

January 30, 1998

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## HOUSE BILL No. 1287

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DIGEST OF HB 1287 (Updated January 28, 1998 9:04 pm - DI 97)

**Citations Affected:** IC 2-5; IC 6-3; IC 22-3; IC 27-1; IC 27-8; IC 27-13; noncode.

**Synopsis:** Conformity with federal HIPA act. 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, (Continued next page)

**Effective:** April 1, 1998; July 1, 1998.

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**Fry, M. Smith**

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January 13, 1998, read first time and referred to Committee on Insurance, Corporations and Small Business.  
January 29, 1998, amended, reported — Do Pass.

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Digest Continued

or that the person is a federally 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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January 30, 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.

## HOUSE BILL No. 1287

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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

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

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

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

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

41 (a) "Employer" includes the state and any political subdivision, any  
 42 municipal corporation within the state, any individual or the legal



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

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

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

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

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

34 (4) An owner of a sole proprietorship may elect to include the  
 35 owner as an employee under IC 22-3-2 through IC 22-3-6 if the  
 36 owner is actually engaged in the proprietorship business. If the  
 37 owner makes this election, the owner must serve upon the owner's  
 38 insurance carrier and upon the board written notice of the  
 39 election. No owner of a sole proprietorship may be considered an  
 40 employee under IC 22-3-2 through IC 22-3-6 until the notice has  
 41 been received. **If the owner of a sole proprietorship is an**  
 42 **independent contractor in the construction trades and does not**

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1        ~~make the election provided under this subdivision, the owner~~  
 2        ~~must obtain an affidavit of exemption under IC 22-3-2-14.5.~~

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

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

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

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

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

38       (9) (7) A member or manager in a limited liability company may  
 39       elect to include the member or manager as an employee under  
 40       IC 22-3-2 through IC 22-3-6 if the member or manager is actually  
 41       engaged in the limited liability company business. If a member or  
 42       manager makes this election, the member or manager must serve

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

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

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

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

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

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

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

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1 except as follows:

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

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

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

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

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

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

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

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

42 (g) "Billing review standard" means the data used by a billing

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1 review service to determine pecuniary liability.

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

5 (1) The geographic service area served by zip codes with the first  
6 three (3) digits 463 and 464.

7 (2) The geographic service area served by zip codes with the first  
8 three (3) digits 465 and 466.

9 (3) The geographic service area served by zip codes with the first  
10 three (3) digits 467 and 468.

11 (4) The geographic service area served by zip codes with the first  
12 three (3) digits 469 and 479.

13 (5) The geographic service area served by zip codes with the first  
14 three (3) digits 460, 461 (except 46107), and 473.

15 (6) The geographic service area served by the 46107 zip code and  
16 zip codes with the first three (3) digits 462.

17 (7) The geographic service area served by zip codes with the first  
18 three (3) digits 470, 471, 472, 474, and 478.

19 (8) The geographic service area served by zip codes with the first  
20 three (3) digits 475, 476, and 477.

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

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

30 SECTION 4. IC 22-3-7-9, AS AMENDED BY P.L.258-1997(ss),  
31 SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
32 APRIL 1, 1998]: Sec. 9. (a) As used in this chapter, "employer"  
33 includes the state and any political subdivision, any municipal  
34 corporation within the state, any individual or the legal representative  
35 of a deceased individual, firm, association, limited liability company,  
36 or corporation or the receiver or trustee of the same, using the services  
37 of another for pay. If the employer is insured, the term includes his  
38 insurer so far as applicable. However, the inclusion of an employer's  
39 insurer within this definition does not allow an employer's insurer to  
40 avoid payment for services rendered to an employee with the approval  
41 of the employer.

42 (b) As used in this chapter, "employee" means every person,

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1 including a minor, in the service of another, under any contract of hire  
 2 or apprenticeship written or implied, except one whose employment is  
 3 both casual and not in the usual course of the trade, business,  
 4 occupation, or profession of the employer. For purposes of this chapter  
 5 the following apply:

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

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

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

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

32 (A) they are licensed real estate agents;

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

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

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

42 (6) ~~An owner-operator that provides a motor vehicle and the~~

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

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

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

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

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

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

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

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

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

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

40 (g) For the purposes of this chapter, no compensation shall be  
41 payable for or on account of death resulting from any occupational  
42 disease unless death occurs within two (2) years after the date of

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1 disablement. However, this subsection does not bar compensation for  
2 death:

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

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

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

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

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

22 (1) The geographic service area served by zip codes with the first  
23 three (3) digits 463 and 464.

24 (2) The geographic service area served by zip codes with the first  
25 three (3) digits 465 and 466.

26 (3) The geographic service area served by zip codes with the first  
27 three (3) digits 467 and 468.

28 (4) The geographic service area served by zip codes with the first  
29 three (3) digits 469 and 479.

30 (5) The geographic service area served by zip codes with the first  
31 three (3) digits 460, 461 (except 46107), and 473.

32 (6) The geographic service area served by the 46107 zip code and  
33 zip codes with the first three (3) digits 462.

34 (7) The geographic service area served by zip codes with the first  
35 three (3) digits 470, 471, 472, 474, and 478.

36 (8) The geographic service area served by zip codes with the first  
37 three (3) digits 475, 476, and 477.

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

41 (l) As used in this chapter, "pecuniary liability" means the  
42 responsibility of an employer or the employer's insurance carrier for the

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1 payment of the charges for each specific service or product for human  
 2 medical treatment provided under this chapter in a defined community,  
 3 equal to or less than the charges made by medical service providers at  
 4 the eightieth percentile in the same community for like services or  
 5 products."

6 SECTION 5. IC 27-1-3-20 IS AMENDED TO READ AS  
 7 FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 20. (a) The  
 8 commissioner may issue a certificate of authority to any company when  
 9 it shall have complied with the requirements of the laws of this state so  
 10 as to entitle it to do business herein. The certificate shall be issued  
 11 under the seal of the department authorizing and empowering the  
 12 company to make the kind or kinds of insurance specified in the  
 13 certificate. No certificate of authority shall be issued until the  
 14 commissioner has found that:

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

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

28 (b) Every company possessing a certificate of authority shall notify  
 29 the commissioner of the election or appointment of every new director  
 30 or principal officer, within thirty (30) days thereafter. If in the  
 31 commissioner's opinion such a new principal officer or director does  
 32 not meet the standards set forth in this section, he shall request that the  
 33 company effect the removal of such persons from office. If such  
 34 removal is not accomplished as promptly as under the circumstances  
 35 and in the opinion of the commissioner is possible, then upon notice to  
 36 both the company and such principal officer or director and after  
 37 notice, hearing, and right of appeal pursuant to IC 4-21.5, and after a  
 38 finding that such person is incompetent or untrustworthy or of known  
 39 bad character, the commissioner may order the removal of such person  
 40 from office and may, unless such removal is promptly accomplished,  
 41 suspend the company's certificate of authority until there is compliance  
 42 with such order.



