CONFERENCE COMMITTEE REPORT
DIGEST FOR HB 1286

Citations Affected: IC 2-5-23-8; IC 10-1-2-2; IC 27-1; IC 27-7-9-8; IC 27-8; IC 27-13-29-1; IC 27-8-15-34.

Synopsis: Various insurance matters. Conference committee report for EHB 1286. Makes the following changes in the insurance law: (1) Requires the filing of the annual report on the state police pension trust with the state board of accounts rather than the insurance commissioner. (2) Requires an insurance agent whose license is expired for more than 24 months to retake the licensure examination and complete certain educational requirements before the license may be renewed. (Current law provides a limit of 60 months.) (3) Authorizes the insurance commissioner to suspend, revoke, or refuse to renew the license of an insurance agent who pleads guilty or no contest to a felony or a misdemeanor involving moral turpitude. (4) Requires insurers to file quarterly statements, at no charge, with the department of insurance. (5) Requires the department of insurance, which is required to prepare an annual report concerning worker's compensation insurance rates based on information reported by insurers to the worker's compensation rating bureau, to make the report available upon request. (6) Amends the law on mine subsidence insurance to require an insurer to provide information on the availability of mine subsidence coverage only when proposing to issue a new policy. (7) Relieves an insurer of the duty to inform the policyholder of the availability of mine subsidence coverage when proposing to renew a policy already in force. (8) Provides that an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 2000. (Under current law, an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 1997.) (9) Provides that a health care provider for whom an insurer submits proof of financial responsibility and payment of the surcharge to the department of insurance in an untimely manner may be in compliance with patient compensation fund requirements if certain conditions are met by the insurer. Amends the insurance laws to conform to the federal Health Insurance Portability and Accountability (HIPA) Act of 1996. Provides that a provision concerning guaranteed renewability in compliance with the Health Insurance Portability and Accountability Act must be included in each individual accident and sickness policy and each group accident and sickness policy. Requires the inclusion of a provision concerning group portability in each group accident and sickness policy. Makes the following changes in the law concerning the Indiana comprehensive health insurance association (ICHIA): (1) Adds definitions to the law, including a definition of the term "federally eligible individual". (2) Allows a person to qualify for a health insurance policy issued by ICHIA upon a showing that a conventional insurer has refused to issue the person a policy, except at a rate exceeding the association plan rate, or that the person is a federally eligible individual. (3) Changes the composition of the association board of directors. (4) Changes the preexisting condition limitations time period from 6 months to 3 months for individuals for whom medical treatment was recommended or received within 3 months before the effective date of coverage. 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. THIS CONFERENCE COMMITTEE REPORT makes the following changes in the insurance law: (1) Requires the filing of the annual report on the state police pension trust with the state board of accounts rather than the insurance commissioner. (2) Requires an insurance agent whose license is expired for more than 24 months to retake the licensure examination and complete certain educational requirements before the license may be renewed. (Current law provides a limit of 60 months.) (3) Authorizes the insurance commissioner to suspend, revoke, or refuse to renew the license of an insurance agent who pleads guilty or no contest to a felony or a misdemeanor involving moral turpitude. (4) Requires insurers to file quarterly statements, at no charge, with the department of insurance. (5) Requires the department of insurance, which is required to prepare an annual report concerning worker's compensation insurance rates based on information reported by insurers to the worker's compensation rating bureau, to make the report available upon request. (6) Amends the law on mine subsidence insurance to require an insurer to provide information on the availability of mine subsidence coverage only when proposing to issue a new policy. (7) Relieves an insurer of the duty to inform the policyholder of the availability of mine subsidence coverage when proposing to renew a policy already in force. (8) Provides that an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 2000. (Under current law, an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 1997.) (9) Provides that a health care provider for whom an insurer submits proof of financial responsibility and payment of the surcharge to the department of insurance in an untimely manner may be in compliance with patient compensation fund requirements if certain conditions are met by the insurer. Amends the insurance laws to conform to the federal Health Insurance Portability and Accountability (HIPA) Act of 1996. Provides that a provision concerning guaranteed renewability in compliance with the Health Insurance Portability and Accountability Act must be included in each individual accident and sickness policy and each group accident and sickness policy. Requires the inclusion of a provision concerning group portability in each group accident and sickness policy. Makes the following changes in the law concerning the Indiana comprehensive health insurance association (ICHIA): (1) Adds definitions to the law, including a definition of the term "federally eligible individual". (2) Allows a person to qualify for a health insurance policy issued by ICHIA upon a showing that a conventional insurer has refused to issue the person a policy, except at a rate exceeding the association plan rate, or that the person is a federally eligible individual. (3) Changes the composition of the association board of directors. (4) Changes the preexisting condition limitations time period from 6 months to 3 months for individuals for whom medical treatment was recommended or received within 3 months before the effective date of coverage. 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. Provides that dependents of eligible employees are entitled to small group conversion policies.

