

## CONFERENCE COMMITTEE REPORT DIGEST FOR HB 1286

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

**Synopsis:** Various insurance matters. Conference committee report for EHB 1286. Makes the following changes in the insurance law: (1) Requires the filing of the annual report on the state police pension trust with the state board of accounts rather than the insurance commissioner. (2) Requires an insurance agent whose license is expired for more than 24 months to retake the licensure examination and complete certain educational requirements before the license may be renewed. (Current law provides a limit of 60 months.) (3) Authorizes the insurance commissioner to suspend, revoke, or refuse to renew the license of an insurance agent who pleads guilty or no contest to a felony or a misdemeanor involving moral turpitude. (4) Requires insurers to file quarterly statements, at no charge, with the department of insurance. (5) Requires the department of insurance, which is required to prepare an annual report concerning worker's compensation insurance rates based on information reported by insurers to the worker's compensation rating bureau, to make the report available upon request. (6) Amends the law on mine subsidence insurance to require an insurer to provide information on the availability of mine subsidence coverage only when proposing to issue a new policy. (7) Relieves an insurer of the duty to inform the policyholder of the availability of mine subsidence coverage when proposing to renew a policy already in force. (8) Provides that an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 2000. (Under current law, an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 1997.) (9) Provides that a health care provider for whom an insurer submits proof of financial responsibility and payment of the surcharge to the department of insurance in an untimely manner may be in compliance with patient compensation fund requirements if certain conditions are met by the insurer. Amends the insurance laws to conform to the federal Health Insurance Portability and Accountability (HIPA) Act of 1996. Provides that a provision concerning guaranteed renewability in compliance with the Health Insurance Portability and Accountability Act must be included in each individual accident and sickness policy and each group accident and sickness policy. Requires the inclusion of a provision concerning group portability in each group accident and sickness policy. Makes the following changes in the law concerning the Indiana comprehensive health insurance association (ICHIA): (1) Adds definitions to the law, including a definition of the term "federally eligible individual". (2) Allows a person to qualify for a health insurance policy issued by ICHIA upon a showing that a conventional insurer has refused to issue the person a policy, except at a rate exceeding the association plan rate, or that the person is a federally eligible individual. (3) Changes the composition of the association board of directors. (4) Changes the preexisting condition limitations time period from 6 months to 3 months for individuals for whom medical treatment was recommended or received within 3 months before the effective date of coverage. Makes the following changes in the law on small employer group health insurance: (1) Makes the small employer group health insurance laws apply to an employer that employs only two employees. (2) Restricts a small employer insurer's ability to cancel health insurance coverage or to exclude coverage. (3) Reduces the permissible duration of a preexisting condition exclusion by the amount of time an individual applicant for insurance has continuously served under a preexisting condition clause of a small employer group health insurance policy if the individual applies for the new coverage within 63 days of the expiration of the individual's coverage under the policy.

(4) Provides that a pregnancy existing at the time of enrollment in a small employer group health insurance plan may not be excluded as a preexisting condition. (5) Repeals a provision that prohibits a small employer insurer from discriminating against an employer based on the nature of the employer's business and replaces it with a provision requiring a small employer insurer to cover any small employer that applies for coverage. (6) Changes the grounds on which a small employer group health insurance policy may be canceled. (7) Amends the definition of "late enrollee" for purposes of the law on small employer group health insurance. Provides that a group contract or an individual contract with a health maintenance organization must include a provision complying with the guaranteed renewability and group portability requirements of the federal Health Insurance Portability and Accountability Act. THIS CONFERENCE COMMITTEE REPORT makes the following changes in the insurance law: (1) Requires the filing of the annual report on the state police pension trust with the state board of accounts rather than the insurance commissioner. (2) Requires an insurance agent whose license is expired for more than 24 months to retake the licensure examination and complete certain educational requirements before the license may be renewed. (Current law provides a limit of 60 months.) (3) Authorizes the insurance commissioner to suspend, revoke, or refuse to renew the license of an insurance agent who pleads guilty or no contest to a felony or a misdemeanor involving moral turpitude. (4) Requires insurers to file quarterly statements, at no charge, with the department of insurance. (5) Requires the department of insurance, which is required to prepare an annual report concerning worker's compensation insurance rates based on information reported by insurers to the worker's compensation rating bureau, to make the report available upon request. (6) Amends the law on mine subsidence insurance to require an insurer to provide information on the availability of mine subsidence coverage only when proposing to issue a new policy. (7) Relieves an insurer of the duty to inform the policyholder of the availability of mine subsidence coverage when proposing to renew a policy already in force. (8) Provides that an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 2000. (Under current law, an insurer is not required to inform a prospective policyholder of the availability of mine subsidence coverage if the issuance of the policy will take place after June 30, 1997.) (9) Provides that a health care provider for whom an insurer submits proof of financial responsibility and payment of the surcharge to the department of insurance in an untimely manner may be in compliance with patient compensation fund requirements if certain conditions are met by the insurer. Amends the insurance laws to conform to the federal Health Insurance Portability and Accountability (HIPA) Act of 1996. Provides that a provision concerning guaranteed renewability in compliance with the Health Insurance Portability and Accountability Act must be included in each individual accident and sickness policy and each group accident and sickness policy. Requires the inclusion of a provision concerning group portability in each group accident and sickness policy. Makes the following changes in the law concerning the Indiana comprehensive health insurance association (ICHIA): (1) Adds definitions to the law, including a definition of the term "federally eligible individual". (2) Allows a person to qualify for a health insurance policy issued by ICHIA upon a showing that a conventional insurer has refused to issue the person a policy, except at a rate exceeding the association plan rate, or that the person is a federally eligible individual. (3) Changes the composition of the association board of directors. (4) Changes the preexisting condition limitations time period from 6 months to 3 months for individuals for whom medical treatment was recommended or received within 3 months before the effective date of coverage. Makes the following changes in the law on small employer group health insurance: (1) Makes the small employer group health insurance laws apply to an employer that employs only two employees. (2) Restricts a small employer insurer's ability to cancel health insurance coverage or to exclude coverage. (3) Reduces the permissible duration of a preexisting condition exclusion by the amount of time an individual applicant for insurance has continuously served under a preexisting condition clause of a small employer group health insurance policy if the individual applies for the new coverage within 63 days of the expiration of the individual's coverage under the policy. (4) Provides that a pregnancy existing at the time of enrollment in a small employer group health insurance plan may not be excluded as a preexisting condition. (5) Repeals a provision that prohibits a small employer insurer from discriminating against an employer based

