

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.

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

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

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

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

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

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

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

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

24 SCHEDULE I. Receipts and disbursements.

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

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

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

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

38 SCHEDULE VI. An actuarial computation of the pension

1 liability for all employees retired before the close of the fiscal
2 year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **(1) chiropractic;**

24 **(2) optometry; or**

25 **(3) podiatry.**

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

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

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

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

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

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

1 **efficient and effective utilization of hospital resources as**
 2 **developed by the hospital's medical staff.**

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

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

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

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

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

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

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

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

- 36 **(1) Consider a health care provider's postgraduate**
 37 **education, training, experience, and other facts concerning**
 38 **the provider that may affect the provider's professional**

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

33 SECTION 6. IC 22-3-5-6 IS AMENDED TO READ AS

34 FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 6. (a) The worker's

35 compensation supplemental administrative fund is established for the

36 purpose of carrying out the administrative purposes and functions of

37 the worker's compensation board. The fund consists of fees collected

38 from employers under sections 1 through 2 of this chapter. ~~and from~~

1 ~~fees collected under IC 22-3-2-14.5 and IC 22-3-7-34.5.~~ The fund shall
 2 be administered by the worker's compensation board. ~~Money in the~~
 3 ~~fund is annually appropriated to the worker's compensation board for~~
 4 ~~its use in carrying out the administrative purposes and functions of the~~
 5 ~~worker's compensation board.~~

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

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

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

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

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

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

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

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

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

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

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

- 35 (A) they are licensed real estate agents;
36 (B) substantially all their remuneration is directly related to
37 sales volume and not the number of hours worked; and
38 (C) they have written agreements with real estate brokers

1 stating that they are not to be treated as employees for tax
2 purposes.

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

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

20 ~~(9)~~ (8) A member or manager in a limited liability company may
21 elect to include the member or manager as an employee under
22 IC 22-3-2 through IC 22-3-6 if the member or manager is
23 actually engaged in the limited liability company business. If a
24 member or manager makes this election, the member or manager
25 must serve upon the member's or manager's insurance carrier and
26 upon the board written notice of the election. A member or
27 manager may not be considered an employee under IC 22-3-2
28 through IC 22-3-6 until the notice has been received.

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

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

34 (2) If the employee is a minor who, at the time of the accident,
35 is employed, required, suffered, or permitted to work in violation
36 of IC 20-8.1-4-25, the amount of compensation and death
37 benefits, as provided in IC 22-3-2 through IC 22-3-6, shall be
38 double the amount which would otherwise be recoverable. The

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

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

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

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

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

35 (2) Where the employment prior to the injury extended over a
36 period of less than fifty-two (52) weeks, the method of dividing
37 the earnings during that period by the number of weeks and parts
38 thereof during which the employee earned wages shall be

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 (b) As used in this chapter, "employee" means every person,
37 including a minor, in the service of another, under any contract of hire
38 or apprenticeship written or implied, except one whose employment is

1 both casual and not in the usual course of the trade, business,
 2 occupation, or profession of the employer. For purposes of this chapter
 3 the following apply:

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

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

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

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

31 (A) they are licensed real estate agents;

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

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

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

1 independent contractor under the guidelines of the United States
2 Internal Revenue Service:

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

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

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

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

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

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

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

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

31 (3) In all cases of occupational diseases caused by the inhalation
32 of asbestos dust, no compensation shall be payable unless
33 disablement, as defined in subsection (e), occurs within three (3)
34 years after the last day of the last exposure to the hazards of the
35 disease if the last day of the last exposure was before July 1,
36 1985.