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

Adopted	Rejected

CONFERENCE COMMITTEE REPORT

MR. SPEAKER:

Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed Senate Amendments to Engrossed House Bill No. 1286 respectfully reports that said two committees have conferred and agreed as follows to wit:

that the House recede from its dissent from all Senate amendments and that the House now concur in all Senate amendments to the bill and that the bill be further amended as follows:

Between the enacting clause and line 1, begin a new paragraph and insert:

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

(1) The interests of public hospitals.

(2) The interests of community mental health centers.

(3) The interests of community health centers.

(4) The interests of the long term care industry.

(5) The interests of health care professionals licensed under IC 25, but not licensed under IC 25-22.5.

(6) The interests of rural hospitals. An individual appointed under this subdivision must be licensed under IC 25-22.5.

(7) The interests of health maintenance organizations (as defined in IC 27-13-1-19).

(8) The interests of for-profit health care facilities (as defined in ~~IC 27-8-10-1(g)).~~ **IC 27-8-10-1(l)).**

(9) A statewide consumer organization.

(10) A statewide senior citizen organization.

(11) A statewide organization representing people with

disabilities.

(12) Organized labor.

(13) The interests of businesses that purchase health insurance policies.

(14) The interests of businesses that provide employee welfare benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

(15) A minority community.

(16) The uninsured. An individual appointed under this subdivision must be and must have been chronically uninsured.

(17) An individual who is not associated with any organization, business, or profession represented in this subsection other than as a consumer.

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

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

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

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

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

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

SCHEDULE I. Receipts and disbursements.

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

year.

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

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

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

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

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

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

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

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

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

(c) The commissioner shall collect the following fees for copying

and certifying the copy of any filed document relating to a domestic or foreign corporation:

Per page for copying . . . . . As determined by the commissioner but not to exceed actual cost

For the certificate $10

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

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

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

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

SECTION 4. IC 27-1-3-28, AS AMENDED BY P.L.252-1995, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 28. (a) The department of insurance fund is established for the ~~purpose~~ **following purposes:**

(1) ~~of Providing~~ **To provide** supplemental funding for the operations of the department of insurance.

(2) To pay the costs of hiring and employing staff.

(3) To provide staff salary differentials as necessary to equalize the average salaries and staffing levels of the department of insurance with the average salaries and staffing levels reported in the most recent Insurance Department Resources Report published by the National Association of Insurance Commissioners.

(4) To enable the department of insurance to maintain accreditation by the National Association of Insurance Commissioners.

(b) The fund shall be administered by the commissioner. The following shall be deposited in the department of insurance fund:

(1) Audit fees remitted by insurers to the commissioner under IC 27-1-3-15(d).

(2) Filing fees remitted by insurers to the commissioner under IC 27-1-3-15(e).

(3) Any other amounts remitted to the commissioner or the department that are required by rule or statute to be deposited into the department of insurance fund.

~~(b)~~ **(c)** The expenses of administering the fund shall be paid from money in the fund.

~~(c)~~ **(d)** The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

~~(d)~~ **(e)** Money in the fund at the end of a particular fiscal year does not revert to the state general fund.

~~(e)~~ **(f)** There is annually appropriated to the department of insurance, for the ~~purpose~~ **purposes** set forth in subsection (a), the entire amount of money deposited in the fund in each year.

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

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

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

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

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

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

(b) A corporation or limited liability company may be licensed as an insurance agent, surplus lines insurance agent, or limited insurance representative. Every officer, director, stockholder, or employee of the corporation or limited liability company personally engaged in Indiana in soliciting or negotiating policies of insurance shall be registered with the commissioner as to its license, and each such member, officer, director, stockholder, or employee shall also qualify as an individual

licensee. However, this section does not apply to a management association, partnership, or corporation whose operations do not entail the solicitation of insurance from the public.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) satisfy the requirements of IC 27-1-15.5-7.1(b); and

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

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

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

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

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

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

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

(h) An insurer shall require that a person who, on behalf of the insurer, makes any oral, written, or electronic communication with an

individual regarding insurance coverage, rates, benefits, or policy terms, for the purpose of soliciting insurance shall be licensed under this chapter.

