

Adopted	Rejected
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## COMMITTEE REPORT

YES:	13
NO:	2

### MR. SPEAKER:

*Your Committee on Insurance, Corporations and Small Business, to which was referred Senate Bill 292, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill **be amended** as follows:*

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

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

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

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

34 (c) The trust fund may not be commingled with any other funds  
 35 and shall be invested only in accordance with Indiana laws for the  
 36 investment of trust funds, together with such other investments as are  
 37 specifically designated in the pension trust. Subject to the terms of the  
 38 pension trust, the trustee, with the approval of the Department and the

1 Pension Advisory Board, may establish investment guidelines and  
 2 limits on all types of investments (including, but not limited to, stocks  
 3 and bonds) and take other action necessary to fulfill its duty as a  
 4 fiduciary for the trust fund. However, the trustee shall invest the trust  
 5 fund assets with the same care, skill, prudence, and diligence that a  
 6 prudent person acting in a like capacity and familiar with such matters  
 7 would use in the conduct of an enterprise of a like character with like  
 8 aims. The trustee shall also diversify such investments in accordance  
 9 with prudent investment standards. The investment of trust funds is  
 10 subject to section 2.5 of this chapter.

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

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

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

23 SCHEDULE I. Receipts and disbursements.

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

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

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

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

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

1           year.

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

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

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

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

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

38           (3) A blood bank, community mental health center, community

1 mental retardation center, community health center, or migrant  
2 health center.

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

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

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

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

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

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

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

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

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

22 **(1) chiropractic;**

23 **(2) optometry; or**

24 **(3) podiatry.**

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

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

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

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

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

- 1           **(1) Practice in the hospital.**
- 2           **(2) The granting of privileges to a provider.**
- 3           **(3) The retention of privileges.**
- 4           **(c) The fact that an applicant for privileges to provide patient**  
5 **care services is a health care provider may not serve as a basis for**  
6 **denying the applicant privileges to provide patient care services**  
7 **that are allowed under the professional license held by the**  
8 **applicant.**
- 9           **(d) The board may determine the kinds of health care**  
10 **procedures and treatments that are appropriate for an inpatient or**  
11 **outpatient hospital setting.**
- 12           **(e) The standards and rules described in subsection (b) may,**  
13 **in the interest of good patient care, allow the board to do the**  
14 **following:**
  - 15           **(1) Consider a health care provider's postgraduate**  
16 **education, training, experience, and other facts concerning**  
17 **the provider that may affect the provider's professional**  
18 **competence.**
  - 19           **(2) Consider the scope of practice allowed under the**  
20 **professional license held by a health care provider.**
  - 21           **(3) Limit privileges for admitting patients to the hospital to**  
22 **physicians licensed under IC 25-22.5.**
  - 23           **(4) Limit responsibility for the management of a patient's**  
24 **care to physicians licensed under IC 25-22.5.**
  - 25           **(5) Limit or preclude a health care provider's performance**  
26 **of x-rays or other imaging procedures in an inpatient or**  
27 **outpatient hospital setting. However, this subdivision does**  
28 **not affect the ability of a health care provider to order x-rays**  
29 **under that provider's scope of practice.**
- 30           **(f) The standards and rules described in subsection (b) may**  
31 **include a requirement for the following:**
  - 32           **(1) Submitting proof that a health care provider is qualified**  
33 **under IC 27-12-3-2.**
  - 34           **(2) Performing patient care and related duties in a manner**  
35 **that is not disruptive to the delivery of quality care in the**  
36 **hospital setting.**
  - 37           **(3) Maintaining standards of quality care that recognize the**  
38 **efficient and effective utilization of hospital resources as**

- 1           **developed by the hospital's medical staff.**
- 2           **(g) The standards and rules described in subsection (b) must**  
3 **allow a health care provider who applies for privileges an**  
4 **opportunity to appear before a peer review committee that is**  
5 **established by the board to make recommendations regarding**  
6 **applications for privileges by health care providers before the peer**  
7 **review committee makes its recommendations regarding the**  
8 **applicant's request for privileges.**
- 9           **(h) The board must provide for a hearing before a peer review**  
10 **committee for a health care provider whose privileges have been**  
11 **recommended for termination.**
- 12           SECTION 5. IC 16-22-8-39.5 IS ADDED TO THE INDIANA  
13 CODE AS A NEW SECTION TO READ AS FOLLOWS  
14 [EFFECTIVE JANUARY 1, 1999]: **Sec. 39.5. (a) The governing**  
15 **board may delineate privileges for the provision of patient care**  
16 **services by a health care provider.**
- 17           **(b) A health care provider is eligible for privileges to provide**  
18 **patient care services, but the board shall establish and enforce**  
19 **reasonable standards and rules concerning a health care provider's**  
20 **qualifications for the following:**
- 21               **(1) Practice in the hospital.**  
22               **(2) The granting of privileges to a provider.**  
23               **(3) The retention of privileges.**
- 24           **(c) The fact that an applicant for privileges to provide patient**  
25 **care services is a health care provider may not serve as a basis for**  
26 **denying the applicant privileges to provide patient care services**  
27 **that are allowed under the professional license held by the**  
28 **applicant.**
- 29           **(d) The board may determine the kinds of health care**  
30 **procedures and treatments that are appropriate for an inpatient or**  
31 **outpatient hospital setting.**
- 32           **(e) The standards and rules described in subsection (b) may,**  
33 **in the interest of good patient care, allow the board to do the**  
34 **following:**
- 35               **(1) Consider a health care provider's postgraduate**  
36 **education, training, experience, and other facts concerning**  
37 **the provider that may affect the provider's professional**  
38 **competence.**

- 1           **(2) Consider the scope of practice allowed under the**  
 2           **professional license held by a health care provider.**  
 3           **(3) Limit privileges for admitting patients to the hospital to**  
 4           **physicians licensed under IC 25-22.5.**  
 5           **(4) Limit responsibility for the management of a patient's**  
 6           **care to physicians licensed under IC 25-22.5.**  
 7           **(5) Limit or preclude a health care provider's performance**  
 8           **of x-rays or other imaging procedures in an inpatient or**  
 9           **outpatient hospital setting. However, this subdivision does**  
 10           **not affect the ability of a health care provider to order x-rays**  
 11           **under that provider's scope of practice.**  
 12           **(f) The standards and rules described in subsection (b) may**  
 13           **include a requirement for the following:**  
 14               **(1) Submitting proof that a health care provider is qualified**  
 15               **under IC 27-12-3-2.**  
 16               **(2) Performing patient care and related duties in a manner**  
 17               **that is not disruptive to the delivery of quality care in the**  
 18               **hospital setting.**  
 19               **(3) Maintaining standards of quality care that recognize the**  
 20               **efficient and effective utilization of hospital resources as**  
 21               **developed by the hospital's medical staff.**  
 22           **(g) The standards and rules described in subsection (b) must**  
 23           **allow a health care provider who applies for privileges an**  
 24           **opportunity to appear before a peer review committee that is**  
 25           **established by the board to make recommendations regarding**  
 26           **applications for privileges by health care providers before the peer**  
 27           **review committee makes its recommendations regarding the**  
 28           **applicant's request for privileges.**  
 29           **(h) The board must provide for a hearing before a peer review**  
 30           **committee for a health care provider whose privileges have been**  
 31           **recommended for termination.**

32           SECTION 6. IC 22-3-5-6 IS AMENDED TO READ AS  
 33           FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 6. (a) The worker's  
 34           compensation supplemental administrative fund is established for the  
 35           purpose of carrying out the administrative purposes and functions of  
 36           the worker's compensation board. The fund consists of fees collected  
 37           from employers under sections 1 through 2 of this chapter. ~~and from~~  
 38           ~~fees collected under IC 22-3-2-14.5 and IC 22-3-7-34.5.~~ The fund shall