37 (4) In all cases of occupational disease caused by the inhalation
38 of asbestos dust in which the last date of the last exposure occurs

1 on or after July 1, 1985, and before July 1, 1988, no
2 compensation shall be payable unless disablement, as defined in
3 subsection (e), occurs within twenty (20) years after the last day
4 of the last exposure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Document	Fee
28 Articles of incorporation	\$ 350
29 Amendment of articles of	
30 incorporation	\$ 10
31 Filing of annual statement	
32 and consolidated statement	\$ 100
33 Annual renewal of company license	
34 fee	\$ 50
35 Appointment of commissioner for	
36 service of process	\$ 10
37 Withdrawal of certificate	
38	

1 of authority \$ 25
2 Certified statement of condition \$ 5
3 Any other document required to be
4 filed by this article \$ 25
5 (b) The commissioner shall collect a fee of ten dollars (\$10) each
6 time process is served on the commissioner under this title.
7 (c) The commissioner shall collect the following fees for copying
8 and certifying the copy of any filed document relating to a domestic or
9 foreign corporation:
10 Per page for copying As determined by
11 the commissioner but not to exceed actual cost
12 For the certificate \$10
13 (d) Each domestic and foreign insurer shall remit annually to the
14 commissioner for deposit into the department of insurance fund
15 established by IC 27-1-3-28 three hundred fifty dollars (\$350) as an
16 internal audit fee. All assessment insurers, farm mutuals, fraternal
17 benefit societies, and health maintenance organizations shall remit to
18 the commissioner for deposit into the department of insurance fund one
19 hundred dollars (\$100) annually as an internal audit fee.
20 (e) Beginning July 1, 1994, each insurer shall remit to the
21 commissioner for deposit into the department of insurance fund
22 established by IC 27-1-3-28 a fee of thirty-five dollars (\$35) for each
23 policy, rider, and endorsement filed with the state. However, each
24 policy, rider, and endorsement filed as part of a particular product
25 filing and associated with that product filing shall be considered to be
26 a single filing and subject only to one (1) thirty-five dollar (\$35) fee.
27 (f) The commissioner shall pay into the state general fund by the
28 end of each calendar month the amounts collected during that month
29 under subsections (a), (b), and (c). ~~of this section.~~
30 **(g) The commissioner may not collect fees for quarterly**
31 **statements filed under IC 27-1-20-33.**
32 SECTION 10. IC 27-1-3-20 IS AMENDED TO READ AS
33 FOLLOWS [EFFECTIVE APRIL 1, 1998]: Sec. 20. (a) The
34 commissioner may issue a certificate of authority to any company when
35 it shall have complied with the requirements of the laws of this state so
36 as to entitle it to do business herein. The certificate shall be issued
37 under the seal of the department authorizing and empowering the
38 company to make the kind or kinds of insurance specified in the

1 certificate. No certificate of authority shall be issued until the
2 commissioner has found that:

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

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

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

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

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

38 SECTION 11. IC 27-1-8-13 IS AMENDED TO READ AS

1 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 13. (a) Any domestic
 2 mutual insurance company may by amendment of its articles of
 3 incorporation convert to a stock insurance company only upon
 4 compliance with the requirements of this section and applicable
 5 requirements of sections 1 through 8 and 11 of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (i) that the company will assure that an active
 38 public trading market for the capital stock of the

1 **company will develop within a reasonable time**
 2 **after the effective date of the plan of conversion or**
 3 **after the delivery of stock certificates to the**
 4 **members or policyholders; and**
 5 **(ii) with the terms and conditions of any public**
 6 **offering or other stock offerings or sales by the**
 7 **company proposed to be made during the three (3)**
 8 **year period following the effective date of the plan**
 9 **of conversion, including any stock subscription**
 10 **rights of the members and policyholders.**

11 **(6) The plan of conversion may include procedures for:**
 12 **(A) establishment of a noninsurance stock holding**
 13 **corporation for the company concurrent with or**
 14 **immediately following the effective date of the plan of**
 15 **conversion and for the exchange or conversion of the**
 16 **members' or policyholders' rights to and interests in**
 17 **capital stock of the company for or into equivalent**
 18 **rights to and interests in capital stock of the**
 19 **noninsurance stock holding corporation;**
 20 **(B) delayed delivery of stock certificates or cash to the**
 21 **members or policyholders of the company, or**
 22 **restrictions on sale or transfer of capital stock by**
 23 **members or policyholders of the company, for a**
 24 **reasonable time following the effective date of the plan**
 25 **of conversion; and**
 26 **(C) delayed establishment of the formulas required by**
 27 **subdivision (2)(A) or establishment in the plan of**
 28 **conversion of specific conditional or alternative**
 29 **formulas.**

30 ~~(8)~~ **(7) The plan of conversion may contain** such other terms
 31 and provisions as the company deems necessary or desirable.