on the nature of the employer's business and replaces it with a provision requiring a small employer insurer to cover any small employer that applies for coverage. (6) Changes the grounds on which a small employer group health insurance policy may be canceled. (7) Amends the definition of "late enrollee" for purposes of the law on small employer group health insurance. Provides that a group contract or an individual contract with a health maintenance organization must include a provision complying with the guaranteed renewability and group portability requirements of the federal Health Insurance Portability and Accountability Act. Provides that dependents of eligible employees are entitled to small group conversion policies.

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

Adopted

Rejected

## CONFERENCE COMMITTEE REPORT

**MR. PRESIDENT:**

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

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

- 1           Between the enacting clause and line 1, begin a new paragraph
- 2           and insert:
- 3           "SECTION 1. IC 2-5-23-8, AS ADDED BY P.L.11-1995,
- 4           SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 5           APRIL 1, 1998]: Sec. 8. Beginning May 1, 1997, the health policy
- 6           advisory committee is established. At the request of the chairman, the
- 7           health policy advisory committee shall provide information and
- 8           otherwise assist the commission to perform the duties of the
- 9           commission under this chapter. The health policy advisory committee
- 10          members are ex officio and may not vote. The health policy advisory
- 11          committee members shall be appointed from the general public and
- 12          must include one (1) individual who represents each of the following:
- 13               (1) The interests of public hospitals.
- 14               (2) The interests of community mental health centers.
- 15               (3) The interests of community health centers.
- 16               (4) The interests of the long term care industry.
- 17               (5) The interests of health care professionals licensed under
- 18               IC 25, but not licensed under IC 25-22.5.
- 19               (6) The interests of rural hospitals. An individual appointed
- 20               under this subdivision must be licensed under IC 25-22.5.
- 21               (7) The interests of health maintenance organizations (as defined
- 22               in IC 27-13-1-19).
- 23               (8) The interests of for-profit health care facilities (as defined in
- 24               ~~IC 27-8-10-1(g)~~; **IC 27-8-10-1(i)**).
- 25               (9) A statewide consumer organization.
- 26               (10) A statewide senior citizen organization.
- 27               (11) A statewide organization representing people with

- 1 disabilities.
- 2 (12) Organized labor.
- 3 (13) The interests of businesses that purchase health insurance
- 4 policies.
- 5 (14) The interests of businesses that provide employee welfare
- 6 benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.
- 7 (15) A minority community.
- 8 (16) The uninsured. An individual appointed under this
- 9 subdivision must be and must have been chronically uninsured.
- 10 (17) An individual who is not associated with any organization,
- 11 business, or profession represented in this subsection other than
- 12 as a consumer.

13 SECTION 2. IC 10-1-2-2, AS AMENDED BY P.L.40-1997,

14 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

15 JULY 1, 1998]: Sec. 2. (a) Authority is granted to the department to

16 establish and operate an actuarially sound pension plan governed by a

17 pension trust and to make the necessary annual contribution in order to

18 prevent any deterioration in the actuarial status of the trust fund.