1 be administered by the worker's compensation board. ~~Money in the~~  
 2 ~~fund is annually appropriated to the worker's compensation board for~~  
 3 ~~its use in carrying out the administrative purposes and functions of the~~  
 4 ~~worker's compensation board.~~

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

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

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

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

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

32 (2) An executive officer of a municipal corporation or other  
 33 governmental subdivision or of a charitable, religious,  
 34 educational, or other nonprofit corporation may, notwithstanding  
 35 any other provision of IC 22-3-2 through IC 22-3-6, be brought  
 36 within the coverage of its insurance contract by the corporation  
 37 by specifically including the executive officer in the contract of  
 38 insurance. The election to bring the executive officer within the

1 coverage shall continue for the period the contract of insurance  
2 is in effect, and during this period, the executive officers thus  
3 brought within the coverage of the insurance contract are  
4 employees of the corporation under IC 22-3-2 through IC 22-3-6.  
5 (3) Any reference to an employee who has been injured, when  
6 the employee is dead, also includes the employee's legal  
7 representatives, dependents, and other persons to whom  
8 compensation may be payable.  
9 (4) An owner of a sole proprietorship may elect to include the  
10 owner as an employee under IC 22-3-2 through IC 22-3-6 if the  
11 owner is actually engaged in the proprietorship business. If the  
12 owner makes this election, the owner must serve upon the  
13 owner's insurance carrier and upon the board written notice of  
14 the election. No owner of a sole proprietorship may be  
15 considered an employee under IC 22-3-2 through IC 22-3-6 until  
16 the notice has been received. ~~If the owner of a sole~~  
17 ~~proprietorship is an independent contractor in the construction~~  
18 ~~trades and does not make the election provided under this~~  
19 ~~subdivision, the owner must obtain an affidavit of exemption~~  
20 ~~under IC 22-3-2-14.5.~~  
21 (5) A partner in a partnership may elect to include the partner as  
22 an employee under IC 22-3-2 through IC 22-3-6 if the partner is  
23 actually engaged in the partnership business. If a partner makes  
24 this election, the partner must serve upon the partner's insurance  
25 carrier and upon the board written notice of the election. No  
26 partner may be considered an employee under IC 22-3-2 through  
27 IC 22-3-6 until the notice has been received. ~~If a partner in a~~  
28 ~~partnership is an independent contractor in the construction~~  
29 ~~trades and does not make the election provided under this~~  
30 ~~subdivision, the partner must obtain an affidavit of exemption~~  
31 ~~under IC 22-3-2-14.5.~~  
32 (6) Real estate professionals are not employees under IC 22-3-2  
33 through IC 22-3-6 if:  
34 (A) they are licensed real estate agents;  
35 (B) substantially all their remuneration is directly related to  
36 sales volume and not the number of hours worked; and  
37 (C) they have written agreements with real estate brokers  
38 stating that they are not to be treated as employees for tax

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purposes.

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

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

~~(9)~~ (8) A member or manager in a limited liability company may elect to include the member or manager as an employee under IC 22-3-2 through IC 22-3-6 if the member or manager is actually engaged in the limited liability company business. If a member or manager makes this election, the member or manager must serve upon the member's or manager's insurance carrier and upon the board written notice of the election. A member or manager may not be considered an employee under IC 22-3-2 through IC 22-3-6 until the notice has been received.

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

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

(2) If the employee is a minor who, at the time of the accident, is employed, required, suffered, or permitted to work in violation of IC 20-8.1-4-25, the amount of compensation and death benefits, as provided in IC 22-3-2 through IC 22-3-6, shall be double the amount which would otherwise be recoverable. The insurance carrier shall be liable on its policy for one-half (1/2) of

1 the compensation or benefits that may be payable on account of  
2 the injury or death of the minor, and the employer shall be liable  
3 for the other one-half (1/2) of the compensation or benefits. If  
4 the employee is a minor who is not less than sixteen (16) years  
5 of age and who has not reached seventeen (17) years of age and  
6 who at the time of the accident is employed, suffered, or  
7 permitted to work at any occupation which is not prohibited by  
8 law, this subdivision does not apply.

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

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

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

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

34 (2) Where the employment prior to the injury extended over a  
35 period of less than fifty-two (52) weeks, the method of dividing  
36 the earnings during that period by the number of weeks and parts  
37 thereof during which the employee earned wages shall be  
38 followed, if results just and fair to both parties will be obtained.

1           Where by reason of the shortness of the time during which the  
2           employee has been in the employment of the employee's  
3           employer or of the casual nature or terms of the employment it  
4           is impracticable to compute the average weekly wages, as  
5           defined in this subsection, regard shall be had to the average  
6           weekly amount which during the fifty-two (52) weeks previous  
7           to the injury was being earned by a person in the same grade  
8           employed at the same work by the same employer or, if there is  
9           no person so employed, by a person in the same grade employed  
10          in the same class of employment in the same district.

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

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

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

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

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

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

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

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

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

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

- 1 three (3) digits 465 and 466.
- 2 (3) The geographic service area served by zip codes with the first
- 3 three (3) digits 467 and 468.
- 4 (4) The geographic service area served by zip codes with the first
- 5 three (3) digits 469 and 479.
- 6 (5) The geographic service area served by zip codes with the first
- 7 three (3) digits 460, 461 (except 46107), and 473.
- 8 (6) The geographic service area served by the 46107 zip code
- 9 and zip codes with the first three (3) digits 462.
- 10 (7) The geographic service area served by zip codes with the first
- 11 three (3) digits 470, 471, 472, 474, and 478.
- 12 (8) The geographic service area served by zip codes with the first
- 13 three (3) digits 475, 476, and 477.
- 14 (i) "Medical service provider" refers to a person or an entity that
- 15 provides medical services, treatment, or supplies to an employee under
- 16 IC 22-3-2 through IC 22-3-6.
- 17 (j) "Pecuniary liability" means the responsibility of an employer
- 18 or the employer's insurance carrier for the payment of the charges for
- 19 each specific service or product for human medical treatment provided
- 20 under IC 22-3-2 through IC 22-3-6 in a defined community, equal to or
- 21 less than the charges made by medical service providers at the eightieth
- 22 percentile in the same community for like services or products.
- 23 SECTION 8. IC 22-3-7-9, AS AMENDED BY P.L.258-1997(ss),
- 24 SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 25 APRIL 1, 1998]: Sec. 9. (a) As used in this chapter, "employer"
- 26 includes the state and any political subdivision, any municipal
- 27 corporation within the state, any individual or the legal representative
- 28 of a deceased individual, firm, association, limited liability company,
- 29 or corporation or the receiver or trustee of the same, using the services
- 30 of another for pay. If the employer is insured, the term includes his
- 31 insurer so far as applicable. However, the inclusion of an employer's
- 32 insurer within this definition does not allow an employer's insurer to
- 33 avoid payment for services rendered to an employee with the approval
- 34 of the employer.
- 35 (b) As used in this chapter, "employee" means every person,
- 36 including a minor, in the service of another, under any contract of hire
- 37 or apprenticeship written or implied, except one whose employment is
- 38 both casual and not in the usual course of the trade, business,

1 occupation, or profession of the employer. For purposes of this chapter  
2 the following apply:

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

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

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

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

30 (A) they are licensed real estate agents;

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

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

36 ~~(5) A person is an independent contractor in the construction  
37 trades and not an employee under this chapter if the person is an  
38 independent contractor under the guidelines of the United States~~

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

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

35           (d) This chapter does not apply to casual laborers as defined in  
36           subsection (b), nor to farm or agricultural employees, nor to household  
37           employees, nor to railroad employees engaged in train service as  
38           engineers, firemen, conductors, brakemen, flagmen, baggagemen, or

1 foremen in charge of yard engines and helpers assigned thereto, nor to  
2 their employers with respect to these employees. Also, this chapter  
3 does not apply to employees or their employers with respect to  
4 employments in which the laws of the United States provide for  
5 compensation or liability for injury to the health, disability, or death by  
6 reason of diseases suffered by these employees.