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

1 necessary.

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

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

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

1 if any, shall be and remain unaffected by the proposed
2 conversion and shall continue in full force in accordance with
3 the terms of the policy of each such member and policyholder.

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

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

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

38 (i) The plan of conversion and proposed amendment to the articles

1 of incorporation shall become effective upon the later of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (1) insurance written on the interests of the licensee or those of

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

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

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

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

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

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

36 (2) pay, pledge, assign, or grant a security interest in the person's
 37 commission to a lending institution as collateral for a loan if the
 38 payment, pledge, assignment, or grant of a security interest is

1 not, directly or indirectly, in exchange for insurance services
2 performed.

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

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

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

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

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

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

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

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

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

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

1 the negotiation or solicitation of insurance.

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

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

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

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

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

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

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

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

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

1 that is authorized to transact business in Indiana.

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

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

12 (1) must be:

13 (A) in the same format; and

14 (B) of the same scope;

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

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

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

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

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

32 (e) A foreign company that:

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

35 (2) complies with that law;

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

37 (f) In the absence of actual malice:

38 (1) members of the NAIC;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (e) An insurer is not required to provide mine subsidence coverage
27 under subsection (a) under any insurance policy in an amount
28 exceeding the amount that is reimbursable from the fund under section
29 9(a)(4) of this chapter.

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

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

1 SECTION 20. IC 27-8-5-1 IS AMENDED TO READ AS
 2 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) The term "policy
 3 of accident and sickness insurance", as used in this chapter, includes
 4 any policy or contract covering one (1) or more of the kinds of
 5 insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies
 6 may be on the individual basis under this section and sections 2
 7 through 9 of this chapter, on the group basis under this section and
 8 sections 16 through 19 of this chapter, on the franchise basis under this
 9 section and section 11 of this chapter, or on a blanket basis under
 10 section 15 of this chapter and (except as otherwise expressly provided
 11 in this chapter) shall be exclusively governed by this chapter.

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

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

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

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

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

36 (e) If the commissioner notifies the insurer that ~~filed a form made~~
 37 **a filing** that the ~~form~~ **filing** does not comply with this section, it is
 38 unlawful thereafter for the insurer to issue ~~or use the form or use it~~

1 **filing** in connection with any policy. In the notice given under this
 2 subsection, the commissioner shall specify the reasons for his
 3 disapproval and state that a hearing will be granted within twenty (20)
 4 days after request in writing by the insurer.

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

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

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

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

36 (2) A provision as follows: TIME LIMIT ON CERTAIN
 37 DEFENSES: (A) After two (2) years from the date of issue of this
 38 policy no misstatements, except fraudulent misstatements, made by the

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

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

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

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

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

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

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

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

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

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

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

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

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

1 age, for at least five (5) years from its date of issue.

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

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

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

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

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

1 other loss within ninety (90) days after the date of such loss. Failure to
 2 furnish such proof within the time required shall not invalidate nor
 3 reduce any claim if it was not reasonably possible to give proof within
 4 such time, provided such proof is furnished as soon as reasonably
 5 possible and in no event, except in the absence of legal capacity, later
 6 than one (1) year from the time proof is otherwise required.

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

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

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

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

36 Subject to any written direction of the insured in the application
 37 or otherwise all or a portion of any indemnities provided by this policy
 38 on account of hospital, nursing, medical, or surgical services may, at

1 the insurer's option and unless the insured requests otherwise in writing
 2 not later than the time of filing proofs of such loss, be paid directly to
 3 the hospital or person rendering such services; but it is not required that
 4 the service be rendered by a particular hospital or person.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 organizations.