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1 (c) No company shall transact any business of insurance **or hold**  
2 **itself out as a company in the business of insurance** in this state  
3 **Indiana** until it shall have received a certificate of authority as  
4 prescribed in this section. ~~and:~~

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

8 SECTION 6. IC 27-8-5-3, AS AMENDED BY P.L.93-1995,  
9 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
10 APRIL 1, 1998]: Sec. 3. (a) Except as provided in subsection (c), each  
11 policy delivered or issued for delivery to any person in this state shall  
12 contain the provisions specified in this subsection in the words in  
13 which the same appear in this section. However, the insurer may, at its  
14 option, substitute for one (1) or more of the provisions corresponding  
15 provisions of different wording approved by the commissioner that are  
16 in each instance no less favorable in any respect to the insured or the  
17 beneficiary. The provisions shall be preceded individually by the  
18 caption appearing in this subsection or, at the option of the insurer, by  
19 appropriate individual or group captions or subcaptions as the  
20 commissioner may approve.

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

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

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

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

- 41 (1) until at least age fifty (50); or
- 42 (2) in the case of a policy issued after forty-four (44) years of age,

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1 for at least five (5) years from its date of issue;  
 2 may contain in lieu of the foregoing the following provision (from  
 3 which the clause in parentheses may be omitted at the insurer's option)  
 4 under the caption "INCONTESTABLE": After this policy has been in  
 5 force for a period of two (2) years during the lifetime of the insured  
 6 (excluding any period during which the insured is disabled), it shall  
 7 become incontestable as to the statements contained in the application.

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

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

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

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

37 (4) A provision as follows: REINSTATEMENT: If any renewal  
 38 premium is not paid within the time granted the insured for payment,  
 39 a subsequent acceptance of premium by the insurer or by any agent  
 40 authorized by the insurer to accept such premium, without requiring in  
 41 connection therewith an application for reinstatement, shall reinstate  
 42 the policy. Provided, that if the insurer or such agent requires an



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1 application for reinstatement and issues a conditional receipt for the  
 2 premium tendered, the policy will be reinstated upon approval of such  
 3 application by the insurer or, lacking such approval, upon the forty-fifth  
 4 day following the date of such conditional receipt unless the insurer has  
 5 previously notified the insured in writing of its disapproval of such  
 6 application. The reinstated policy shall cover only loss resulting from  
 7 such accidental injury as may be sustained after the date of  
 8 reinstatement and loss due to such sickness as may begin more than ten  
 9 (10) days after such date. In all other respects the insured and insurer  
 10 shall have the same rights as they had under the policy immediately  
 11 before the due date of the defaulted premium, subject to any provisions  
 12 endorsed hereon or attached hereto in connection with the  
 13 reinstatement. Any premium accepted in connection with a  
 14 reinstatement shall be applied to a period for which premium has not  
 15 been previously paid, but not to any period more than sixty (60) days  
 16 prior to the date of reinstatement.

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

20 (1) until at least fifty (50) years of age; or

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

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

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

34 Subject to the qualifications set forth below, if the insured suffers  
 35 loss of time on account of disability for which indemnity may be  
 36 payable for at least two (2) years, the insured shall, at least once in  
 37 every six (6) months after having given notice of claim, give to the  
 38 insurer notice of continuance of said disability, except in the event of  
 39 legal incapacity. The period of six (6) months following any filing of  
 40 proof by the insured or any payment by the insurer on account of such  
 41 claim or any denial of liability in whole or in part by the insurer shall  
 42 be excluded in applying this provision. Delay in the giving of such



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1 notice shall not impair the insurer's right to any indemnity which would  
2 otherwise have accrued during the period of six (6) months preceding  
3 the date on which such notice is actually given.

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

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

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

33 (9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for  
34 loss of life will be payable in accordance with the beneficiary  
35 designation and the provisions respecting such payment which may be  
36 prescribed herein and effective at the time of payment. If no such  
37 designation or provision is then effective, such indemnity shall be  
38 payable to the estate of the insured. Any other accrued indemnities  
39 unpaid at the insured's death may, at the option of the insurer, be paid  
40 either to such beneficiary or to such estate. All other indemnities will  
41 be payable to the insured.

42 The following provisions, or either of them, may be included with

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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 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:**

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1 **In compliance with the federal Health Insurance Portability and**  
 2 **Accountability Act of 1996 (P.L.104-191), renewability is**  
 3 **guaranteed.**

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

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

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

42 (3) A provision as follows: OTHER INSURANCE IN THIS

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

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

29 If the foregoing policy provision is included in a policy which also  
 30 contains the next following policy provision there shall be added to the  
 31 caption of the foregoing provision the phrase "EXPENSE INCURRED  
 32 BENEFITS". The insurer may, at its option, include in this provision  
 33 a definition of "other valid coverage," approved as to form by the  
 34 commissioner, which definition shall be limited in subject matter to  
 35 coverage provided by organizations subject to regulation by insurance  
 36 law or by insurance authorities of this or any other state of the United  
 37 States or any province of Canada, and by hospital or medical service  
 38 organizations, and to any other coverage the inclusion of which may be  
 39 approved by the commissioner. In the absence of such definition such  
 40 term shall not include group insurance, automobile medical payments  
 41 insurance, or coverage provided by hospital or medical service  
 42 organizations or by union welfare plans or employer or employee

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1 benefit organizations. For the purpose of applying the foregoing policy  
 2 provision with respect to any insured, any amount of benefit provided  
 3 for such insured pursuant to any compulsory benefit statute (including  
 4 any worker's compensation or employer's liability statute) whether  
 5 provided by a governmental agency or otherwise shall in all cases be  
 6 deemed to be "other valid coverage" of which the insurer has had  
 7 notice. In applying the foregoing policy provision no third party  
 8 liability coverage shall be included as "other valid coverage".

9 (5) A provision as follows: **INSURANCE WITH OTHER**  
 10 **INSURERS:** If there is other valid coverage, not with this insurer,  
 11 providing benefits for the same loss on other than an expense incurred  
 12 basis and of which this insurer has not been given written notice prior  
 13 to the occurrence or commencement of loss, the only liability for such  
 14 benefits under this policy shall be for such proportion of the  
 15 indemnities otherwise provided hereunder for such loss as the like  
 16 indemnities of which the insurer had notice (including the indemnities  
 17 under this policy) bear to the total amount of all like indemnities for  
 18 such loss, and for the return of such portion of the premium paid as  
 19 shall exceed the pro-rata portion for the indemnities thus determined.  
 20 If the foregoing policy provision is included in a policy which also  
 21 contains the next preceding policy provision, there shall be added to the  
 22 caption of the foregoing provision the phrase "-OTHER BENEFITS."  
 23 The insurer may, at its option, include in this provision a definition of  
 24 "other valid coverage," approved as to form by the commissioner,  
 25 which definition shall be limited in subject matter to coverage provided  
 26 by organizations subject to regulation by insurance law or by insurance  
 27 authorities of this or any other state of the United States or any  
 28 province of Canada, and to any other coverage to the inclusion of  
 29 which may be approved by the commissioner. In the absence of such  
 30 definition such term shall not include group insurance or benefits  
 31 provided by union welfare plans or by employer or employee benefit  
 32 organizations. For the purpose of applying the foregoing policy  
 33 provision with respect to any insured, any amount of benefit provided  
 34 for such insured pursuant to any compulsory benefit statute (including  
 35 any worker's compensation or employer's liability statute) whether  
 36 provided by a governmental agency or otherwise shall in all cases be  
 37 deemed to be "other valid coverage" of which the insurer has had  
 38 notice. In applying the foregoing policy provision no third party  
 39 liability coverage shall be included as "other valid coverage".