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

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

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

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

30 (3) In all cases of occupational diseases caused by the inhalation  
31 of asbestos dust, no compensation shall be payable unless  
32 disablement, as defined in subsection (e), occurs within three (3)  
33 years after the last day of the last exposure to the hazards of the  
34 disease if the last day of the last exposure was before July 1,  
35 1985.

36 (4) In all cases of occupational disease caused by the inhalation  
37 of asbestos dust in which the last date of the last exposure occurs  
38 on or after July 1, 1985, and before July 1, 1988, no

1 compensation shall be payable unless disablement, as defined in  
2 subsection (e), occurs within twenty (20) years after the last day  
3 of the last exposure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Certified statement of condition . . . . . \$ 5  
 2 Any other document required to be  
 3 filed by this article . . . . . \$ 25

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

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

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

11 For the certificate . . . . . \$10

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

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

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

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

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

1 commissioner has found that:

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

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

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

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

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

37       SECTION 11. IC 27-1-8-13 IS AMENDED TO READ AS  
 38 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 13. (a) Any domestic

1 mutual insurance company may by amendment of its articles of  
 2 incorporation convert to a stock insurance company only upon  
 3 compliance with the requirements of this section and applicable  
 4 requirements of sections 1 through 8 and 11 of this chapter.

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

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

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

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

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

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

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

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

38 (A) **The members and policyholders of the company**

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

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

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

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

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

36 (i) **that the company will assure that an active**  
 37 **public trading market for the capital stock of the**  
 38 **company will develop within a reasonable time**

- 1                   **after the effective date of the plan of conversion or**  
 2                   **after the delivery of stock certificates to the**  
 3                   **members or policyholders; and**  
 4                   **(ii) with the terms and conditions of any public**  
 5                   **offering or other stock offerings or sales by the**  
 6                   **company proposed to be made during the three (3)**  
 7                   **year period following the effective date of the plan**  
 8                   **of conversion, including any stock subscription**  
 9                   **rights of the members and policyholders.**
- 10           **(6) The plan of conversion may include procedures for:**
- 11                   **(A) establishment of a noninsurance stock holding**  
 12                   **corporation for the company concurrent with or**  
 13                   **immediately following the effective date of the plan of**  
 14                   **conversion and for the exchange or conversion of the**  
 15                   **members' or policyholders' rights to and interests in**  
 16                   **capital stock of the company for or into equivalent**  
 17                   **rights to and interests in capital stock of the**  
 18                   **noninsurance stock holding corporation;**
- 19                   **(B) delayed delivery of stock certificates or cash to the**  
 20                   **members or policyholders of the company, or**  
 21                   **restrictions on sale or transfer of capital stock by**  
 22                   **members or policyholders of the company, for a**  
 23                   **reasonable time following the effective date of the plan**  
 24                   **of conversion; and**
- 25                   **(C) delayed establishment of the formulas required by**  
 26                   **subdivision (2)(A) or establishment in the plan of**  
 27                   **conversion of specific conditional or alternative**  
 28                   **formulas.**
- 29           ~~(8)~~ **(7) The plan of conversion may contain** such other terms  
 30                   and provisions as the company deems necessary or desirable.
- 31                   (c) Any such mutual insurance company shall file with the  
 32                   department, following the adoption by its board of directors of such  
 33                   resolution proposing the amendment and plan of conversion, and  
 34                   before its submission to a vote by its members or policyholders, three  
 35                   (3) copies of the proposed amendment to the articles of incorporation,  
 36                   together with three (3) copies of the plan of conversion and such other  
 37                   supporting documents as the company **or the department** deems  
 38                   necessary.

1 (d) The insurance commissioner shall hold a hearing upon the  
2 terms, conditions, and provisions of the plan of conversion, at which  
3 hearing the policyholders of the company and any other interested party  
4 shall have the right to appear and become a party to the proceedings.  
5 The commissioner shall require the company to produce such evidence  
6 as he shall deem necessary to establish that the plan of conversion  
7 meets the requirements set forth in this section and further that it is fair  
8 and equitable to the members and policyholders of the company. Such  
9 hearing shall be commenced not less than twenty (20) days after the  
10 date on which the amendment and plan of conversion are presented to  
11 the department, and shall be held in the city of Indianapolis, Indiana,  
12 at such place, date, and time as the department shall specify. Notice of  
13 the hearing shall be published in a newspaper of general circulation in  
14 the city wherein is located the principal office of the company and in  
15 the city of Indianapolis once a week for two (2) successive weeks.  
16 Written notice of the hearing shall be mailed by the company to its  
17 members and policyholders having voting rights at least ten (10) days  
18 prior to the hearing. Except as otherwise provided in this section, the  
19 hearing and the determination made therein shall be subject to  
20 IC 4-21.5-3.

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

- 25 (1) the plan, including all such modifications, if effected, will  
26 meet all the requirements set forth in this section;
- 27 (2) such plan is equitable to the members and policyholders of  
28 the company;
- 29 (3) the terms and conditions of the plan of conversion are fair  
30 and reasonable;
- 31 (4) upon consummation of the plan of conversion the paid-in  
32 capital and surplus of the company shall be in an amount not less  
33 than the minimum paid-in capital and surplus required to  
34 organize a domestic stock insurance company to transact like  
35 kinds of insurance; and
- 36 (5) all the rights of every member and policyholder as fixed in  
37 any policy of insurance of the company, excluding voting rights,  
38 if any, shall be and remain unaffected by the proposed

1 conversion and shall continue in full force in accordance with  
2 the terms of the policy of each such member and policyholder.

3 (f) The order of the commissioner approving or disapproving the  
4 plan of conversion shall be filed in the department within thirty (30)  
5 days after the last day of the hearing before the commissioner. The  
6 department shall promptly give notice of such order to all persons who  
7 appeared at the hearing and requested to be made parties to the  
8 proceedings, and the department shall endorse the commissioner's  
9 approval or disapproval on the plan of conversion in the manner  
10 provided in IC 27-1-6-8 and shall deliver copies thereof to the  
11 company. The company or any person who was made a party to such  
12 proceedings aggrieved by such order shall be entitled to a judicial  
13 review thereof in accordance with IC 4-21.5-5. Subject only to such  
14 judicial review, the determination and order of the commissioner (or  
15 the court upon judicial review) in approving or disapproving the plan  
16 of conversion shall be binding and conclusive upon all parties to the  
17 proceedings and all policyholders or members with respect to the  
18 fairness of the plan and its compliance with this article and with respect  
19 to the proportionate share, if any, of each policyholder or member in  
20 the equity **or capital stock** of the company and the value **or**  
21 **proportionate share, if any**, of his membership interests or rights as  
22 determined under the ~~formula~~ **formulas** referred to in subsection  
23 (b)(2).

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

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

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

1 (1) the date and time of approval of the articles of amendment by  
 2 the secretary of state as provided in section 8 of this chapter; and  
 3 (2) the date and time of filing with the department a certificate  
 4 setting forth the plan of conversion and the manner of its  
 5 approval by the directors and policyholders of the company,  
 6 which shall be executed on behalf of the company by its  
 7 president or a vice president;  
 8 unless a later date and time is specified in the plan of conversion, in  
 9 which event the plan of conversion and amendment shall become  
 10 effective and take place upon such later date and time.