19 (b) Contributions shall be made to the trust fund by the department

20 and by each employee beneficiary through authorized monthly

21 deductions from wages.

22 (c) The trust fund may not be commingled with any other funds

23 and shall be invested only in accordance with Indiana laws for the

24 investment of trust funds, together with such other investments as are

25 specifically designated in the pension trust. Subject to the terms of the

26 pension trust, the trustee, with the approval of the Department and the

27 Pension Advisory Board, may establish investment guidelines and

28 limits on all types of investments (including, but not limited to, stocks

29 and bonds) and take other action necessary to fulfill its duty as a

30 fiduciary for the trust fund. However, the trustee shall invest the trust

31 fund assets with the same care, skill, prudence, and diligence that a

32 prudent person acting in a like capacity and familiar with such matters

33 would use in the conduct of an enterprise of a like character with like

34 aims. The trustee shall also diversify such investments in accordance

35 with prudent investment standards. The investment of trust funds is

36 subject to section 2.5 of this chapter.

37 (d) The trustee shall receive and hold as trustee for the uses and

38 purposes set forth in the pension trust any and all funds paid by the

39 department, the employee beneficiaries, or by any other person or

40 persons.

41 (e) The trustee shall engage pension consultants to supervise and

42 assist in the technical operation of the pension plan in order that there

43 may be no deterioration in the actuarial status of the plan.

44 (f) Before October 1 of each year, the trustee, with the aid of the

45 pension consultants, shall prepare and file a report with the department

46 and the ~~insurance commissioner~~ **state board of accounts**. The report

47 must include the following with respect to the fiscal year ending on the

48 preceding June 30:

49 SCHEDULE I. Receipts and disbursements.

50 SCHEDULE II. Assets of the pension trust, listing investments

51 as to book value and current market value at the end of the fiscal

- 1 year.
- 2 SCHEDULE III. List of terminations, showing cause and amount
- 3 of refund.
- 4 SCHEDULE IV. The application of actuarially computed
- 5 "reserve factors" to the payroll data, properly classified for the
- 6 purpose of computing the reserve liability of the trust fund as of
- 7 the end of the fiscal year.
- 8 SCHEDULE V. The application of actuarially computed "current
- 9 liability factors" to the payroll data, properly classified for the
- 10 purpose of computing the liability of the trust fund for the end of
- 11 the fiscal year.
- 12 SCHEDULE VI. An actuarial computation of the pension
- 13 liability for all employees retired before the close of the fiscal
- 14 year.

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

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

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

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

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

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

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

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

5 For the certificate ..... \$10

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5           (ⓕ) (e) Money in the fund at the end of a particular fiscal year does  
6 not revert to the state general fund.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 15 (1) Any materially untrue statement in the license application.
- 16 (2) Any cause for which issuance of the license could have been  
 17 refused had it then existed and been known to the commissioner  
 18 at the time of issuance.
- 19 (3) Violation of or noncompliance with any insurance laws,  
 20 violation of any provision of IC 28 concerning the sale of a life  
 21 insurance policy or an annuity contract, or violation of any lawful  
 22 rule, regulation, or order of the commissioner or of a  
 23 commissioner of another state.
- 24 (4) Obtaining or attempting to obtain any such license through  
 25 misrepresentation or fraud.
- 26 (5) Improperly withholding, misappropriating, or converting to  
 27 the licensee's own use any money belonging to policyholders,  
 28 insurers, beneficiaries, or others received in the course of the  
 29 licensee's insurance business.
- 30 (6) Misrepresentation of the terms of any actual or proposed  
 31 insurance contract.
- 32 (7) **A:**  
 33 (A) conviction of; or  
 34 (B) plea of guilty, no contest, or nolo contendere to;  
 35 a felony or misdemeanor involving moral turpitude.
- 36 (8) The licensee has been found guilty of any unfair trade practice  
 37 or of fraud.
- 38 (9) In the conduct of the licensee's affairs under the license, the  
 39 licensee has used fraudulent, coercive, or dishonest practices, or  
 40 has shown himself to be incompetent, untrustworthy, or  
 41 financially irresponsible, or not performing in the best interests of  
 42 the insuring public.
- 43 (10) The licensee's license has been suspended or revoked in any  
 44 ~~other~~ state, province, district, or territory.
- 45 (11) The licensee has forged another's name to an application for  
 46 insurance.
- 47 (12) An applicant has been found to have been cheating on a  
 48 examination for an insurance license.
- 49 (13) The applicant or licensee is on the most recent tax warrant  
 50 list supplied to the commissioner by the department of state  
 51 revenue.