40 (6) A provision as follows: **RELATION OF EARNINGS TO**  
 41 **INSURANCE:** If the total monthly amount of loss of time benefits  
 42 promised for the same loss under all valid loss of time coverage upon

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

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

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

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

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

40 (8) A provision as follows: CONFORMITY WITH STATE  
 41 STATUTES: Any provision of this policy which, on its effective date,  
 42 is in conflict with the statutes of the state in which the insured resides

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1 on such date is hereby amended to conform to the minimum  
2 requirements of such statutes.

3 (9) A provision as follows: **ILLEGAL OCCUPATION**: The insurer  
4 shall not be liable for any loss to which a contributing cause was the  
5 insured's commission of or attempt to commit a felony or to which a  
6 contributing cause was the insured's being engaged in an illegal  
7 occupation.

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

12 (c) If any provision of this section is in whole or in part inapplicable  
13 to or inconsistent with the coverage provided by a particular form of  
14 policy the insurer, with the approval of the commissioner, shall omit  
15 from such policy any inapplicable provision or part of a provision, and  
16 shall modify any inconsistent provision or part of the provision in such  
17 manner as to make the provision as contained in the policy consistent  
18 with the coverage provided by the policy.

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

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

33 (f)(1) Any policy of a foreign or alien insurer, when delivered or  
34 issued for delivery to any person in this state, may contain any  
35 provision which is not less favorable to the insured or the beneficiary  
36 than is provided in this chapter and which is prescribed or required by  
37 the law of the state under which the insurer is organized.

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

41 (g) The commissioner may make reasonable rules under IC 4-22-2  
42 concerning the procedure for the filing or submission of policies

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1 subject to this chapter as are necessary, proper, or advisable to the  
 2 administration of this chapter. This provision shall not abridge any  
 3 other authority granted the commissioner by law.

4 SECTION 7. IC 27-8-5-19, AS AMENDED BY P.L.185-1996,  
 5 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 6 APRIL 1, 1998]: Sec. 19. (a) **As used in this chapter, "late enrollee"**  
 7 **has the meaning set forth in 26 U.S.C. 9801(b)(3).**

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

- 11 (1) the provisions described in subsection ~~(b)~~ (c); or  
 12 (2) provisions that, in the opinion of the commissioner, are:  
 13 (A) more favorable to the persons insured; or  
 14 (B) at least as favorable to the persons insured and more  
 15 favorable to the policyholder;  
 16 than the provisions set forth in subsection ~~(b)~~ (c).

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

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

31 (2) A provision that the validity of the policy may not be  
 32 contested, except for nonpayment of premiums, after the policy  
 33 has been in force for two (2) years after its date of issue, and that  
 34 no statement made by a person covered under the policy relating  
 35 to the person's insurability may be used in contesting the validity  
 36 of the insurance with respect to which the statement was made,  
 37 unless:

- 38 (A) the insurance has not been in force for a period of two (2)  
 39 years or longer during the person's lifetime; or  
 40 (B) the statement is contained in a written instrument signed  
 41 by the insured person.

42 However, a provision under this subdivision may not preclude the

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1 assertion at any time of defenses based upon a person's  
 2 ineligibility for coverage under the policy or based upon other  
 3 provisions in the policy.

4 (3) A provision that a copy of the application, if there is one, of  
 5 the policyholder must be attached to the policy when issued, that  
 6 all statements made by the policyholder or by the persons insured  
 7 are to be deemed representations and not warranties, and that no  
 8 statement made by any person insured may be used in any contest  
 9 unless a copy of the instrument containing the statement is or has  
 10 been furnished to the insured person or, in the event of death or  
 11 incapacity of the insured person, to the insured person's  
 12 beneficiary or personal representative.

13 (4) A provision setting forth the conditions, if any, under which  
 14 the insurer reserves the right to require a person eligible for  
 15 insurance to furnish evidence of individual insurability  
 16 satisfactory to the insurer as a condition to part or all of the  
 17 person's coverage.

18 (5) A provision specifying any additional exclusions or limitations  
 19 applicable under the policy with respect to a disease or physical  
 20 condition of a person that existed before the effective date of the  
 21 person's coverage under the policy and that is not otherwise  
 22 excluded from the person's coverage by name or specific  
 23 description effective on the date of the person's loss. An exclusion  
 24 or limitation that must be specified in a provision under this  
 25 subdivision:

26 (A) may apply only to a disease or physical condition for  
 27 which medical advice, **diagnosis, care,** or treatment was  
 28 received by the person, **or recommended to the person,**  
 29 during the ~~three hundred sixty-five (365) days~~ **six (6) months**  
 30 before the ~~effective enrollment~~ date of the person's coverage;  
 31 and

32 (B) may not apply to a loss incurred or disability beginning  
 33 after the earlier of:

34 (i) the end of a continuous period of ~~three hundred sixty-five~~  
 35 ~~(365) days;~~ **twelve (12) months** beginning on or after the  
 36 ~~effective enrollment~~ date of the person's coverage; ~~during~~  
 37 ~~all of which the person received no medical advice or~~  
 38 ~~treatment in connection with the disease or physical~~  
 39 ~~condition;~~ or

40 (ii) the end of the ~~two (2) year~~ **a continuous period of**  
 41 **eighteen (18) months** beginning on the ~~effective~~  
 42 **enrollment** date of the person's coverage **if the person is a**

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- 1                   **late enrollee.**  
 2                   (6) If premiums or benefits under the policy vary according to a  
 3                   person's age, a provision specifying an equitable adjustment of:  
 4                   (A) premiums;  
 5                   (B) benefits; or  
 6                   (C) both premiums and benefits;  
 7                   to be made if the age of a covered person has been misstated. A  
 8                   provision under this subdivision must contain a clear statement of  
 9                   the method of adjustment to be used.  
 10                  (7) A provision that the insurer will issue to the policyholder, for  
 11                  delivery to each person insured, a certificate setting forth a  
 12                  statement that:  
 13                    (A) explains the insurance protection to which the person  
 14                    insured is entitled;  
 15                    (B) indicates to whom the insurance benefits are payable; and  
 16                    (C) explains any family member's or dependent's coverage  
 17                    under the policy.  
 18                  (8) A provision stating that written notice of a claim must be  
 19                  given to the insurer within twenty (20) days after the occurrence  
 20                  or commencement of any loss covered by the policy, but that a  
 21                  failure to give notice within the twenty (20) day period does not  
 22                  invalidate or reduce any claim if it can be shown that it was not  
 23                  reasonably possible to give notice within that period and that  
 24                  notice was given as soon as was reasonably possible.  
 25                  (9) A provision stating that:  
 26                    (A) the insurer will furnish to the person making a claim, or to  
 27                    the policyholder for delivery to the person making a claim,  
 28                    forms usually furnished by the insurer for filing proof of loss;  
 29                    and  
 30                    (B) if the forms are not furnished within fifteen (15) days after  
 31                    the insurer received notice of a claim, the person making the  
 32                    claim will be deemed to have complied with the requirements  
 33                    of the policy as to proof of loss upon submitting, within the  
 34                    time fixed in the policy for filing proof of loss, written proof  
 35                    covering the occurrence, character, and extent of the loss for  
 36                    which the claim is made.  
 37                  (10) A provision stating that:  
 38                    (A) in the case of a claim for loss of time for disability, written  
 39                    proof of the loss must be furnished to the insurer within ninety  
 40                    (90) days after the commencement of the period for which the  
 41                    insurer is liable, and that subsequent written proofs of the  
 42                    continuance of the disability must be furnished to the insurer