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

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

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

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

26 SECTION 12. IC 27-1-15.5-3, AS AMENDED BY P.L. 185-1996,  
 27 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 28 JULY 1, 1998]: Sec. 3. (a) A person may not act as or hold himself out  
 29 to be an insurance agent, surplus lines insurance agent, limited  
 30 insurance representative, or consultant unless he is duly licensed. An  
 31 insurance agent, surplus lines insurance agent, or limited insurance  
 32 representative may not make application for, procure, negotiate for, or  
 33 place for others any policies for any kinds of insurance as to which he  
 34 is not then qualified and duly licensed. An insurance agent and a  
 35 limited insurance representative may receive qualification for a license  
 36 in one (1) or more of the kinds of insurance defined in Class I, Class II,  
 37 and Class III of IC 27-1-5-1. A surplus lines insurance agent may  
 38 receive qualification for a license in one (1) or more of the kinds of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 performed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (7) **A:**  
27 (A) conviction of; or  
28 (B) **plea of guilty, no contest, or nolo contendere to;**  
29 a felony or misdemeanor involving moral turpitude."

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

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

- 35 (1) domestic company;
  - 36 (2) foreign company; and
  - 37 (3) alien company;
- 38 that is authorized to transact business in Indiana.

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

3 (c) On or before March 1 of each year, an insurer shall file with  
4 the National Association of Insurance Commissioners **and with the**  
5 **department** a copy of the insurer's annual statement convention blank  
6 and additional filings prescribed by the commissioner for the preceding  
7 year. An insurer shall also file quarterly statements with the NAIC **and**  
8 **with the department** on or before May 15, August 15, and November  
9 15 of each year in a form prescribed by the commissioner. The  
10 information filed with the NAIC under this subsection:

11 (1) must be:

12 (A) in the same format; and

13 (B) of the same scope;

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

16 (2) to the extent required by the NAIC, must include the signed  
17 jurat page and the actuarial certification; and

18 (3) must be filed on diskette in accordance with NAIC diskette  
19 filing specifications.

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

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

31 (e) A foreign company that:

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

34 (2) complies with that law;

35 shall be considered to be in compliance with this section.

36 (f) In the absence of actual malice:

37 (1) members of the NAIC;

38 (2) duly authorized committees, subcommittees, and task forces

1 of members of the NAIC;  
 2 (3) delegates of members of the NAIC;  
 3 (4) employees of the NAIC; and  
 4 (5) other persons responsible for collecting, reviewing,  
 5 analyzing, and disseminating information developed from the  
 6 filing of annual statement convention blanks under this section;  
 7 shall be considered to be acting as agents of the commissioner under  
 8 the authority of this section and are not subject to civil liability for  
 9 libel, slander, or any other cause of action by virtue of the collection,  
 10 review, analysis, or dissemination of the data and information collected  
 11 from the filings required by this section.

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

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

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

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

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

37 (b) The commissioner shall designate the bureau to assist in  
 38 gathering, compiling, and reporting relevant statistical information.

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

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

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

20 SECTION 19. IC 27-7-9-8, AS AMENDED BY P.L.116-1994,  
 21 SECTION 57, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 22 JULY 1, 1998]: Sec. 8. (a) Coverage for damage due to mine  
 23 subsidence must be available as an additional form of coverage under  
 24 any insurance policy providing the type of insurance described in Class  
 25 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located  
 26 in a county identified under section 6 of this chapter. The mine  
 27 subsidence coverage must be available in an amount adequate to  
 28 indemnify the insured to the extent of the loss in actual cash value of  
 29 the covered structure due to mine subsidence, less a deductible equal  
 30 to two percent (2%) of the insured value of the structure under the  
 31 policy. However, the deductible must be no less than two hundred fifty  
 32 dollars (\$250) and no more than five hundred dollars (\$500).

33 (b) An insurer proposing to issue ~~or renew~~ a policy providing the  
 34 type of insurance described in Class 3(a) of IC 27-1-5-1 to cover one  
 35 (1) or more structures located in a county identified under section 6 of  
 36 this chapter shall inform the ~~policyholder or~~ prospective policyholder  
 37 of the availability of mine subsidence coverage under this section. An  
 38 insurer shall inform the ~~policyholder or~~ prospective policyholder of the

1 availability of mine subsidence coverage under this subsection when  
 2 a policy described in this subsection is issued. ~~and each time a policy~~  
 3 ~~described in this subsection is renewed.~~ However, an insurer is not  
 4 required to inform a ~~policyholder or~~ prospective policyholder of the  
 5 availability of mine subsidence coverage if ~~(1) the issuance or renewal~~  
 6 of the policy will take place after June 30, ~~1997; 2000.~~ ~~or (2) the policy~~  
 7 ~~to be renewed already includes mine subsidence coverage.~~

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

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

25 (e) An insurer is not required to provide mine subsidence coverage  
 26 under subsection (a) under any insurance policy in an amount  
 27 exceeding the amount that is reimbursable from the fund under section  
 28 9(a)(4) of this chapter.

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

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

38 SECTION 20. IC 27-8-5-1 IS AMENDED TO READ AS

1       FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) The term "policy  
2 of accident and sickness insurance", as used in this chapter, includes  
3 any policy or contract covering one (1) or more of the kinds of  
4 insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies  
5 may be on the individual basis under this section and sections 2  
6 through 9 of this chapter, on the group basis under this section and  
7 sections 16 through 19 of this chapter, on the franchise basis under this  
8 section and section 11 of this chapter, or on a blanket basis under  
9 section 15 of this chapter and (except as otherwise expressly provided  
10 in this chapter) shall be exclusively governed by this chapter.

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

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

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

28       (1) if, in the case of an individual accident and sickness **form;**  
29 **filing**, the benefits provided therein are unreasonable in relation  
30 to the premium charged; or

31       (2) if, in the case of an individual, blanket, or group accident and  
32 sickness **form: filing**, it contains a provision or provisions that  
33 are unjust, unfair, inequitable, misleading, or deceptive or that  
34 encourage misrepresentation of the policy.

35       (e) If the commissioner notifies the insurer that ~~filed a form made~~  
36 **a filing** that the **form filing** does not comply with this section, it is  
37 unlawful thereafter for the insurer to issue **or use the form or use it**  
38 **filing** in connection with any policy. In the notice given under this

1 subsection, the commissioner shall specify the reasons for his  
2 disapproval and state that a hearing will be granted within twenty (20)  
3 days after request in writing by the insurer.

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

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

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

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

35 (2) A provision as follows: TIME LIMIT ON CERTAIN  
36 DEFENSES: (A) After two (2) years from the date of issue of this  
37 policy no misstatements, except fraudulent misstatements, made by the  
38 applicant in the application for such policy shall be used to void the

1 policy or to deny a claim for loss incurred or disability (as defined in  
2 the policy) commencing after the expiration of such two (2) year  
3 period.

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

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

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

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

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

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

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

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

38 Each policy in which the insurer reserves the right to refuse

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

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

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

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

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

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

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

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

33 (7) A provision as follows: PROOFS OF LOSS: Written proof of  
34 loss must be furnished to the insurer at its said office in case of claim  
35 for loss for which this policy provides any periodic payment contingent  
36 upon continuing loss within ninety (90) days after the termination of  
37 the period for which the insurer is liable and in case of claim for any  
38 other loss within ninety (90) days after the date of such loss. Failure to

1 furnish such proof within the time required shall not invalidate nor  
 2 reduce any claim if it was not reasonably possible to give proof within  
 3 such time, provided such proof is furnished as soon as reasonably  
 4 possible and in no event, except in the absence of legal capacity, later  
 5 than one (1) year from the time proof is otherwise required.

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

15 (9) A provision as follows: PAYMENT OF CLAIMS: Indemnity  
 16 for loss of life will be payable in accordance with the beneficiary  
 17 designation and the provisions respecting such payment which may be  
 18 prescribed herein and effective at the time of payment. If no such  
 19 designation or provision is then effective, such indemnity shall be  
 20 payable to the estate of the insured. Any other accrued indemnities  
 21 unpaid at the insured's death may, at the option of the insurer, be paid  
 22 either to such beneficiary or to such estate. All other indemnities will  
 23 be payable to the insured.