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

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

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

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

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

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

37 (e) "Insured", as used in this chapter, shall not be construed as
38 preventing a person other than the insured with a proper insurable

1 interest from making application for and owning a policy covering the
 2 insured or from being entitled under such a policy to any indemnities,
 3 benefits, and rights provided therein.

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

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

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

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

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

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

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

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

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

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

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

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

38 The policy may provide that the policyholder is liable to the

1 insurer for the payment of a pro rata premium for the time the
2 policy was in force during the grace period. A provision under
3 this subdivision may provide that the insurer is not obligated to
4 pay claims incurred during the grace period until the premium
5 due is received.

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

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

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

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

21 (3) A provision that a copy of the application, if there is one, of
22 the policyholder must be attached to the policy when issued, that
23 all statements made by the policyholder or by the persons
24 insured are to be deemed representations and not warranties, and
25 that no statement made by any person insured may be used in
26 any contest unless a copy of the instrument containing the
27 statement is or has been furnished to the insured person or, in the
28 event of death or incapacity of the insured person, to the insured
29 person's beneficiary or personal representative.

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

35 (5) A provision specifying any additional exclusions or
36 limitations applicable under the policy with respect to a disease
37 or physical condition of a person that existed before the effective
38 date of the person's coverage under the policy and that is not

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

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

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

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

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

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

25 (A) premiums;

26 (B) benefits; or

27 (C) both premiums and benefits;

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

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

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

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

38 (C) explains any family member's or dependent's coverage

- 1 under the policy.
- 2 (8) A provision stating that written notice of a claim must be
3 given to the insurer within twenty (20) days after the occurrence
4 or commencement of any loss covered by the policy, but that a
5 failure to give notice within the twenty (20) day period does not
6 invalidate or reduce any claim if it can be shown that it was not
7 reasonably possible to give notice within that period and that
8 notice was given as soon as was reasonably possible.
- 9 (9) A provision stating that:
- 10 (A) the insurer will furnish to the person making a claim, or
11 to the policyholder for delivery to the person making a
12 claim, forms usually furnished by the insurer for filing proof
13 of loss; and
- 14 (B) if the forms are not furnished within fifteen (15) days
15 after the insurer received notice of a claim, the person
16 making the claim will be deemed to have complied with the
17 requirements of the policy as to proof of loss upon
18 submitting, within the time fixed in the policy for filing
19 proof of loss, written proof covering the occurrence,
20 character, and extent of the loss for which the claim is
21 made.
- 22 (10) A provision stating that:
- 23 (A) in the case of a claim for loss of time for disability,
24 written proof of the loss must be furnished to the insurer
25 within ninety (90) days after the commencement of the
26 period for which the insurer is liable, and that subsequent
27 written proofs of the continuance of the disability must be
28 furnished to the insurer at reasonable intervals as may be
29 required by the insurer;
- 30 (B) in the case of a claim for any other loss, written proof of
31 the loss must be furnished to the insurer within ninety (90)
32 days after the date of the loss; and
- 33 (C) the failure to furnish proof within the time required
34 under clause (A) or (B) does not invalidate or reduce any
35 claim if it was not reasonably possible to furnish proof
36 within that time, and if proof is furnished as soon as
37 reasonably possible but (except in case of the absence of
38 legal capacity of the claimant) no later than one (1) year

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

1 policy, and that no action may be brought at all more than three
 2 (3) years after the expiration of the time within which proof of
 3 loss is required by the policy.

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

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

15 (A) incapable of self-sustaining employment because of
 16 mental retardation or a physical disability; and
 17 (B) chiefly dependent upon the group member for support
 18 and maintenance.