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- 1 at reasonable intervals as may be required by the insurer;  
 2 (B) in the case of a claim for any other loss, written proof of  
 3 the loss must be furnished to the insurer within ninety (90)  
 4 days after the date of the loss; and  
 5 (C) the failure to furnish proof within the time required under  
 6 clause (A) or (B) does not invalidate or reduce any claim if it  
 7 was not reasonably possible to furnish proof within that time,  
 8 and if proof is furnished as soon as reasonably possible but  
 9 (except in case of the absence of legal capacity of the  
 10 claimant) no later than one (1) year from the time proof is  
 11 otherwise required under the policy.
- 12 (11) A provision that:
- 13 (A) all benefits payable under the policy (other than benefits  
 14 for loss of time) will be paid within forty-five (45) days after  
 15 the insurer receives all information required to determine  
 16 liability under the terms of the policy; and  
 17 (B) subject to due proof of loss, all accrued benefits under the  
 18 policy for loss of time will be paid not less frequently than  
 19 monthly during the continuance of the period for which the  
 20 insurer is liable, and any balance remaining unpaid at the  
 21 termination of the period for which the insurer is liable will be  
 22 paid as soon as possible after receipt of the proof of loss.
- 23 (12) A provision that benefits for loss of life of the person insured  
 24 are payable to the beneficiary designated by the person insured.  
 25 However, if the policy contains conditions pertaining to family  
 26 status, the beneficiary may be the family member specified by the  
 27 policy terms. In either case, payment of benefits for loss of life is  
 28 subject to the provisions of the policy if no designated or  
 29 specified beneficiary is living at the death of the person insured.  
 30 All other benefits of the policy are payable to the person insured.  
 31 The policy may also provide that if any benefit is payable to the  
 32 estate of a person, or to a person who is a minor or otherwise not  
 33 competent to give a valid release, the insurer may pay the benefit,  
 34 up to an amount of five thousand dollars (\$5,000), to any relative  
 35 by blood or connection by marriage of the person who is deemed  
 36 by the insurer to be equitably entitled to the benefit.
- 37 (13) A provision that the insurer has the right and must be  
 38 allowed the opportunity to:
- 39 (A) examine the person of the individual for whom a claim is  
 40 made under the policy when and as often as the insurer  
 41 reasonably requires during the pendency of the claim; and  
 42 (B) conduct an autopsy in case of death if it is not prohibited

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- 1 by law.
- 2 (14) A provision that no action at law or in equity may be brought
- 3 to recover on the policy less than sixty (60) days after proof of
- 4 loss is filed in accordance with the requirements of the policy, and
- 5 that no action may be brought at all more than three (3) years after
- 6 the expiration of the time within which proof of loss is required
- 7 by the policy.
- 8 (15) In the case of a policy insuring debtors, a provision that the
- 9 insurer will furnish to the policyholder, for delivery to each debtor
- 10 insured under the policy, a certificate of insurance describing the
- 11 coverage and specifying that the benefits payable will first be
- 12 applied to reduce or extinguish the indebtedness.
- 13 (16) If the policy provides that hospital or medical expense
- 14 coverage of a dependent child of a group member terminates upon
- 15 the child's attainment of the limiting age for dependent children
- 16 set forth in the policy, a provision that the child's attainment of the
- 17 limiting age does not terminate the hospital and medical coverage
- 18 of the child while the child is:
- 19 (A) incapable of self-sustaining employment because of
- 20 mental retardation or a physical disability; and
- 21 (B) chiefly dependent upon the group member for support and
- 22 maintenance.
- 23 A provision under this subdivision may require that proof of the
- 24 child's incapacity and dependency be furnished to the insurer by
- 25 the group member within one hundred twenty (120) days of the
- 26 child's attainment of the limiting age and, subsequently, at
- 27 reasonable intervals during the two (2) years following the child's
- 28 attainment of the limiting age. The policy may not require proof
- 29 more than once per year in the time more than two (2) years after
- 30 the child's attainment of the limiting age. This subdivision does
- 31 not require an insurer to provide coverage to a mentally retarded
- 32 or physically disabled child who does not satisfy the requirements
- 33 of the group policy as to evidence of insurability or other
- 34 requirements for coverage under the policy to take effect. In any
- 35 case, the terms of the policy apply with regard to the coverage or
- 36 exclusion from coverage of the child.
- 37 **(17) A provision that complies with the group portability and**
- 38 **guaranteed renewability provisions of the federal Health**
- 39 **Insurance Portability and Accountability Act of 1996**
- 40 **(P.L.104-191).**
- 41 ~~(e)~~ **(d)** Subsection ~~(b)(5); (b)(7); (c)(5), (c)(7), and (b)(12)~~ **(c)(12)**
- 42 do not apply to policies insuring the lives of debtors. The standard

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1 provisions required under section 3(a) of this chapter for individual  
 2 accident and sickness insurance policies do not apply to group accident  
 3 and sickness insurance policies.

4 ~~(d)~~ (e) If any policy provision required under subsection ~~(b)~~ (c) is in  
 5 whole or in part inapplicable to or inconsistent with the coverage  
 6 provided by an insurer under a particular form of policy, the insurer,  
 7 with the approval of the commissioner, shall delete the provision from  
 8 the policy or modify the provision in such a manner as to make it  
 9 consistent with the coverage provided by the policy.

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

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

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

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

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

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

25 (g) "**Creditable coverage**" has the meaning set forth in the  
 26 **federal Health Insurance Portability and Accountability Act of**  
 27 **1996 (26 U.S.C. 9801(c)(1)).**

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

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

31 (1) for whom, as of the date on which the individual seeks  
 32 coverage under this chapter, the aggregate period of  
 33 creditable coverage is at least eighteen (18) months and whose  
 34 most recent prior creditable coverage was under a:

35 (A) group health plan;

36 (B) governmental plan; or

37 (C) church plan;

38 or health insurance coverage in connection with any of these  
 39 plans;

40 (2) who is not eligible for coverage under:

41 (A) a group health plan;

42 (B) Part A or Part B of Title XVIII of the federal Social

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

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1 care, or hospitalization, or incident to the furnishing of such care or  
 2 hospitalization, as well as the furnishing to any person of any other  
 3 services or products for the purpose of preventing, alleviating, curing,  
 4 or healing human illness or injury.

5 ~~(k)~~ **(p)** "Health insurance" means hospital, surgical, and medical  
 6 expense incurred policies, nonprofit service plan contracts, health  
 7 maintenance organizations, limited service health maintenance  
 8 organizations, and self-insured plans. However, the term "health  
 9 insurance" does not include short term travel accident policies,  
 10 accident only policies, fixed indemnity policies, automobile medical  
 11 payment, or incidental coverage issued with or as a supplement to  
 12 liability insurance.

13 ~~(h)~~ **(q)** "Insured" means all individuals who are provided qualified  
 14 comprehensive health insurance coverage under an individual policy,  
 15 including all dependents and other insured persons, if any.

16 ~~(m)~~ **(r)** "Medicaid" means medical assistance provided by the state  
 17 under the Medicaid program under IC 12-15.