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

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

35 Subject to any written direction of the insured in the application  
 36 or otherwise all or a portion of any indemnities provided by this policy  
 37 on account of hospital, nursing, medical, or surgical services may, at  
 38 the insurer's option and unless the insured requests otherwise in writing

1 not later than the time of filing proofs of such loss, be paid directly to  
 2 the hospital or person rendering such services; but it is not required that  
 3 the service be rendered by a particular hospital or person.

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

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

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

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

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

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

32 (b) Except as provided in subsection (c), no policy delivered or  
 33 issued for delivery to any person in Indiana shall contain provisions  
 34 respecting the matters set forth below unless the provisions are in the  
 35 words in which the provisions appear in this section. However, the  
 36 insurer may use, instead of any provision, a corresponding provision of  
 37 different wording approved by the commissioner which is not less  
 38 favorable in any respect to the insured or the beneficiary. Any

1 substitute provision contained in the policy shall be preceded  
2 individually by the appropriate caption appearing in this subsection or,  
3 at the option of the insurer, by appropriate individual or group captions  
4 or subcaptions as the commissioner may approve.

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

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

32 (3) A provision as follows: **OTHER INSURANCE IN THIS**  
33 **INSURER:** If an accident or sickness or accident and sickness policy  
34 or policies previously issued by the insurer to the insured are in force  
35 concurrently herewith, making the aggregate indemnity for \_\_\_\_\_  
36 (insert type of coverage or coverages) in excess of \$ \_\_\_\_\_ (insert  
37 maximum limit of indemnity or indemnities) the excess insurance shall  
38 be void and all premiums paid for such excess shall be returned to the

1 insured or to the insured's estate. Or, instead of that provision:  
2 Insurance effective at any one (1) time on the insured under a like  
3 policy or policies, in this insurer is limited to the one (1) such policy  
4 elected by the insured, the insured's beneficiary or the insured's estate,  
5 as the case may be, and the insurer will return all premiums paid for all  
6 other such policies.

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

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

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

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

38 (6) A provision as follows: RELATION OF EARNINGS TO

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

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

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

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

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

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

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

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

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

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

36 (e) "Insured", as used in this chapter, shall not be construed as  
37 preventing a person other than the insured with a proper insurable  
38 interest from making application for and owning a policy covering the

1 insured or from being entitled under such a policy to any indemnities,  
2 benefits, and rights provided therein.

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

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

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

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

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

- 23 (1) the provisions described in subsection ~~(b)~~ (c); or  
24 (2) provisions that, in the opinion of the commissioner, are:  
25 (A) more favorable to the persons insured; or  
26 (B) at least as favorable to the persons insured and more  
27 favorable to the policyholder;  
28 than the provisions set forth in subsection ~~(b)~~ (c).

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

- 31 (1) A provision that the policyholder is entitled to a grace period  
32 of thirty-one (31) days for the payment of any premium due  
33 except the first, during which grace period the policy will  
34 continue in force, unless the policyholder has given the insurer  
35 written notice of discontinuance in advance of the date of  
36 discontinuance and in accordance with the terms of the policy.  
37 The policy may provide that the policyholder is liable to the  
38 insurer for the payment of a pro rata premium for the time the

- 1 policy was in force during the grace period. A provision under  
2 this subdivision may provide that the insurer is not obligated to  
3 pay claims incurred during the grace period until the premium  
4 due is received.
- 5 (2) A provision that the validity of the policy may not be  
6 contested, except for nonpayment of premiums, after the policy  
7 has been in force for two (2) years after its date of issue, and that  
8 no statement made by a person covered under the policy relating  
9 to the person's insurability may be used in contesting the validity  
10 of the insurance with respect to which the statement was made,  
11 unless:
- 12 (A) the insurance has not been in force for a period of two  
13 (2) years or longer during the person's lifetime; or  
14 (B) the statement is contained in a written instrument signed  
15 by the insured person.
- 16 However, a provision under this subdivision may not preclude  
17 the assertion at any time of defenses based upon a person's  
18 ineligibility for coverage under the policy or based upon other  
19 provisions in the policy.
- 20 (3) A provision that a copy of the application, if there is one, of  
21 the policyholder must be attached to the policy when issued, that  
22 all statements made by the policyholder or by the persons  
23 insured are to be deemed representations and not warranties, and  
24 that no statement made by any person insured may be used in  
25 any contest unless a copy of the instrument containing the  
26 statement is or has been furnished to the insured person or, in the  
27 event of death or incapacity of the insured person, to the insured  
28 person's beneficiary or personal representative.
- 29 (4) A provision setting forth the conditions, if any, under which  
30 the insurer reserves the right to require a person eligible for  
31 insurance to furnish evidence of individual insurability  
32 satisfactory to the insurer as a condition to part or all of the  
33 person's coverage.
- 34 (5) A provision specifying any additional exclusions or  
35 limitations applicable under the policy with respect to a disease  
36 or physical condition of a person that existed before the effective  
37 date of the person's coverage under the policy and that is not  
38 otherwise excluded from the person's coverage by name or

1 specific description effective on the date of the person's loss. An  
 2 exclusion or limitation that must be specified in a provision  
 3 under this subdivision:

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

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

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

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

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

24 (A) premiums;

25 (B) benefits; or

26 (C) both premiums and benefits;

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

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

33 (A) explains the insurance protection to which the person  
 34 insured is entitled;

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

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

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

8 (9) A provision stating that:

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

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

21 (10) A provision stating that:

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

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

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

- 1 (11) A provision that:  
2 (A) all benefits payable under the policy (other than  
3 benefits for loss of time) will be paid within forty-five (45)  
4 days after the insurer receives all information required to  
5 determine liability under the terms of the policy; and  
6 (B) subject to due proof of loss, all accrued benefits under  
7 the policy for loss of time will be paid not less frequently  
8 than monthly during the continuance of the period for which  
9 the insurer is liable, and any balance remaining unpaid at  
10 the termination of the period for which the insurer is liable  
11 will be paid as soon as possible after receipt of the proof of  
12 loss.
- 13 (12) A provision that benefits for loss of life of the person  
14 insured are payable to the beneficiary designated by the person  
15 insured. However, if the policy contains conditions pertaining to  
16 family status, the beneficiary may be the family member  
17 specified by the policy terms. In either case, payment of benefits  
18 for loss of life is subject to the provisions of the policy if no  
19 designated or specified beneficiary is living at the death of the  
20 person insured. All other benefits of the policy are payable to the  
21 person insured. The policy may also provide that if any benefit  
22 is payable to the estate of a person, or to a person who is a minor  
23 or otherwise not competent to give a valid release, the insurer  
24 may pay the benefit, up to an amount of five thousand dollars  
25 (\$5,000), to any relative by blood or connection by marriage of  
26 the person who is deemed by the insurer to be equitably entitled  
27 to the benefit.
- 28 (13) A provision that the insurer has the right and must be  
29 allowed the opportunity to:  
30 (A) examine the person of the individual for whom a claim  
31 is made under the policy when and as often as the insurer  
32 reasonably requires during the pendency of the claim; and  
33 (B) conduct an autopsy in case of death if it is not  
34 prohibited by law.
- 35 (14) A provision that no action at law or in equity may be  
36 brought to recover on the policy less than sixty (60) days after  
37 proof of loss is filed in accordance with the requirements of the  
38 policy, and that no action may be brought at all more than three

1 (3) years after the expiration of the time within which proof of  
2 loss is required by the policy.