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

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

37 ~~(c)~~ (d) Subsection ~~(b)(5); (b)(7); (c)(5), (c)(7), and (b)(12)~~ (c)(12)
 38 do not apply to policies insuring the lives of debtors. The standard

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

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

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

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

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

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

22 (e) **"Church plan" means a plan defined in the federal**
 23 **Employee Retirement Income Security Act of 1974 under 26 U.S.C.**
 24 **414(e).**

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

26 (g) **"Creditable coverage" has the meaning set forth in the**
 27 **federal Health Insurance Portability and Accountability Act of**
 28 **1996 (26 U.S.C. 9801(c)(1)).**

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

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

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

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

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

38 **(C) church plan;**

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

3 **(2) who is not eligible for coverage under:**

4 **(A) a group health plan;**

5 **(B) Part A or Part B of Title XVIII of the federal Social**
 6 **Security Act; or**

7 **(C) a state plan under Title XIX of the federal Social**
 8 **Security Act (or any successor program);**

9 **and does not have other health insurance coverage;**

10 **(3) with respect to whom the individual's most recent**
 11 **coverage was not terminated for factors relating to**
 12 **nonpayment of premiums or fraud;**

13 **(4) who, if after being offered the option of continuation**
 14 **coverage under the Consolidated Omnibus Budget**
 15 **Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)),**
 16 **or under a similar state program, elected such coverage; and**

17 **(5) who, if after electing continuation coverage described in**
 18 **subdivision (4), has exhausted continuation coverage under**
 19 **the provision or program.**

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

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

30 ~~(g)~~ **(l) "Health care facility" means any institution providing health**
 31 **care services that is licensed in this state, including institutions**
 32 **engaged principally in providing services for health maintenance**
 33 **organizations or for the diagnosis or treatment of human disease, pain,**
 34 **injury, deformity, or physical condition, including a general hospital,**
 35 **special hospital, mental hospital, public health center, diagnostic**
 36 **center, treatment center, rehabilitation center, extended care facility,**
 37 **skilled nursing home, nursing home, intermediate care facility,**
 38 **tuberculosis hospital, chronic disease hospital, maternity hospital,**

1 outpatient clinic, home health care agency, bioanalytical laboratory, or
2 central services facility servicing one (1) or more such institutions.

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

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

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

14 ~~(k)~~ **(p)** "Health insurance" means hospital, surgical, and medical
15 expense incurred policies, nonprofit service plan contracts, health
16 maintenance organizations, limited service health maintenance
17 organizations, and self-insured plans. However, the term "health
18 insurance" does not include short term travel accident policies,
19 accident only policies, fixed indemnity policies, automobile medical
20 payment, or incidental coverage issued with or as a supplement to
21 liability insurance.

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

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

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

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

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

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

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

37 (1) are recommended by a legally qualified physician;

38 (2) are commonly and customarily recognized throughout the

1 physician's profession as appropriate in the treatment of the
2 patient's diagnosed illness; and

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

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

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

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

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

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

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

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

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

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

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

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

1 Medicare benefits.

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

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

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

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

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

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

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

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

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

- 29 (1) establish procedures for the handling and accounting of
- 30 assets and money of the association;
- 31 (2) establish the amount and method of reimbursing members of
- 32 the board;
- 33 (3) establish regular times and places for meetings of the board
- 34 of directors;
- 35 (4) establish procedures for records to be kept of all financial
- 36 transactions, and for the annual fiscal reporting to the
- 37 commissioner;
- 38 (5) establish procedures whereby selections for the board of

1 directors will be made and submitted to the commissioner for
2 approval;

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

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

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

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

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

25 (2) Sue or be sued, including taking any legal actions necessary
26 or proper for recovery of any assessments for, on behalf of, or
27 against participating carriers.

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

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

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

38 (6) Pool risks among members.

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

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

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

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

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

36 (j) All policy forms issued by the association must conform in
37 substance to prototype forms developed by the association, must in all
38 other respects conform to the requirements of this chapter, and must be

1 filed with and approved by the commissioner before their use.