18 **(s) "Medical care payment" means amounts paid for:**

- 19 **(1) the diagnosis, care, mitigation, treatment, or prevention of**  
 20 **disease or amounts paid for the purpose of affecting any**  
 21 **structure or function of the body;**  
 22 **(2) transportation primarily for and essential to Medicare**  
 23 **services referred to in subdivision (1); and**  
 24 **(3) insurance covering medical care referred to in**  
 25 **subdivisions (1) and (2).**

26 ~~(n)~~ **(t)** "Medically necessary" means health care services that the  
 27 association has determined:

- 28 (1) are recommended by a legally qualified physician;  
 29 (2) are commonly and customarily recognized throughout the  
 30 physician's profession as appropriate in the treatment of the  
 31 patient's diagnosed illness; and  
 32 (3) are not primarily for the scholastic education or vocational  
 33 training of the provider or patient.

34 ~~(o)~~ **(u)** "Medicare" means Title XVIII of the federal Social Security  
 35 Act (42 U.S.C. 1395 et seq.).

36 ~~(p)~~ **(v)** "Policy" means a contract, policy, or plan of health  
 37 insurance.

38 ~~(q)~~ **(w)** "Policy year" means a twelve (12) month period during  
 39 which a policy provides coverage or obligates the carrier to provide  
 40 health care services.

41 **(x) "Preexisting condition" means:**

- 42 **(1) a condition that manifested itself within a period of six (6)**

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1           **months before the effective date of coverage in such a manner**  
 2           **as would cause an ordinarily prudent person to seek**  
 3           **diagnosis, care, or treatment; or**  
 4           **(2) medical advice or treatment was recommended or received**  
 5           **within a period of six (6) months before the effective date of**  
 6           **coverage.**

7           (†) (y) "Health maintenance organization" has the meaning set out  
 8           in IC 27-13-1-19.

9           (‡) (z) "Self-insurer" means an employer who provides services,  
 10          payment for, or reimbursement of any part of the cost of health care  
 11          services other than payment of insurance premiums or subscriber  
 12          charges to a carrier. However, the term "self-insurer" does not include  
 13          an employer who is exempt from state insurance regulation by federal  
 14          law, or an employer who is a political subdivision of the state of  
 15          Indiana.

16          (†) (aa) "Services of a skilled nursing facility" means services that  
 17          must commence within fourteen (14) days following a confinement of  
 18          at least three (3) consecutive days in a hospital for the same condition.

19          (†) (bb) "Skilled nursing facility", "home health agency", "hospital",  
 20          and "home health services" have the meanings assigned to them in 42  
 21          U.S.C. 1395x.

22          (†) (cc) "Medicare supplement policy" means an individual policy  
 23          of accident and sickness insurance that is designed primarily as a  
 24          supplement to reimbursements under Medicare for the hospital,  
 25          medical, and surgical expenses of individuals who are eligible for  
 26          Medicare benefits.

27          (†) (dd) "Limited service health maintenance organization" has the  
 28          meaning set forth in IC 27-13-34-4.

29          SECTION 9. IC 27-8-10-2.1, AS AMENDED BY P.L.255-1995,  
 30          SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 31          APRIL 1, 1998]: Sec. 2.1. (a) There is established a nonprofit legal  
 32          entity to be referred to as the Indiana comprehensive health insurance  
 33          association, which must assure that health insurance is made available  
 34          throughout the year to each eligible Indiana resident applying to the  
 35          association for coverage. All carriers, health maintenance  
 36          organizations, limited service health maintenance organizations, and  
 37          self-insurers providing health insurance or health care services in  
 38          Indiana must be members of the association. The association shall  
 39          operate under a plan of operation established and approved under  
 40          subsection (c) and shall exercise its powers through a board of directors  
 41          established under this section.

42          (b) The board of directors of the association consists of ~~five (5) to~~



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1 ~~nine (9)~~ **seven (7)** members **whose principal residence is in Indiana**  
 2 **selected by the members of the association; subject to approval by the**  
 3 **commissioner; as follows:**

4 **(1) The commissioner, or the designee of the commissioner,**  
 5 **who shall serve as chairperson of the board of directors.**

6 **(2) Three (3) policyholders or individuals representing**  
 7 **policyholders, appointed by the commissioner.**

8 **(3) Two (2) individuals representing association members,**  
 9 **appointed by the commissioner.**

10 **(4) The director of the budget agency, or the designee of the**  
 11 **director.**

12 To select the initial board of directors and to initially organize the  
 13 association, the commissioner shall give notice to all members in  
 14 Indiana of the time and place of the organizational meeting. In  
 15 determining voting rights at the organizational meeting, each member  
 16 is entitled to one (1) vote in person or by proxy. If the board of  
 17 directors is not selected within sixty (60) days after the organizational  
 18 meeting, the commissioner shall appoint the initial board. In approving  
 19 or selecting members of the board, the commissioner shall consider  
 20 whether all members are fairly represented. Members of the board **who**  
 21 **are not state employees** may be reimbursed from the money of the  
 22 association for expenses incurred by them as members but shall not be  
 23 otherwise compensated by the association for their services.

24 (c) The association shall submit to the commissioner a plan of  
 25 operation for the association and any amendments to the plan necessary  
 26 or suitable to assure the fair, reasonable, and equitable administration  
 27 of the association. The plan of operation becomes effective upon  
 28 approval in writing by the commissioner consistent with the date on  
 29 which the coverage under this chapter must be made available. The  
 30 commissioner shall, after notice and hearing, approve the plan of  
 31 operation if the plan is determined to be suitable to assure the fair,  
 32 reasonable, and equitable administration of the association and  
 33 provides for the sharing of association losses on an equitable,  
 34 proportionate basis among the member carriers, health maintenance  
 35 organizations, limited service health maintenance organizations, and  
 36 self-insurers. If the association fails to submit a suitable plan of  
 37 operation within one hundred eighty (180) days after the appointment  
 38 of the board of directors, or at any time thereafter the association fails  
 39 to submit suitable amendments to the plan, the commissioner shall  
 40 adopt rules under IC 4-22-2 necessary or advisable to implement this  
 41 section. These rules are effective until modified by the commissioner  
 42 or superseded by a plan submitted by the association and approved by



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- 1 the commissioner. The plan of operation must:
- 2 (1) establish procedures for the handling and accounting of assets
- 3 and money of the association;
- 4 (2) establish the amount and method of reimbursing members of
- 5 the board;
- 6 (3) establish regular times and places for meetings of the board of
- 7 directors;
- 8 (4) establish procedures for records to be kept of all financial
- 9 transactions, and for the annual fiscal reporting to the
- 10 commissioner;
- 11 (5) establish procedures whereby selections for the board of
- 12 directors will be made and submitted to the commissioner for
- 13 approval;
- 14 (6) contain additional provisions necessary or proper for the
- 15 execution of the powers and duties of the association; and
- 16 (7) establish procedures for the periodic advertising of the general
- 17 availability of the health insurance coverages from the
- 18 association.
- 19 (d) The plan of operation may provide that any of the powers and
- 20 duties of the association be delegated to a person who will perform
- 21 functions similar to those of this association. A delegation under this
- 22 section takes effect only with the approval of both the board of
- 23 directors and the commissioner. The commissioner may not approve a
- 24 delegation unless the protections afforded to the insured are
- 25 substantially equivalent to or greater than those provided under this
- 26 chapter.
- 27 (e) The association has the general powers and authority enumerated
- 28 by this subsection in accordance with the plan of operation approved
- 29 by the commissioner under subsection (c). The association has the
- 30 general powers and authority granted under the laws of Indiana to
- 31 carriers licensed to transact the kinds of health care services or health
- 32 insurance described in section 1 of this chapter and also has the
- 33 specific authority, **subject to the approval of the commissioner**, to do
- 34 the following:
- 35 (1) Enter into contracts as are necessary or proper to carry out this
- 36 chapter.
- 37 (2) Sue or be sued, including taking any legal actions necessary
- 38 or proper for recovery of any assessments for, on behalf of, or
- 39 against participating carriers.
- 40 (3) Take legal action necessary to avoid the payment of improper
- 41 claims against the association or the coverage provided by or
- 42 through the association.