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

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

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

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

18 A provision under this subdivision may require that proof of the  
19 child's incapacity and dependency be furnished to the insurer by  
20 the group member within one hundred twenty (120) days of the  
21 child's attainment of the limiting age and, subsequently, at  
22 reasonable intervals during the two (2) years following the  
23 child's attainment of the limiting age. The policy may not require  
24 proof more than once per year in the time more than two (2)  
25 years after the child's attainment of the limiting age. This  
26 subdivision does not require an insurer to provide coverage to a  
27 mentally retarded or physically disabled child who does not  
28 satisfy the requirements of the group policy as to evidence of  
29 insurability or other requirements for coverage under the policy  
30 to take effect. In any case, the terms of the policy apply with  
31 regard to the coverage or exclusion from coverage of the child.

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

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

1 accident and sickness insurance policies do not apply to group accident  
2 and sickness insurance policies.

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

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

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

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

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

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

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

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

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

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

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

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

36 **(B) governmental plan; or**

37 **(C) church plan;**

38 **or health insurance coverage in connection with any of these**

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

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

1 patient's diagnosed illness; and  
 2 (3) are not primarily for the scholastic education or vocational  
 3 training of the provider or patient.

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

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

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

11 (x) "Preexisting condition" means:

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

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

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

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

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

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

34 (v) (cc) "Medicare supplement policy" means an individual policy  
 35 of accident and sickness insurance that is designed primarily as a  
 36 supplement to reimbursements under Medicare for the hospital,  
 37 medical, and surgical expenses of individuals who are eligible for  
 38 Medicare benefits.

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

3           SECTION 24. IC 27-8-10-2.1, AS AMENDED BY P.L.255-1995,  
4 SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
5 SEPTEMBER 1, 1998]: Sec. 2.1. (a) There is established a nonprofit  
6 legal entity to be referred to as the Indiana comprehensive health  
7 insurance association, which must assure that health insurance is made  
8 available throughout the year to each eligible Indiana resident applying  
9 to the association for coverage. All carriers, health maintenance  
10 organizations, limited service health maintenance organizations, and  
11 self-insurers providing health insurance or health care services in  
12 Indiana must be members of the association. The association shall  
13 operate under a plan of operation established and approved under  
14 subsection (c) and shall exercise its powers through a board of directors  
15 established under this section.

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

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

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

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

28           **The commissioner shall appoint the chairman of the board, and the**  
29 **board shall elect a secretary from its membership. To select the**  
30 **initial board of directors and to initially organize the association, the**  
31 **commissioner shall give notice to all members in Indiana of the time**  
32 **and place of the organizational meeting. In determining voting rights**  
33 **at the organizational meeting, each member is entitled to one (1) vote**  
34 **in person or by proxy. If the board of directors is not selected within**  
35 **sixty (60) days after the organizational meeting, the commissioner shall**  
36 **appoint the initial board. In approving or selecting members of the**  
37 **board, the commissioner shall consider whether all members are fairly**  
38 **represented. The term of office of each appointed member is three**

1       **(3) years, subject to eligibility for reappointment.** Members of the  
2 board **who are not state employees** may be reimbursed from the  
3 ~~money of the association~~ **association's funds** for expenses incurred by  
4 ~~them as members but shall not be otherwise compensated by the~~  
5 ~~association for their services.~~ **in attending meetings. The board shall**  
6 **meet at least semiannually, with the first meeting to be held not**  
7 **later than May 15 of each year.**

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

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

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

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

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

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

- 1 approval;
- 2 (6) contain additional provisions necessary or proper for the
- 3 execution of the powers and duties of the association; and
- 4 (7) establish procedures for the periodic advertising of the
- 5 general availability of the health insurance coverages from the
- 6 association.
- 7 (d) The plan of operation may provide that any of the powers and
- 8 duties of the association be delegated to a person who will perform
- 9 functions similar to those of this association. A delegation under this
- 10 section takes effect only with the approval of both the board of
- 11 directors and the commissioner. The commissioner may not approve a
- 12 delegation unless the protections afforded to the insured are
- 13 substantially equivalent to or greater than those provided under this
- 14 chapter.
- 15 (e) The association has the general powers and authority
- 16 enumerated by this subsection in accordance with the plan of operation
- 17 approved by the commissioner under subsection (c). The association
- 18 has the general powers and authority granted under the laws of Indiana
- 19 to carriers licensed to transact the kinds of health care services or
- 20 health insurance described in section 1 of this chapter and also has the
- 21 specific authority to do the following:
- 22 (1) Enter into contracts as are necessary or proper to carry out
- 23 this chapter, **subject to the approval of the commissioner.**
- 24 (2) Sue or be sued, including taking any legal actions necessary
- 25 or proper for recovery of any assessments for, on behalf of, or
- 26 against participating carriers.
- 27 (3) Take legal action necessary to avoid the payment of improper
- 28 claims against the association or the coverage provided by or
- 29 through the association.
- 30 (4) Establish a medical review committee to determine the
- 31 reasonably appropriate level and extent of health care services in
- 32 each instance.
- 33 (5) Establish appropriate rates, scales of rates, rate classifications
- 34 and rating adjustments, such rates not to be unreasonable in
- 35 relation to the coverage provided and the reasonable operational
- 36 expenses of the association.
- 37 (6) Pool risks among members.
- 38 (7) Issue policies of insurance on an indemnity or provision of

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

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

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

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

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

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

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

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

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

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

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

31 (o) The association shall provide for the option of monthly  
 32 collection of premiums. SECTION 25. IC 27-8-10-5.1, AS  
 33 AMENDED BY P.L.2-1995, SECTION 109, IS AMENDED TO  
 34 READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 5.1. (a)  
 35 Except as provided in subsections (b) and (c), a person is not eligible  
 36 for an association policy ~~who~~, **if**, at the effective date of coverage, **the**  
 37 **person** has or is eligible for coverage under any insurance plan that  
 38 equals or exceeds the minimum requirements for accident and sickness

1 insurance policies issued in Indiana as set forth in IC 27. Coverage  
 2 under any association policy is in excess of, and may not duplicate,  
 3 coverage under any other form of health insurance.

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

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

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

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

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

18 (c) The board of directors may establish procedures that would  
 19 permit ~~(H)~~ an association policy to be issued to persons who are  
 20 covered by a group insurance arrangement when that person or a  
 21 dependent's health condition is such that the group's coverage is in  
 22 jeopardy of termination or material rate increases because of that  
 23 person's or dependent's medical claims experience ~~and~~.

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

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

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

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

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

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

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

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

27 (2) medical advice or treatment was recommended or received  
 28 within a period of six (6) months before the effective date of  
 29 coverage.