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

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

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

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

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

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

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

1 equals or exceeds the minimum requirements for accident and sickness
 2 insurance policies issued in Indiana as set forth in IC 27. Coverage
 3 under any association policy is in excess of, and may not duplicate,
 4 coverage under any other form of health insurance.

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

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

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

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

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

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

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

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

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

38 (2) chiefly dependent upon the person in whose name the

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

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

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

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

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

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

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

38 (1) coverage as to a given individual is delayed to a date after the

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

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

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

17 ~~(h)~~ (i) For purposes of this section, coverage under a health
 18 insurance arrangement includes, but is not limited to, coverage
 19 pursuant to the Consolidated Omnibus Budget Reconciliation Act of
 20 1985.

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

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

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

32 (2) If the insured is:

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

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

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

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

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

3 (B) a woman at risk;
4 one (1) breast cancer screening mammography performed upon
5 the insured every year.

6 (4) If the insured is at least fifty (50) forty (40) years of age,
7 whether or not at risk; one (1) breast cancer screening
8 mammography performed upon the insured every year.

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

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

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

16 (1) the limitation on payment for screening mammography
17 services established in 42 CFR 405.534(b)(3) according to the
18 Medicare Economic Index at the time the breast cancer
19 screening mammography is performed; or

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

22 whichever is lower.

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

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

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

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

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

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

8 (i) the termination of employment or eligibility;

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

11 (iii) the death of a spouse; or

12 (iv) the dissolution of marriage; and

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (1) Nonpayment of required premiums.

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

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

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

- 1 (5) The small employer is no longer actively engaged in the
2 business in which the small employer was engaged on the
3 effective date of the plan.
- 4 **(3) The small employer has failed to comply with a material**
5 **plan provision relating to employer contribution or group**
6 **participation rules.**
- 7 **(4) In the case of a small employer insurer that offers**
8 **coverage in a market through a network plan, there is no**
9 **longer any insured individual in connection with the plan**
10 **who lives, resides, or works:**
- 11 **(A) in the service area of the small employer insurer; or**
12 **(B) in the area for which the issuer is authorized to do**
13 **business.**
- 14 **(5) In the case of coverage that is made available through one**
15 **(1) or more bona fide associations, the membership of the**
16 **small employer in the association ceases, but only if the**
17 **coverage is terminated under this subdivision uniformly**
18 **without regard to any health status related factor relating to**
19 **an insured individual.**
- 20 **(6) In a case in which an insurer decides to discontinue**
21 **offering a particular type of group health insurance coverage**
22 **offered in the small employer market, that coverage may be**
23 **discontinued by the insurer only if:**
- 24 **(A) the insurer provides notice of the insurer's intent to**
25 **discontinue the coverage to each small employer**
26 **provided with the coverage;**
- 27 **(B) the insurer offers the option to purchase all other**
28 **health insurance coverage currently being offered by the**
29 **insurer to the small employer to each small employer**
30 **that is provided with the coverage; and**
- 31 **(C) in exercising the option to discontinue the coverage**
32 **in offering the option of coverage under clause (B), the**
33 **insurer acts uniformly without regard to:**
- 34 **(i) the claims experience of the small employer**
35 **groups; or**
- 36 **(ii) any health status related factor relating to any**
37 **eligible employee or dependent of an eligible**
38 **employee who is covered or who may become**

1 **eligible for the coverage.**

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

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

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

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

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

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

1 (b) Except as provided in section 29 of this chapter, a small
 2 employer insurer shall waive the exclusion period described in section
 3 27 of this chapter applicable to a preexisting condition or the limitation
 4 period with respect to a particular service in a health insurance plan for
 5 the time an eligible employee or a dependent of an eligible employee
 6 was previously covered by a health insurance plan if the following
 7 conditions are met:

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

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

14 (A) the eligible employee; or

15 (B) a dependent of the eligible employee.

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

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

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

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

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

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

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

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

1 responsibility and the surcharge constitutes compliance with section 2
2 of this chapter:

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

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

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

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

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

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

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

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

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

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

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

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

7 (2) Eligibility requirements.

