health care professionals (as defined in IC 23-1.5-1-8); or
  - (C) professional health care providers described in subdivisions (1) through (13) and professional corporations comprised of persons described in subdivisions (1) through (13);
- (15) a private psychiatric hospital licensed under IC 12-25;
- (16) a preferred provider organization (including a preferred provider arrangement or reimbursement agreement under IC 27-8-11);

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(17) a health maintenance organization (as defined in IC 27-13-1-19) or a limited service health maintenance organization (as defined in IC 27-13-34-4);

(18) a respiratory care practitioner certified under IC 25-34.5;

(19) an occupational therapist certified under IC 25-23.5;

(20) a state institution (as defined in IC 12-7-2-184);

(21) a clinical social worker who is licensed under IC 25-23.6-5-2;

(22) a managed care provider (as defined in IC 12-7-2-127(b)); or

(23) a nonprofit health care organization affiliated with a hospital that is owned or operated by a religious order, whose members are members of that religious order.

(b) As used in this chapter, "evaluation of patient care" relates to:

(1) the accuracy of diagnosis;

(2) the propriety, appropriateness, quality, or necessity of care rendered by a professional health care provider; and

(3) the reasonableness of the utilization of services, procedures, and facilities in the treatment of individual patients.

As used in this chapter, the term does not relate to charges for services or to methods used in arriving at diagnoses.

(c) As used in this chapter, "peer review committee" means a committee that:

(1) has the responsibility of evaluation of:

(A) qualifications of professional health care providers;

(B) patient care rendered by professional health care providers; or

(C) the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint, and the complaint is based on the competence or professional conduct of an individual health care provider which competence or conduct affects or could affect adversely the health or welfare of a patient or patients; and

(2) meets the following criteria:

(A) The committee is organized:

(i) by a state, regional, or local organization of professional health care providers or by a nonprofit foundation created by the professional organization for purposes of improvement of patient care;

(ii) by the professional staff of a hospital, another health care facility, a nonprofit health care organization (under subsection (a)(23)), or a professional health care

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organization;

(iii) by state or federal law or regulation;

(iv) by a governing board of a hospital, a nonprofit health care organization (under subsection (a)(23)), or professional health care organization;

(v) as a governing board or committee of the board of a hospital, a nonprofit health care organization (under subsection (a)(23)), or professional health care organization;

(vi) by an organization, a plan, or a program described in subsection (a)(16) through (a)(17);

(vii) as a hospital or a nonprofit health care organization (under subsection (a)(23)) medical staff or a section of that staff; or

(viii) as a governing board or committee of the board of a professional health care provider (as defined in subsection (a)(16) through (a)(17)).

(B) At least fifty percent (50%) of the committee members are:

(i) individual professional health care providers, the governing board of a hospital, the governing board of a nonprofit health care organization (under subsection (a)(23)), or professional health care organization, or the governing board or a committee of the board of a professional health care provider (as defined in subsection (a)(16) through (a)(17)); or

(ii) individual professional health care providers and the committee is organized as an interdisciplinary committee to conduct evaluation of patient care services.

However, "peer review committee" does not include a medical review panel created under IC 27-12-10.

(d) As used in this chapter, "professional staff" means:

(1) all individual professional health care providers authorized to provide health care in a hospital or other health care facility; or

(2) the multidisciplinary staff of a community mental health center (as defined in IC 12-7-2-38).

(e) As used in this chapter, "personnel of a peer review committee" means not only members of the committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity.

(f) As used in this chapter, "in good faith" refers to an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the

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facts known. In all actions to which this chapter applies, good faith shall be presumed, and malice shall be required to be proven by the person aggrieved.

(g) As used in this chapter, "professional health care organization" refers to an organization described in subsection (a)(14).

**(h) As used in this chapter, "professional review activity" means an activity of a peer review committee of a hospital licensed under IC 16-21 with respect to a professional health care provider to:**

- (1) determine whether the professional health care provider may have privileges with respect to the hospital;**
- (2) determine the scope or conditions of the privileges; or**
- (3) change or modify the privileges.**

**The term includes the establishment and enforcement of standards and rules by the governing board of a hospital concerning practice in the hospital and the granting and retention of privileges within the hospital.**

SECTION 41. IC 34-4-12.6-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 3. (a) There shall be no liability on the part of, and no action of any nature shall arise against, **an organization, a peer review committee, or** the personnel of a peer review committee for any act, statement made in the confines of the **organization or** committee, or proceeding ~~thereof of the organization or committee~~ made in good faith in regard to:

- (1) evaluation of patient care as that term is defined and limited in section 1(b) of this chapter; or**
- (2) professional review activity as defined and limited in section 1(h) of this chapter.**

(b) Notwithstanding any other law, a peer review committee, an organization, or any other person who, in good faith and as a witness or in some other capacity, furnishes records, information, or assistance to a peer review committee that is engaged in:

- (1) the evaluation of the qualifications, competence, or professional conduct of a professional health care provider; or
- (2) the evaluation of patient care;

is immune from any civil action arising from the furnishing of the records, information, or assistance, unless the person knowingly furnishes false records or information.

(c) The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(d) No restraining order or injunction shall be issued against a peer



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review committee or any of the personnel thereof of the committee to interfere with the proper functions of the committee acting in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(e) If the action of the peer review committee meets the standards specified by this chapter and the federal Health Care Quality Improvement Act of 1986, P.L.99-660, the following persons are not liable for damages under any federal, state, or local law with respect to the action:

- (1) The peer review committee.
- (2) Any person acting as a member or staff to the peer review committee.
- (3) Any person under a contract or other formal agreement with the peer review committee.
- (4) Any person who participates with or assists the peer review committee with respect to the action.

(f) Subsection (e) does not apply to damages under any federal or state law relating to the civil rights of a person including:

- (1) the federal Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq.; and
- (2) the federal Civil Rights Act, 42 U.S.C. 1981, et seq.

SECTION 42. THE FOLLOWING ARE REPEALED [EFFECTIVE APRIL 1, 1998]: IC 6-3-7-5; IC 22-3-2-14.5; IC 22-3-7-34.5; IC 27-8-15-34.

SECTION 43. [EFFECTIVE JULY 1, 1998] (a) **Notwithstanding IC 27-8-10-2.1, the terms of the members of the Indiana Comprehensive Health Insurance Association board of directors serving on August 31, 1998, expire August 31, 1998.**

(b) **The commissioner shall appoint, not later than September 1, 1998, the members of the Indiana Comprehensive Health Insurance Association board of directors as required under IC 27-8-10-2.1(b), as amended by this act, for terms commencing on September 1, 1998.**

(c) **This SECTION expires January 1, 2000.**

SECTION 44. [EFFECTIVE APRIL 1, 1998] (a) **IC 27-8-5-3 and IC 27-8-5-19, both as amended by this act, apply to all accident and sickness policies in force on April 1, 1998.**

(b) **IC 27-8-15-10.5, IC 27-8-15-14, IC 27-8-15-19, IC 27-8-15-27, IC 27-8-15-28, all as amended by this act, and IC 27-8-15-34.1, as added by this act, apply to all small employer health insurance plans in force under IC 27-8-15 on April 1, 1998.**

SECTION 45. **An emergency is declared for this act."**



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Renumber all SECTIONS consecutively.  
and when so amended that said bill do pass.

(Reference is to Senate Bill 292 as reprinted February 3, 1998.)

FRY, Chair

Committee Vote: yeas 13, nays 2.

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