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- 1 (4) Establish a medical review committee to determine the  
2 reasonably appropriate level and extent of health care services in  
3 each instance.
- 4 (5) Establish appropriate rates, scales of rates, rate classifications  
5 and rating adjustments, such rates not to be unreasonable in  
6 relation to the coverage provided and the reasonable operational  
7 expenses of the association.
- 8 (6) Pool risks among members.
- 9 (7) Issue policies of insurance on an indemnity or provision of  
10 service basis providing the coverage required by this chapter.
- 11 (8) Administer separate pools, separate accounts, or other plans  
12 or arrangements considered appropriate for separate members or  
13 groups of members.
- 14 (9) Operate and administer any combination of plans, pools, or  
15 other mechanisms considered appropriate to best accomplish the  
16 fair and equitable operation of the association.
- 17 (10) Appoint from among members appropriate legal, actuarial,  
18 and other committees as necessary to provide technical assistance  
19 in the operation of the association, policy and other contract  
20 design, and any other function within the authority of the  
21 association.
- 22 (11) Hire an independent consultant.
- 23 (12) Develop a method of advising applicants of the availability  
24 of other coverages outside the association and may promulgate a  
25 list of health conditions the existence of which would deem an  
26 applicant eligible without demonstrating a rejection of coverage  
27 by one (1) carrier.
- 28 (13) Provide for the use of managed care plans for insureds,  
29 including the use of:
- 30 (A) health maintenance organizations; and  
31 (B) preferred provider plans.
- 32 (14) Solicit bids directly from providers for coverage under this  
33 chapter.
- 34 (f) Rates for coverages issued by the association may not be  
35 unreasonable in relation to the benefits provided, the risk experience,  
36 and the reasonable expenses of providing the coverage. Separate scales  
37 of premium rates based on age apply for individual risks. Premium  
38 rates must take into consideration the extra morbidity and  
39 administration expenses, if any, for risks insured in the association. The  
40 rates for a given classification may not be more than one hundred fifty  
41 percent (150%) of the average premium rate for that class charged by  
42 the five (5) carriers with the largest premium volume in the state during

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1 the preceding calendar year. In determining the average rate of the five  
 2 (5) largest carriers, the rates charged by the carriers shall be actuarially  
 3 adjusted to determine the rate that would have been charged for  
 4 benefits identical to those issued by the association. All rates adopted  
 5 by the association must be submitted to the commissioner for approval.

6 (g) Following the close of the association's fiscal year, the  
 7 association shall determine the net premiums, the expenses of  
 8 administration, and the incurred losses for the year. Any net loss shall  
 9 be assessed by the association to all members in proportion to their  
 10 respective shares of total health insurance premiums, excluding  
 11 premiums for Medicaid contracts with the state of Indiana, received in  
 12 Indiana during the calendar year (or with paid losses in the year)  
 13 coinciding with or ending during the fiscal year of the association or  
 14 any other equitable basis as may be provided in the plan of operation.  
 15 For self-insurers, health maintenance organizations, and limited service  
 16 health maintenance organizations that are members of the association,  
 17 the proportionate share of losses must be determined through the  
 18 application of an equitable formula based upon claims paid, excluding  
 19 claims for Medicaid contracts with the state of Indiana, or the value of  
 20 services provided. In sharing losses, the association may abate or defer  
 21 in any part the assessment of a member, if, in the opinion of the board,  
 22 payment of the assessment would endanger the ability of the member  
 23 to fulfill its contractual obligations. The association may also provide  
 24 for interim assessments against members of the association if necessary  
 25 to assure the financial capability of the association to meet the incurred  
 26 or estimated claims expenses or operating expenses of the association  
 27 until the association's next fiscal year is completed. Net gains, if any,  
 28 must be held at interest to offset future losses or allocated to reduce  
 29 future premiums.

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

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

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

42 (k) The association may not issue an association policy to any

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1 individual who, on the effective date of the coverage applied for, does  
2 not meet the eligibility requirements of section 5.1 of this chapter.

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

6 (m) The association and the premium collected by the association  
7 shall be exempt from the premium tax, the gross income tax, the  
8 adjusted gross income tax, supplemental corporate net income, or any  
9 combination of these, or similar taxes upon revenues or income that  
10 may be imposed by the state.

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

13 (1) take a credit against premium taxes, gross income taxes,  
14 adjusted gross income taxes, supplemental corporate net income  
15 taxes, or any combination of these, or similar taxes upon revenues  
16 or income of member insurers that may be imposed by the state,  
17 up to the amount of the taxes due for each calendar year in which  
18 the assessments were paid and for succeeding years until the  
19 aggregate of those assessments have been offset by either credits  
20 against those taxes or refunds from the association; or

21 (2) any member insurer may include in the rates for premiums  
22 charged for insurance policies to which this chapter applies  
23 amounts sufficient to recoup a sum equal to the amounts paid to  
24 the association by the member less any amounts returned to the  
25 member insurer by the association, and the rates shall not be  
26 deemed excessive by virtue of including an amount reasonably  
27 calculated to recoup assessments paid by the member.

28 (o) The association shall provide for the option of monthly  
29 collection of premiums.

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

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

42 (1) the person has been rejected by one (1) carrier for coverage

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1 under any insurance plan that equals or exceeds the minimum  
 2 requirements for accident and sickness insurance policies issued  
 3 in Indiana, as set forth in IC 27, without material underwriting  
 4 ~~restriction at a rate equal to or less than the association plan rate:~~  
 5 **restrictions;**

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

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

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

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

18 ~~(2) an association policy to be issued without any limitation on~~  
 19 ~~preexisting conditions to a person who is covered by a health~~  
 20 ~~insurance arrangement when that person's coverage is scheduled~~  
 21 ~~to terminate for any reason beyond the person's control:~~

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

29 (1) incapable of self-sustaining employment by reason of mental  
 30 retardation or physical disability; and

31 (2) chiefly dependent upon the person in whose name the contract  
 32 is issued for support and maintenance.

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

38 (e) An association policy that provides coverage for a family  
 39 member of the person in whose name the contract is issued must, as to  
 40 the family member's coverage, also provide that the health insurance  
 41 benefits applicable for children are payable with respect to a newly  
 42 born child of the person in whose name the contract is issued from the

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1 moment of birth. The coverage for newly born children must consist of  
 2 coverage of injury or illness, including the necessary care and treatment  
 3 of medically diagnosed congenital defects and birth abnormalities. If  
 4 payment of a specific premium is required to provide coverage for the  
 5 child, the contract may require that notification of the birth of a child  
 6 and payment of the required premium must be furnished to the carrier  
 7 within thirty-one (31) days after the date of birth in order to have the  
 8 coverage continued beyond the thirty-one (31) day period.