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

9 (4) Emergency care benefits and services.

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

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

12 (7) Limitations and exclusions.

13 (8) Enrollee termination provisions.

14 (9) Any enrollee reinstatement provisions.

15 (10) Claims procedures.

16 (11) Enrollee grievance procedures.

17 (12) Continuation of coverage provisions.

18 (13) Conversion provisions.

19 (14) Extension of benefit provisions.

20 (15) Coordination of benefit provisions.

21 (16) Any subrogation provisions.

22 (17) A description of the service area.

23 (18) The entire contract provisions.

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

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

27 (21) Right of renewal provisions.

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

30 (23) Grace period provisions.

31 (24) A provision on conformity with state law.

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

33 **(A) guaranteed renewability; and**

34 **(B) group portability;**

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

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

- 1 Page 9, after line 11, begin a new paragraph and insert:
 2 "SECTION 39. IC 27-13-29-1, AS AMENDED BY P.L.255-1995,
 3 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 4 JULY 1, 1998]: Sec. 1. (a) Except as provided in subsection (b) or as
 5 otherwise provided in this article or IC 27:
 6 (1) IC 27; and
 7 (2) the provisions of IC 16 regulating hospitals;
 8 do not apply to any health maintenance organization or limited service
 9 health maintenance organization (**as defined in IC 27-13-34-4**) that is
 10 granted a certificate of authority under this article. However, this
 11 section does not apply to an insurer or a hospital that is licensed under
 12 Indiana law, except with respect to the health maintenance organization
 13 activities of the hospital or insurer that are authorized and regulated
 14 under this article.
 15 (b) Every:
 16 (1) health maintenance organization; **and**
 17 (2) **limited service health maintenance organization (as**
 18 **defined in IC 27-13-34-4);**
 19 authorized to do business in Indiana is subject to IC 27-4-1 relating to
 20 unfair methods of competition and unfair or deceptive acts or practices
 21 to the extent that IC 27-4-1 does not conflict with this article. If a
 22 provision in IC 27-4-1 conflicts with this article, this article governs
 23 and controls.
 24 SECTION 40. IC 34-4-12.6-1, AS AMENDED BY P.L.147-1997,
 25 SECTION 74, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 26 JANUARY 1, 1999]: Sec. 1. (a) As used in this chapter, "professional
 27 health care provider" means:
 28 (1) a physician licensed under IC 25-22.5;
 29 (2) a dentist licensed under IC 25-14;
 30 (3) a hospital licensed under IC 16-21;
 31 (4) a podiatrist licensed under IC 25-29;
 32 (5) a chiropractor licensed under IC 25-10;
 33 (6) an optometrist licensed under IC 25-24;
 34 (7) a psychologist licensed under IC 25-33;
 35 (8) a pharmacist licensed under IC 25-26;
 36 (9) a health facility licensed under IC 16-28-2;
 37 (10) a registered or licensed practical nurse licensed under
 38 IC 25-23;

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

- 1 or to methods used in arriving at diagnoses.
- 2 (c) As used in this chapter, "peer review committee" means a
3 committee that:
- 4 (1) has the responsibility of evaluation of:
- 5 (A) qualifications of professional health care providers;
- 6 (B) patient care rendered by professional health care
7 providers; or
- 8 (C) the merits of a complaint against a professional health
9 care provider that includes a determination or
10 recommendation concerning the complaint, and the
11 complaint is based on the competence or professional
12 conduct of an individual health care provider which
13 competence or conduct affects or could affect adversely the
14 health or welfare of a patient or patients; and
- 15 (2) meets the following criteria:
- 16 (A) The committee is organized:
- 17 (i) by a state, regional, or local organization of
18 professional health care providers or by a nonprofit
19 foundation created by the professional organization for
20 purposes of improvement of patient care;
- 21 (ii) by the professional staff of a hospital, another
22 health care facility, a nonprofit health care organization
23 (under subsection (a)(23)), or a professional health
24 care organization;
- 25 (iii) by state or federal law or regulation;
- 26 (iv) by a governing board of a hospital, a nonprofit
27 health care organization (under subsection (a)(23)), or
28 professional health care organization;
- 29 (v) as a governing board or committee of the board of
30 a hospital, a nonprofit health care organization (under
31 subsection (a)(23)), or professional health care
32 organization;
- 33 (vi) by an organization, a plan, or a program described
34 in subsection (a)(16) through (a)(17);
- 35 (vii) as a hospital or a nonprofit health care
36 organization (under subsection (a)(23)) medical staff
37 or a section of that staff; or
- 38 (viii) as a governing board or committee of the board