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

SECTION 6. IC 27-1-15.5-8, AS AMENDED BY P.L.253-1997(ss), SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 8. (a) The commissioner may suspend, revoke, refuse to continue, renew, or issue any license issued under this chapter, or impose any of the disciplinary sanctions under subsection (f) if, after notice to the licensee and to the insurer represented and a hearing, the commissioner finds as to the licensee any one (1) or more of the following conditions:

(1) Any materially untrue statement in the license application.

(2) Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner at the time of issuance.

(3) Violation of or noncompliance with any insurance laws, violation of any provision of IC 28 concerning the sale of a life insurance policy or an annuity contract, or violation of any lawful rule, regulation, or order of the commissioner or of a commissioner of another state.

(4) Obtaining or attempting to obtain any such license through misrepresentation or fraud.

(5) Improperly withholding, misappropriating, or converting to the licensee's own use any money belonging to policyholders, insurers, beneficiaries, or others received in the course of the licensee's insurance business.

(6) Misrepresentation of the terms of any actual or proposed insurance contract.

(7) **A:**

(A) conviction of; **or**

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

a felony or misdemeanor involving moral turpitude.

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

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

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

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

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

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

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

(b) The commissioner shall refuse to:

(1) issue a license; or

(2) renew a license issued;

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

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

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

(e) In addition to or in lieu of any applicable denial, suspension, or revocation of a license, any person violating this chapter may, after hearing, be subject to a civil penalty of not less than fifty dollars ($50) nor more than ten thousand dollars ($10,000). Such a penalty may be enforced in the same manner as civil judgments.

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

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

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

(3) Suspend a licensee's certificate.

(4) Censure a licensee.

(5) Issue a letter of reprimand.

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

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

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

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

The commissioner may withdraw the probation if the

commissioner finds that the deficiency that required disciplinary action has been remedied.

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

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

SECTION 7. IC 27-1-20-33, AS AMENDED BY P.L.251-1995, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 33. (a) As used in this section, "insurer" refers to each:

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

that is authorized to transact business in Indiana.

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

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

(1) must be:
(A) in the same format; and
(B) of the same scope;

as is required by the commissioner under section 21 of this chapter;

(2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and
(3) must be filed on diskette in accordance with NAIC diskette filing specifications.

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

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

(e) A foreign company that:

(1) is domiciled in a state that has a law substantially similar to subsection (c); and

(2) complies with that law;

shall be considered to be in compliance with this section.

(f) In the absence of actual malice:

(1) members of the NAIC;

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

(3) delegates of members of the NAIC;

(4) employees of the NAIC; and

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

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

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

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

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

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

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

SECTION 9. IC 27-7-9-8, AS AMENDED BY P.L.116-1994, SECTION 57, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 8. (a) Coverage for damage due to mine subsidence must be available as an additional form of coverage under any insurance policy providing the type of insurance described in Class

3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located in a county identified under section 6 of this chapter. The mine subsidence coverage must be available in an amount adequate to indemnify the insured to the extent of the loss in actual cash value of the covered structure due to mine subsidence, less a deductible equal to two percent (2%) of the insured value of the structure under the policy. However, the deductible must be no less than two hundred fifty dollars ($250) and no more than five hundred dollars ($500).

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

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

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

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

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

(1) declined to issue the policy;

(2) declined to renew the policy; or

(3) canceled all coverage under the policy for underwriting reasons unrelated to mine subsidence.

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

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

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

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

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

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

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

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

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

(3) A provision as follows: GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will

be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

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

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

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

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

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

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

(5) A provision as follows: NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as

soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

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

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

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

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

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

(9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary

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

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

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

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

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

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

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

(12) A provision as follows: CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

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

(13) A provision as follows: GUARANTEED RENEWABILITY: In compliance with the federal Health Insurance Portability and

Accountability Act of 1996 (P.L.104-191), renewability is guaranteed.