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

13 (1) the condition manifested itself within a period of six (6)  
 14 months before the effective date of coverage in such a manner as  
 15 would cause an ordinarily prudent person to seek diagnosis, care,  
 16 or treatment; or

17 (2) medical advice or treatment was recommended or received  
 18 within a period of six (6) months before the effective date of  
 19 coverage.

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

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

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

29 (2) coverage as to a given condition is denied;

30 on the basis of a preexisting health condition. This subsection may not  
 31 be construed to prohibit preexisting condition provisions in an  
 32 insurance policy that are more favorable to the insured.

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

37 (h) Coverage for a preexisting condition of a person described  
 38 in subsection (g) may not be delayed or restricted to a date later  
 39 than six (6) months after the effective date. However, the six (6)  
 40 months must be reduced by one (1) month for each thirty (30) day  
 41 period of continuous coverage under a health insurance plan, as  
 42 defined in IC 27-8-15-28(a), that the person had during the twelve

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1 **(12) months immediately preceding enrollment.**

2 ~~(h)~~ (i) For purposes of this section, coverage under a health  
3 insurance arrangement includes, but is not limited to, coverage  
4 pursuant to the Consolidated Omnibus Budget Reconciliation Act of  
5 1985.

6 SECTION 11. IC 27-8-15-10.5, AS AMENDED BY P.L.190-1996,  
7 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
8 APRIL 1, 1998]: Sec. 10.5. (a) As used in this chapter, "late enrollee"  
9 means an eligible employee or a dependent of an eligible employee  
10 who did not request enrollment in a health insurance plan of a small  
11 employer during the initial enrollment period during which the  
12 individual was entitled to enroll under the health insurance plan.

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

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

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

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

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

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

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

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

25 **or had health insurance coverage at the time coverage was**  
26 **previously offered to the employee or to the dependent of the**  
27 **employee;**

28 (2) **who stated in writing at the time coverage was offered that**  
29 **coverage under another health insurance plan was the reason**  
30 **for declining the enrollment, but only if the insurer required**  
31 **such a statement at the time and provided the employee with**  
32 **notice of the requirement (and the consequences of the**  
33 **requirement) at the time;**

34 (3) **whose coverage under this subsection:**

35 (A) **was under a COBRA continuation provision and the**  
36 **coverage under the provision was exhausted; or**

37 (B) **was not under a COBRA continuation provision and**  
38 **either the coverage was terminated as a result of loss of**  
39 **eligibility for the coverage (including as a result of legal**  
40 **separation, divorce, death, termination of employment, or**  
41 **reduction in the number of hours of employment) or**  
42 **employer contributions toward the coverage were**

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1                    **terminated; and**  
 2                    **(4) who requests enrollment under the terms of the plan not**  
 3                    **later than thirty (30) days after the date of exhaustion of**  
 4                    **coverage as described in subdivision (3)(A) or the termination**  
 5                    **of coverage or employer contributions as described in**  
 6                    **subdivision (3)(B).**

7                    ~~(2)~~ (c) The term "late enrollee" does not include an eligible  
 8 employee **who** is employed by a small employer that offers multiple  
 9 health insurance plans and ~~the eligible employee who~~ elects a different  
 10 plan during an open enrollment period.

11                    ~~(3)~~ (d) **The term "late enrollee" does not include an eligible**  
 12 **employee or the eligible employee's spouse or minor or dependent**  
 13 **child where:**

14                    (1) a court has ordered that health insurance coverage be provided  
 15 for ~~a~~ **the** spouse or a minor or dependent child of an eligible  
 16 employee under the eligible employee's insurance plan; and

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

19                    SECTION 12. IC 27-8-15-14, AS AMENDED BY P.L.190-1996,  
 20 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 21 APRIL 1, 1998]: Sec. 14. As used in this chapter, "small employer"  
 22 means any person, firm, corporation, limited liability company,  
 23 partnership, or association actively engaged in business who, on at least  
 24 fifty percent (50%) of the working days of the employer during the  
 25 preceding calendar year, employed at least ~~three~~ ~~(3)~~ **two (2)** but not  
 26 more than fifty (50) eligible employees, the majority of whom work in  
 27 Indiana. In determining the number of eligible employees, companies  
 28 that are affiliated companies or that are eligible to file a combined tax  
 29 return for purposes of state taxation are considered one (1) employer.

30                    SECTION 13. IC 27-8-15-19, AS AMENDED BY P.L.93-1995,  
 31 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 32 APRIL 1, 1998]: Sec. 19. Except as provided in section 20 of this  
 33 chapter, a small employer insurer may only cancel or refuse to renew  
 34 a health insurance plan for the following reasons:

35                    (1) Nonpayment of required premiums.

36                    (2) Fraud or misrepresentation of the small employer, or with  
 37 respect to coverage of an insured individual, fraud or  
 38 misrepresentation by the insured individual or the individual's  
 39 representative.

40                    ~~(3)~~ **Noncompliance with the plan's provisions:**

41                    ~~(4)~~ **The number of individuals covered under the plan is less than**  
 42 **the number of percentage of eligible individuals required by**

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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:

(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 14. IC 27-8-15-27, AS ADDED BY P.L.93-1995,  
SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE



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1 APRIL 1, 1998]: Sec. 27. A health insurance plan provided by a small  
2 employer insurer to a small employer must comply with the following:

3 (1) The benefits provided by a plan to an eligible employee  
4 enrolled in the plan may not be excluded, limited, or denied for  
5 more than nine (9) months after the effective date of the coverage  
6 because of a preexisting condition of the eligible employee, the  
7 eligible employee's spouse, or the eligible employee's dependent.

8 (2) The plan may not define a preexisting condition, rider, or  
9 endorsement more restrictively than as (A) a condition that would  
10 have caused an ordinarily prudent person to seek medical advice,  
11 diagnosis, care, or treatment during the nine (9) months  
12 immediately preceding the effective date of enrollment in the  
13 plan; (B) a condition for which medical advice, diagnosis, care,  
14 or treatment was recommended or received during the nine (9) six  
15 (6) months immediately preceding the effective date of  
16 enrollment in the plan. or

17 ~~(C) a pregnancy existing on the effective date of enrollment in~~  
18 ~~the plan.~~

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

- 23 (1) A hospital or medical expense incurred policy or certificate.  
24 (2) A hospital or medical service plan contract.  
25 (3) A health maintenance organization subscriber contract.  
26 (4) Medicare or Medicaid.  
27 (5) An employer based health insurance arrangement.  
28 (6) An individual health insurance policy.  
29 (7) A policy issued by the Indiana comprehensive health  
30 insurance association under IC 27-8-10.  
31 (8) An employee welfare benefit plan (as defined in 29 U.S.C.  
32 1002) that is self-funded.  
33 (9) A conversion policy issued under section 31 or 31.1 of this  
34 chapter.

35 (b) Except as provided in section 29 of this chapter, a small  
36 employer insurer shall waive the exclusion period described in section  
37 27 of this chapter applicable to a preexisting condition or the limitation  
38 period with respect to a particular service in a health insurance plan for  
39 the time an eligible employee or a dependent of an eligible employee  
40 was previously covered by a health insurance plan if the following  
41 conditions are met:

- 42 (1) The eligible employee or a dependent of the eligible employee



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1 was previously covered by a health insurance plan that provided  
2 benefits with respect to the particular service.