1 of a professional health care provider (as defined in
2 subsection (a)(16) through (a)(17)).

3 (B) At least fifty percent (50%) of the committee members
4 are:

5 (i) individual professional health care providers, the
6 governing board of a hospital, the governing board of
7 a nonprofit health care organization (under subsection
8 (a)(23)), or professional health care organization, or
9 the governing board or a committee of the board of a
10 professional health care provider (as defined in
11 subsection (a)(16) through (a)(17)); or

12 (ii) individual professional health care providers and
13 the committee is organized as an interdisciplinary
14 committee to conduct evaluation of patient care
15 services.

16 However, "peer review committee" does not include a medical review
17 panel created under IC 27-12-10.

18 (d) As used in this chapter, "professional staff" means:

19 (1) all individual professional health care providers authorized
20 to provide health care in a hospital or other health care facility;

21 or

22 (2) the multidisciplinary staff of a community mental health
23 center (as defined in IC 12-7-2-38).

24 (e) As used in this chapter, "personnel of a peer review committee"
25 means not only members of the committee but also all of the
26 committee's employees, representatives, agents, attorneys,
27 investigators, assistants, clerks, staff, and any other person or
28 organization who serves a peer review committee in any capacity.

29 (f) As used in this chapter, "in good faith" refers to an act taken
30 without malice after a reasonable effort to obtain the facts of the matter
31 and in the reasonable belief that the action taken is warranted by the
32 facts known. In all actions to which this chapter applies, good faith
33 shall be presumed, and malice shall be required to be proven by the
34 person aggrieved.

35 (g) As used in this chapter, "professional health care organization"
36 refers to an organization described in subsection (a)(14).

37 **(h) As used in this chapter, "professional review activity"**
38 **means an activity of a peer review committee of a hospital licensed**

1 **under IC 16-21 with respect to a professional health care provider**
 2 **to:**

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

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

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

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

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

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

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

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

36 (d) No restraining order or injunction shall be issued against a peer
 37 review committee or any of the personnel **thereof of the committee** to
 38 interfere with the proper functions of the committee acting in good

1 faith in regard to evaluation of patient care as that term is defined and
2 limited in section 1(b) of this chapter.

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

- 8 (1) The peer review committee.
9 (2) Any person acting as a member or staff to the peer review
10 committee.
11 (3) Any person under a contract or other formal agreement with
12 the peer review committee.
13 (4) Any person who participates with or assists the peer review
14 committee with respect to the action.

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

- 17 (1) the federal Civil Rights Act of 1964, 42 U.S.C. 2000e, et
18 seq.; and
19 (2) the federal Civil Rights Act, 42 U.S.C. 1981, et seq.

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

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

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

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

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

36 (b) **IC 27-8-15-10.5, IC 27-8-15-14, IC 27-8-15-19,**
37 **IC 27-8-15-27, IC 27-8-15-28, all as amended by this act, and**
38 **IC 27-8-15-34.1, as added by this act, apply to all small employer**

- 1 **health insurance plans in force under IC 27-8-15 on April 1, 1998.**
- 2 **SECTION 45. An emergency is declared for this act."**
- 3 Renumber all SECTIONS consecutively.
(Reference is to SB 292 as reprinted February 3, 1998.)

and when so amended that said bill do pass.

Representative Fry