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

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

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

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

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

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

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

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

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

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

31 (2) ~~If the insured is:~~

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

33 ~~and~~

34 ~~(B) not a woman at risk;~~

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

37 ~~(3) If the insured is:~~

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

- 1                    ~~and~~
- 2                    ~~(B) a woman at risk;~~
- 3                    ~~one (1) breast cancer screening mammography performed upon~~
- 4                    ~~the insured every year.~~
- 5                    ~~(4) If the insured is at least fifty (50) forty (40) years of age,~~
- 6                    ~~whether or not at risk; one (1) breast cancer screening~~
- 7                    ~~mammography performed upon the insured every year.~~
- 8                    **(3) Any additional views that are required for proper**
- 9                    **evaluation.**
- 10                   **(4) Ultrasound services, if determined medically necessary by**
- 11                   **the physician treating the insured.**
- 12                   (c) The coverage that an insurer must offer to provide under this
- 13                   section must provide reimbursement for breast cancer screening
- 14                   mammography at a level at least as high as:
- 15                   (1) the limitation on payment for screening mammography
- 16                   services established in 42 CFR 405.534(b)(3) according to the
- 17                   Medicare Economic Index at the time the breast cancer
- 18                   screening mammography is performed; or
- 19                   (2) the rate negotiated by a contract provider according to the
- 20                   provisions of the insurance policy;
- 21                   whichever is lower.
- 22                   (d) The coverage that an insurer must offer to provide under this
- 23                   section may not be subject to dollar limits, deductibles, or coinsurance
- 24                   provisions that are less favorable to the insured than the dollar limits,
- 25                   deductibles, or coinsurance provisions applying to physical illness
- 26                   generally under the accident and sickness insurance policy.
- 27                   (e) The coverage that an insurer must offer is in addition to any
- 28                   benefits specifically provided for x-rays, laboratory testing, or wellness
- 29                   examinations.
- 30                   SECTION 27. IC 27-8-15-10.5, AS AMENDED BY
- 31                   P.L.190-1996, SECTION 3, IS AMENDED TO READ AS FOLLOWS
- 32                   [EFFECTIVE APRIL 1, 1998]: Sec. 10.5. (a) As used in this chapter,
- 33                   "late enrollee" means an eligible employee or a dependent of an
- 34                   eligible employee who did not request enrollment in a health insurance
- 35                   plan of a small employer during the initial enrollment period during
- 36                   which the individual was entitled to enroll under the health insurance
- 37                   plan.
- 38                   (b) The term "**late enrollee**" does not include an eligible

1 employee or the dependent of an eligible employee: who meets any  
2 of the following conditions:

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

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

7 (i) the termination of employment or eligibility;

8 (ii) the involuntary termination of the health insurance  
9 plan;

10 (iii) the death of a spouse; or

11 (iv) the dissolution of marriage; and

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

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

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

23 (3) whose coverage under this subsection:

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

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

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

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

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

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

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

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

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

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

29 (1) Nonpayment of required premiums.

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

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

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

38 ~~(5) The small employer is no longer actively engaged in the~~

1 business in which the small employer was engaged on the  
2 effective date of the plan.

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

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

10 **(A) in the service area of the small employer insurer; or**  
11 **(B) in the area for which the issuer is authorized to do**  
12 **business.**

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

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

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

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

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

33 **(i) the claims experience of the small employer**  
34 **groups; or**

35 **(ii) any health status related factor relating to any**  
36 **eligible employee or dependent of an eligible**  
37 **employee who is covered or who may become**  
38 **eligible for the coverage.**

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

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

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

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

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

- 26 (1) A hospital or medical expense incurred policy or certificate.  
 27 (2) A hospital or medical service plan contract.  
 28 (3) A health maintenance organization subscriber contract.  
 29 (4) Medicare or Medicaid.  
 30 (5) An employer based health insurance arrangement.  
 31 (6) An individual health insurance policy.  
 32 (7) A policy issued by the Indiana comprehensive health  
 33 insurance association under IC 27-8-10.  
 34 (8) An employee welfare benefit plan (as defined in 29 U.S.C.  
 35 1002) that is self-funded.  
 36 (9) A conversion policy issued under section 31 or 31.1 of this  
 37 chapter.

38 (b) Except as provided in section 29 of this chapter, a small

1 employer insurer shall waive the exclusion period described in section  
 2 27 of this chapter applicable to a preexisting condition or the limitation  
 3 period with respect to a particular service in a health insurance plan for  
 4 the time an eligible employee or a dependent of an eligible employee  
 5 was previously covered by a health insurance plan if the following  
 6 conditions are met:

7 (1) The eligible employee or a dependent of the eligible  
 8 employee was previously covered by a health insurance plan that  
 9 provided benefits with respect to the particular service.

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

13 (A) the eligible employee; or

14 (B) a dependent of the eligible employee.

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

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

22 Page 7, between lines 30 and 31, begin a new paragraph and  
 23 insert:

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

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

31 (2) **accept any employer that applies for any of those**  
 32 **products."**

33 Page 7, between lines 36 and 37, begin a new paragraph and and  
 34 insert:

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

1 of this chapter:

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

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

4 if this proof is filed with and the surcharge paid to the department of  
5 insurance not later than ninety (90) days after the effective date of the  
6 insurance policy. ~~If proof of financial responsibility and the payment~~  
7 ~~of the surcharge is not made within ninety (90) days after the policy~~  
8 ~~effective date, compliance occurs on the date when proof is filed and~~  
9 ~~the surcharge is paid.~~

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

17 (1) received the premium and surcharge in a timely manner;  
18 and

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

20 (c) If the commissioner accepts a filing as timely under  
21 subsection (b), the filing must be accompanied by a penalty amount  
22 as follows:

23 (1) Ten percent (10%) of the surcharge, if the proof of  
24 financial responsibility and surcharge are received by the  
25 commissioner at least ninety-one (91) days and not more  
26 than one hundred twenty (120) days after the original  
27 effective date of the policy.

28 (2) Twenty percent (20%) of the surcharge, if the proof of  
29 financial responsibility and surcharge are received by the  
30 commissioner at least one hundred twenty-one (121) days  
31 and not more than one hundred fifty (150) days after the  
32 original effective date of the policy.

33 (3) Fifty percent (50%) of the surcharge, if the proof of  
34 financial responsibility and surcharge are received by the  
35 commissioner at least one hundred fifty-one (151) days and  
36 not more than one hundred eighty (180) days after the  
37 original effective date of the policy.

38 SECTION 36. IC 27-13-7-3, AS ADDED BY P.L.26-1994,

1 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
2 JULY 1, 1998]: Sec. 3. (a) A contract referred to in section 1 of this  
3 chapter must clearly state the following:

- 4 (1) The name and address of the health maintenance  
5 organization.
- 6 (2) Eligibility requirements.
- 7 (3) Benefits and services within the service area.
- 8 (4) Emergency care benefits and services.
- 9 (5) Any out-of-area benefits and services.
- 10 (6) Copayments, deductibles, and other out-of-pocket costs.
- 11 (7) Limitations and exclusions.
- 12 (8) Enrollee termination provisions.
- 13 (9) Any enrollee reinstatement provisions.
- 14 (10) Claims procedures.
- 15 (11) Enrollee grievance procedures.
- 16 (12) Continuation of coverage provisions.
- 17 (13) Conversion provisions.
- 18 (14) Extension of benefit provisions.
- 19 (15) Coordination of benefit provisions.
- 20 (16) Any subrogation provisions.
- 21 (17) A description of the service area.
- 22 (18) The entire contract provisions.
- 23 (19) The term of the coverage provided by the contract.
- 24 (20) Any right of cancellation of the group or individual contract  
25 holder.
- 26 (21) Right of renewal provisions.
- 27 (22) Provisions regarding reinstatement of a group or an  
28 individual contract holder.
- 29 (23) Grace period provisions.
- 30 (24) A provision on conformity with state law.
- 31 **(25) A provision or provisions that comply with the:**  
32 **(A) guaranteed renewability; and**  
33 **(B) group portability;**  
34 **requirements of the federal Health Insurance Portability and**  
35 **Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).**
- 36 (b) For purposes of subsection (a), an evidence of coverage which  
37 is filed with a contract may be considered part of the contract."