3 (2) Coverage under the health insurance plan was continuous to  
4 a date not more than ~~thirty (30)~~ **sixty-three (63)** days before the  
5 effective date of enrollment by:

6 (A) the eligible employee; or

7 (B) a dependent of the eligible employee.

8 (c) In determining whether an eligible employee or a dependent of  
9 the eligible employee meets the requirements of subsection (b)(2), a  
10 waiting period imposed by a small employer insurer or small employer  
11 before new coverage may become effective must be excluded from the  
12 calculation.

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

15 SECTION 16. IC 27-8-15-34.1 IS ADDED TO THE INDIANA  
16 CODE AS A NEW SECTION TO READ AS FOLLOWS  
17 [EFFECTIVE APRIL 1, 1998]: **Sec. 34.1. Except as provided in 29**  
18 **U.S.C. 1191a and 42 U.S.C. 300gg, a small employer insurer must:**

19 **(1) offer to any small employer all products that are approved**  
20 **for sale in the small group market and that the insurer is**  
21 **actively marketing; and**

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

23 SECTION 17. IC 27-13-7-3, AS ADDED BY P.L.26-1994,  
24 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
25 JULY 1, 1998]: Sec. 3. (a) A contract referred to in section 1 of this  
26 chapter must clearly state the following:

27 (1) The name and address of the health maintenance organization.

28 (2) Eligibility requirements.

29 (3) Benefits and services within the service area.

30 (4) Emergency care benefits and services.

31 (5) Any out-of-area benefits and services.

32 (6) Copayments, deductibles, and other out-of-pocket costs.

33 (7) Limitations and exclusions.

34 (8) Enrollee termination provisions.

35 (9) Any enrollee reinstatement provisions.

36 (10) Claims procedures.

37 (11) Enrollee grievance procedures.

38 (12) Continuation of coverage provisions.

39 (13) Conversion provisions.

40 (14) Extension of benefit provisions.

41 (15) Coordination of benefit provisions.

42 (16) Any subrogation provisions.



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- 1 (17) A description of the service area.  
 2 (18) The entire contract provisions.  
 3 (19) The term of the coverage provided by the contract.  
 4 (20) Any right of cancellation of the group or individual contract  
 5 holder.  
 6 (21) Right of renewal provisions.  
 7 (22) Provisions regarding reinstatement of a group or an  
 8 individual contract holder.  
 9 (23) Grace period provisions.  
 10 (24) A provision on conformity with state law.  
 11 **(25) A provision or provisions that comply with the:**  
 12 **(A) guaranteed renewability; and**  
 13 **(B) group portability;**  
 14 **requirements of the federal Health Insurance Portability and**  
 15 **Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).**  
 16 (b) For purposes of subsection (a), an evidence of coverage which  
 17 is filed with a contract may be considered part of the contract.  
 18 SECTION 18. THE FOLLOWING ARE REPEALED [EFFECTIVE  
 19 APRIL 1, 1998]: IC 6-3-7-5; IC 22-3-2-14.5; IC 22-3-7-34.5;  
 20 IC 27-8-15-34.  
 21 SECTION 19. [EFFECTIVE APRIL 1, 1998] (a) **IC 27-8-5-3 and**  
 22 **IC 27-8-5-19, both as amended by this act, apply to all accident and**  
 23 **sickness policies in force on April 1, 1998.**  
 24 (b) **IC 27-8-15-10.5, IC 27-8-15-14, IC 27-8-15-19, IC 27-8-15-27,**  
 25 **IC 27-8-15-28, all as amended by this act, and IC 27-8-15-34.1, as**  
 26 **added by this act, apply to all small employer health insurance**  
 27 **plans in force under IC 27-8-15 on April 1, 1998.**  
 28 SECTION 20. **An emergency is declared for this act.**

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1287, 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 2, between lines 22 and 23, begin a new paragraph and insert:

"SECTION 2. 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 3. 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 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,

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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 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;

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(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) 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) (7) 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 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

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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 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

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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.

(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.



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(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 4. 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.

(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~~

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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 22-3-7-34.5.

(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.

(6) 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



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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 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 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.



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(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 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 5. 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,

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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 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 **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."

Page 14, line 1, after "received by the person," insert "or".

Page 14, line 1, after "recommended to the person," delete "or".

Page 14, line 2, delete "would have been sought by a prudent person,".

Page 20, between lines 13 and 14, begin a new paragraph and insert:

**"(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**

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**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."**

Page 20, line 14, delete "(x)" and insert "(y)".

Page 20, line 16, delete "(y)" and insert "(z)".

Page 20, line 23, delete "(z)" and insert "(aa)".

Page 20, line 26, delete "(aa)" and insert "(bb)".

Page 20, line 29, delete "(bb)" and insert "(cc)".

Page 20, line 34, delete "(cc)" and insert "(dd)".

Page 20, between lines 35 and 36, begin a new paragraph and insert:

"SECTION 5. IC 27-8-10-2.1, AS AMENDED BY P.L.255-1995, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 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)~~ **seven (7)** members **whose principal residence is in Indiana** selected by the members of the association, subject to approval by the ~~commissioner~~. **as follows:**

- (1) The commissioner, or the designee of the commissioner, who shall serve as chairperson of the board of directors.**
- (2) Three (3) policyholders or individuals representing policyholders, appointed by the commissioner.**
- (3) Two (2) individuals representing association members, appointed by the commissioner.**
- (4) The director of the budget agency, or the designee of the director.**

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



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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. Members of the board **who are not state employees** may be reimbursed from the money of the association for expenses incurred by them as members but shall not be otherwise compensated by the association for their services.

(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 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

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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, **subject to the approval of the commissioner**, to do the following:

- (1) Enter into contracts as are necessary or proper to carry out this chapter.
- (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 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,

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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 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

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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.

(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 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

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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."

Page 21, line 19, delete ":".

Page 21, line 20, strike "(1)".

Page 21, run in lines 19 and 20.

Page 21, line 24, delete ";".

Page 21, line 24, strike "and" and insert ".".

Page 21, strike lines 25 through 28.

Page 22, strike lines 16 through 28.

Page 22, line 29, strike "(g)" and insert "(f)".

Page 22, line 29, strike "person applies for an association policy within six (6)".

Page 22, strike line 30.

Page 22, line 31, strike "insurance arrangement and the".

Page 22, between lines 39 and 40, begin a new paragraph and insert:

**"(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 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."**

Page 22, line 40, strike "(h)" and insert "(i)".

Page 26, line 4, delete ":".

Page 26, strike lines 5 through 6.

Page 26, line 7, strike "during the".

Page 26, line 7, delete "six (6)".

Page 26, line 7, strike "months immediately preceding the".

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Page 26, line 8, strike "effective date of enrollment in the plan;".

Page 26, line 8, delete "or".

Page 26, line 9, strike "(B)".

Page 26, run in lines 4 and 9.

Page 27, line 14, delete "that" and insert "**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 27, delete lines 15 through 16.

Page 28, line 12, delete "IC 27-8-15-34 IS REPEALED [EFFECTIVE APRIL" and insert "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."

Page 28, delete line 13.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to House Bill 1287 as introduced.)

FRY, Chair

Committee Vote: yeas 8, nays 7.

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