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

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

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

(3) A provision as follows: OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $ _____ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate. Or, instead of that provision: Insurance effective at any one (1) time on the insured under a like policy or policies, in this insurer is limited to the one (1) such policy elected by the insured, the insured's beneficiary or the insured's estate,

as the case may be, and the insurer will return all premiums paid for all other such policies.

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

If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(5) A provision as follows: INSURANCE WITH OTHER INSURERS: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "-OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage to the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

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

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

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

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

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of

this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) more favorable to the persons insured; or

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

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

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

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

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

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of

the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

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

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

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

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

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

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

(6) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(7) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement that:

(A) explains the insurance protection to which the person

insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

(8) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(9) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(10) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(11) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid within forty-five (45) days after the insurer receives all information required to determine liability under the terms of the policy; and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(12) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(13) A provision that the insurer has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(14) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy, and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(15) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(16) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of mental retardation or a physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded

or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) group health plan;

(B) governmental plan; or

(C) church plan;

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

(2) who is not eligible for coverage under:

(A) a group health plan;
(B) Part A or Part B of Title XVIII of the federal Social Security Act; or
(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);
and does not have other health insurance coverage;
(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;
(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and
(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(j) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(k) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

~~(g)~~ **(l)** "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

~~(h)~~ **(m)** "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

~~(i)~~ **(n)** "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

~~(j)~~ **(o)** "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

~~(k)~~ **(p)** "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance

organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

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

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

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

(1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

(3) insurance covering medical care referred to in subdivisions (1) and (2).

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

(1) are recommended by a legally qualified physician;

(2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and

(3) are not primarily for the scholastic education or vocational training of the provider or patient.

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

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

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

~~(r)~~ **(x)** "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

~~(s)~~ **(y)** "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

~~(t)~~ **(z)** "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

~~(u)~~ **(a)** "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

~~(v)~~ **(b)** "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital,

medical, and surgical expenses of individuals who are eligible for Medicare benefits.

~~(w)~~ **(c)** "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 13. IC 27-8-10-2.1, AS AMENDED BY P.L.255-1995, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 1, 1998]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

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

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

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

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

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

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon

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

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

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

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter**, subject to the approval of the commissioner**.

(2) Sue or be sued, including taking any legal actions necessary

or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

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

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

by the association must be submitted to the commissioner for approval.

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

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

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

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

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

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

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

(n) Members who after July 1, 1983, during any calendar year, have

paid one (1) or more assessments levied under this chapter may either:

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

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

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

SECTION 14. IC 27-8-10-5.1, AS AMENDED BY P.L.2-1995, SECTION 109, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy ~~who,~~ **if,** at the effective date of coverage, **the person** has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

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

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

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

(3) the person is a federally eligible individual.

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

(c) The board of directors may establish procedures that would permit:

(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and

(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health

insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

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

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

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

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

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

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of ~~six (6)~~ **three (3)** months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as

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

~~(2)~~ medical advice or treatment was recommended or received within a period of ~~six (6)~~ **three (3)** months before the effective date of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) whose coverage under this subsection:

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

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

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

~~(2)~~ **(c)** The **term "late enrollee" does not include an** eligible

employee **who** is employed by a small employer that offers multiple health insurance plans and ~~the eligible employee~~ **who** elects a different plan during an open enrollment period.

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

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

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

SECTION 16. IC 27-8-15-14, AS AMENDED BY P.L.190-1996, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 14. As used in this chapter, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least ~~three (3)~~ **two (2)** but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

SECTION 17. IC 27-8-15-19, AS AMENDED BY P.L.93-1995, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 19. Except as provided in section 20 of this chapter, a small employer insurer may only cancel or refuse to renew a health insurance plan for the following reasons:

(1) Nonpayment of required premiums.

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

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

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

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

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

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

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

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

(5) In the case of coverage that is made available through one (1) or more bona fide associations, the membership of the

small employer in the association ceases, but only if the coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to an insured individual.

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

(A) the insurer provides notice of the insurer's intent to discontinue the coverage to each small employer provided with the coverage;

(B) the insurer offers the option to purchase all other health insurance coverage currently being offered by the insurer to the small employer to each small employer that is provided with the coverage; and

(C) in exercising the option to discontinue the coverage in offering the option of coverage under clause (B), the insurer acts uniformly without regard to:

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

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

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

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

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

(1) A hospital or medical expense incurred policy or certificate.