38 Page 9, after line 11, begin a new paragraph and insert:

1 "SECTION 39. IC 27-13-29-1, AS AMENDED BY P.L.255-1995,  
 2 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 3 JULY 1, 1998]: Sec. 1. (a) Except as provided in subsection (b) or as  
 4 otherwise provided in this article or IC 27:

5 (1) IC 27; and

6 (2) the provisions of IC 16 regulating hospitals;

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

14 (b) Every:

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

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

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

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

27 (1) a physician licensed under IC 25-22.5;

28 (2) a dentist licensed under IC 25-14;

29 (3) a hospital licensed under IC 16-21;

30 (4) a podiatrist licensed under IC 25-29;

31 (5) a chiropractor licensed under IC 25-10;

32 (6) an optometrist licensed under IC 25-24;

33 (7) a psychologist licensed under IC 25-33;

34 (8) a pharmacist licensed under IC 25-26;

35 (9) a health facility licensed under IC 16-28-2;

36 (10) a registered or licensed practical nurse licensed under  
 37 IC 25-23;

38 (11) a physical therapist licensed under IC 25-27;

- 1 (12) a home health agency licensed under IC 16-27-1;  
 2 (13) a community mental health center (as defined in  
 3 IC 12-7-2-38);  
 4 (14) a health care organization whose members, shareholders, or  
 5 partners are:  
 6 (A) professional health care providers described in  
 7 subdivisions (1) through (13);  
 8 (B) professional corporations comprised of health care  
 9 professionals (as defined in IC 23-1.5-1-8); or  
 10 (C) professional health care providers described in  
 11 subdivisions (1) through (13) and professional corporations  
 12 comprised of persons described in subdivisions (1) through  
 13 (13);  
 14 (15) a private psychiatric hospital licensed under IC 12-25;  
 15 (16) a preferred provider organization (including a preferred  
 16 provider arrangement or reimbursement agreement under  
 17 IC 27-8-11);  
 18 (17) a health maintenance organization (as defined in  
 19 IC 27-13-1-19) or a limited service health maintenance  
 20 organization (as defined in IC 27-13-34-4);  
 21 (18) a respiratory care practitioner certified under IC 25-34.5;  
 22 (19) an occupational therapist certified under IC 25-23.5;  
 23 (20) a state institution (as defined in IC 12-7-2-184);  
 24 (21) a clinical social worker who is licensed under  
 25 IC 25-23.6-5-2;  
 26 (22) a managed care provider (as defined in IC 12-7-2-127(b));  
 27 or  
 28 (23) a nonprofit health care organization affiliated with a  
 29 hospital that is owned or operated by a religious order, whose  
 30 members are members of that religious order.  
 31 (b) As used in this chapter, "evaluation of patient care" relates to:  
 32 (1) the accuracy of diagnosis;  
 33 (2) the propriety, appropriateness, quality, or necessity of care  
 34 rendered by a professional health care provider; and  
 35 (3) the reasonableness of the utilization of services, procedures,  
 36 and facilities in the treatment of individual patients.  
 37 As used in this chapter, the term does not relate to charges for services  
 38 or to methods used in arriving at diagnoses.

1 (c) As used in this chapter, "peer review committee" means a  
2 committee that:

3 (1) has the responsibility of evaluation of:

4 (A) qualifications of professional health care providers;

5 (B) patient care rendered by professional health care  
6 providers; or

7 (C) the merits of a complaint against a professional health  
8 care provider that includes a determination or  
9 recommendation concerning the complaint, and the  
10 complaint is based on the competence or professional  
11 conduct of an individual health care provider which  
12 competence or conduct affects or could affect adversely the  
13 health or welfare of a patient or patients; and

14 (2) meets the following criteria:

15 (A) The committee is organized:

16 (i) by a state, regional, or local organization of  
17 professional health care providers or by a nonprofit  
18 foundation created by the professional organization for  
19 purposes of improvement of patient care;

20 (ii) by the professional staff of a hospital, another  
21 health care facility, a nonprofit health care organization  
22 (under subsection (a)(23)), or a professional health  
23 care organization;

24 (iii) by state or federal law or regulation;

25 (iv) by a governing board of a hospital, a nonprofit  
26 health care organization (under subsection (a)(23)), or  
27 professional health care organization;

28 (v) as a governing board or committee of the board of  
29 a hospital, a nonprofit health care organization (under  
30 subsection (a)(23)), or professional health care  
31 organization;

32 (vi) by an organization, a plan, or a program described  
33 in subsection (a)(16) through (a)(17);

34 (vii) as a hospital or a nonprofit health care  
35 organization (under subsection (a)(23)) medical staff  
36 or a section of that staff; or

37 (viii) as a governing board or committee of the board  
38 of a professional health care provider (as defined in

- 1 subsection (a)(16) through (a)(17)).
- 2 (B) At least fifty percent (50%) of the committee members
- 3 are:
- 4 (i) individual professional health care providers, the
- 5 governing board of a hospital, the governing board of
- 6 a nonprofit health care organization (under subsection
- 7 (a)(23)), or professional health care organization, or
- 8 the governing board or a committee of the board of a
- 9 professional health care provider (as defined in
- 10 subsection (a)(16) through (a)(17)); or
- 11 (ii) individual professional health care providers and
- 12 the committee is organized as an interdisciplinary
- 13 committee to conduct evaluation of patient care
- 14 services.

15 However, "peer review committee" does not include a medical review

16 panel created under IC 27-12-10.

- 17 (d) As used in this chapter, "professional staff" means:
- 18 (1) all individual professional health care providers authorized
- 19 to provide health care in a hospital or other health care facility;
- 20 or
- 21 (2) the multidisciplinary staff of a community mental health
- 22 center (as defined in IC 12-7-2-38).

23 (e) As used in this chapter, "personnel of a peer review committee"

24 means not only members of the committee but also all of the

25 committee's employees, representatives, agents, attorneys,

26 investigators, assistants, clerks, staff, and any other person or

27 organization who serves a peer review committee in any capacity.

28 (f) As used in this chapter, "in good faith" refers to an act taken

29 without malice after a reasonable effort to obtain the facts of the matter

30 and in the reasonable belief that the action taken is warranted by the

31 facts known. In all actions to which this chapter applies, good faith

32 shall be presumed, and malice shall be required to be proven by the

33 person aggrieved.

34 (g) As used in this chapter, "professional health care organization"

35 refers to an organization described in subsection (a)(14).

36 **(h) As used in this chapter, "professional review activity"**

37 **means an activity of a peer review committee of a hospital licensed**

38 **under IC 16-21 with respect to a professional health care provider**

1 to:

- 2 (1) determine whether the professional health care provider  
 3 may have privileges with respect to the hospital;  
 4 (2) determine the scope or conditions of the privileges; or  
 5 (3) change or modify the privileges.

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

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

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

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

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

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

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

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

1 limited in section 1(b) of this chapter.

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

7 (1) The peer review committee.

8 (2) Any person acting as a member or staff to the peer review  
9 committee.

10 (3) Any person under a contract or other formal agreement with  
11 the peer review committee.

12 (4) Any person who participates with or assists the peer review  
13 committee with respect to the action.

14 (f) Subsection (e) does not apply to damages under any federal or  
15 state law relating to the civil rights of a person including:

16 (1) the federal Civil Rights Act of 1964, 42 U.S.C. 2000e, et  
17 seq.; and

18 (2) the federal Civil Rights Act, 42 U.S.C. 1981, et seq.

19 SECTION 42. THE FOLLOWING ARE REPEALED  
20 [EFFECTIVE APRIL 1, 1998]: IC 6-3-7-5; IC 22-3-2-14.5;  
21 IC 22-3-7-34.5; IC 27-8-15-34.

22 SECTION 43. [EFFECTIVE JULY 1, 1998] (a) **Notwithstanding**  
23 **IC 27-8-10-2.1, the terms of the members of the Indiana**  
24 **Comprehensive Health Insurance Association board of directors**  
25 **servicing on August 31, 1998, expire August 31, 1998.**

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

31 (c) **This SECTION expires January 1, 2000.**

32 SECTION 44. [EFFECTIVE APRIL 1, 1998] (a) **IC 27-8-5-3 and**  
33 **IC 27-8-5-19, both as amended by this act, apply to all accident and**  
34 **sickness policies in force on April 1, 1998.**

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

- 1 SECTION 45. **An emergency is declared for this act.**"
- 2 Renumber all SECTIONS consecutively.  
(Reference is to SB 292 as reprinted February 3, 1998.)

**and when so amended that said bill do pass.**

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**Representative Fry**