(2) A hospital or medical service plan contract.

(3) A health maintenance organization subscriber contract.

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

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

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

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

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

SECTION 20. IC 27-8-15-34.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: **Sec. 34.1. Except as provided in 29 U.S.C. 1191a and 42 U.S.C. 300gg, a small employer insurer must:**

(1) offer to any small employer all products that are approved for sale in the small group market and that the insurer is actively marketing; and
(2) accept any employer that applies for any of those products.".

Page 1, delete lines 1 through 5.

Page 1, line 6, delete "IC 27-12-3-5" and insert "IC 34-18-3-5, AS ADDED BY HEA 1011-1998,".

Page 2, line 12, delete "failed to transmit" and insert "**erred in transmitting**".

Page 2, line 14, after "must" insert "**, in addition to any penalties under IC 34-18-5-3,**".

Page 2, between lines 30 and 31, begin a new paragraph and insert:

"SECTION 22. IC 27-13-7-3, AS ADDED BY P.L.26-1994, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 3. (a) A contract referred to in section 1 of this

chapter must clearly state the following:

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

(2) Eligibility requirements.

(3) Benefits and services within the service area.

(4) Emergency care benefits and services.

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

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

(7) Limitations and exclusions.

(8) Enrollee termination provisions.

(9) Any enrollee reinstatement provisions.

(10) Claims procedures.

(11) Enrollee grievance procedures.

(12) Continuation of coverage provisions.

(13) Conversion provisions.

(14) Extension of benefit provisions.

(15) Coordination of benefit provisions.

(16) Any subrogation provisions.

(17) A description of the service area.

(18) The entire contract provisions.

(19) The term of the coverage provided by the contract.

(20) Any right of cancellation of the group or individual contract holder.

(21) Right of renewal provisions.

(22) Provisions regarding reinstatement of a group or an individual contract holder.

(23) Grace period provisions.

(24) A provision on conformity with state law.

(25) A provision or provisions that comply with the:

(A) guaranteed renewability; and

(B) group portability;

requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

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

SECTION 23. IC 27-13-29-1, AS AMENDED BY P.L.255-1995, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) Except as provided in subsection (b) or as otherwise provided in this article or IC 27:

(1) IC 27; and

(2) the provisions of IC 16 regulating hospitals;

do not apply to any health maintenance organization or limited service health maintenance organization **(as defined in IC 27-13-34-4)** that is granted a certificate of authority under this article. However, this section does not apply to an insurer or a hospital that is licensed under Indiana law, except with respect to the health maintenance organization activities of the hospital or insurer that are authorized and regulated under this article.

(b) Every:

(1) health maintenance organization; **and**

(2) limited service health maintenance organization (as defined in IC 27-13-34-4);

authorized to do business in Indiana is subject to IC 27-4-1 relating to unfair methods of competition and unfair or deceptive acts or practices to the extent that IC 27-4-1 does not conflict with this article. If a provision in IC 27-4-1 conflicts with this article, this article governs and controls.

SECTION 24. IC 27-8-15-34 IS REPEALED [EFFECTIVE APRIL 1, 1998].

SECTION 25. [EFFECTIVE JULY 1, 1998] **(a) Notwithstanding IC 27-8-10-2.1, the terms of the members of the Indiana Comprehensive Health Insurance Association board of directors serving on August 31, 1998, expire August 31, 1998.**

(b) The commissioner shall appoint, not later than September 1, 1998, the members of the Indiana Comprehensive Health Insurance Association board of directors as required under IC 27-8-10-2.1(b), as amended by this act, for terms commencing on September 1, 1998.

(c) This SECTION expires January 1, 2000.

SECTION 26. [EFFECTIVE APRIL 1, 1998] **(a) IC 27-8-5-3 and IC 27-8-5-19, both as amended by this act, apply to all accident and sickness policies in force on April 1, 1998.**

(b) IC 27-8-15-10.5, IC 27-8-15-14, IC 27-8-15-19, IC 27-8-15-27, IC 27-8-15-28, all as amended by this act, and IC 27-8-15-34.1, as added by this act, apply to all small employer health insurance plans in force under IC 27-8-15 on April 1, 1998.".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1286 as printed February 17, 1998.)

Conference Committee Report
on
House Bill 1286

Signed by:

Senator	Representative Fry
Senator	Representative Torr
Senate Conferees	**House Conferees**