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

3 (b) The commissioner shall refuse to:

4 (1) issue a license; or

5 (2) renew a license issued;

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

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

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

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

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

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

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

38 (3) Suspend a licensee's certificate.

39 (4) Censure a licensee.

40 (5) Issue a letter of reprimand.

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

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

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

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

51 The commissioner may withdraw the probation if the

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

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

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

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

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

18 that is authorized to transact business in Indiana.

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

21 (c) On or before March 1 of each year, an insurer shall file with the  
22 National Association of Insurance Commissioners **and with the**  
23 **department** a copy of the insurer's annual statement convention blank  
24 and additional filings prescribed by the commissioner for the preceding  
25 year. An insurer shall also file quarterly statements with the NAIC **and**  
26 **with the department** on or before May 15, August 15, and November  
27 15 of each year in a form prescribed by the commissioner. The  
28 information filed with the NAIC under this subsection:

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

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

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

49 (e) A foreign company that:

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

1 (2) complies with that law;  
2 shall be considered to be in compliance with this section.

3 (f) In the absence of actual malice:

4 (1) members of the NAIC;

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

7 (3) delegates of members of the NAIC;

8 (4) employees of the NAIC; and

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

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

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

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

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

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

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

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

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

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

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

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

39 (e) An insurer is not required to provide mine subsidence coverage  
 40 under subsection (a) under any insurance policy in an amount  
 41 exceeding the amount that is reimbursable from the fund under section  
 42 9(a)(4) of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 (A) premiums;

43 (B) benefits; or

44 (C) both premiums and benefits;

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

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

51 (A) explains the insurance protection to which the person

- 1 insured is entitled;
- 2 (B) indicates to whom the insurance benefits are payable; and
- 3 (C) explains any family member's or dependent's coverage
- 4 under the policy.
- 5 (8) A provision stating that written notice of a claim must be
- 6 given to the insurer within twenty (20) days after the occurrence
- 7 or commencement of any loss covered by the policy, but that a
- 8 failure to give notice within the twenty (20) day period does not
- 9 invalidate or reduce any claim if it can be shown that it was not
- 10 reasonably possible to give notice within that period and that
- 11 notice was given as soon as was reasonably possible.
- 12 (9) A provision stating that:
- 13 (A) the insurer will furnish to the person making a claim, or to
- 14 the policyholder for delivery to the person making a claim,
- 15 forms usually furnished by the insurer for filing proof of loss;
- 16 and
- 17 (B) if the forms are not furnished within fifteen (15) days after
- 18 the insurer received notice of a claim, the person making the
- 19 claim will be deemed to have complied with the requirements
- 20 of the policy as to proof of loss upon submitting, within the
- 21 time fixed in the policy for filing proof of loss, written proof
- 22 covering the occurrence, character, and extent of the loss for
- 23 which the claim is made.
- 24 (10) A provision stating that:
- 25 (A) in the case of a claim for loss of time for disability, written
- 26 proof of the loss must be furnished to the insurer within ninety
- 27 (90) days after the commencement of the period for which the
- 28 insurer is liable, and that subsequent written proofs of the
- 29 continuance of the disability must be furnished to the insurer
- 30 at reasonable intervals as may be required by the insurer;
- 31 (B) in the case of a claim for any other loss, written proof of
- 32 the loss must be furnished to the insurer within ninety (90)
- 33 days after the date of the loss; and
- 34 (C) the failure to furnish proof within the time required under
- 35 clause (A) or (B) does not invalidate or reduce any claim if it
- 36 was not reasonably possible to furnish proof within that time,
- 37 and if proof is furnished as soon as reasonably possible but
- 38 (except in case of the absence of legal capacity of the
- 39 claimant) no later than one (1) year from the time proof is
- 40 otherwise required under the policy.
- 41 (11) A provision that:
- 42 (A) all benefits payable under the policy (other than benefits
- 43 for loss of time) will be paid within forty-five (45) days after
- 44 the insurer receives all information required to determine
- 45 liability under the terms of the policy; and
- 46 (B) subject to due proof of loss, all accrued benefits under the
- 47 policy for loss of time will be paid not less frequently than
- 48 monthly during the continuance of the period for which the
- 49 insurer is liable, and any balance remaining unpaid at the
- 50 termination of the period for which the insurer is liable will be
- 51 paid as soon as possible after receipt of the proof of loss.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 **(g) "Creditable coverage" has the meaning set forth in the**  
 37 **federal Health Insurance Portability and Accountability Act of**  
 38 **1996 (26 U.S.C. 9801(c)(1)).**

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

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

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

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

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

48 **(C) church plan;**

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

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

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

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

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

9 (r) "Medicaid" means medical assistance provided by the state  
10 under the Medicaid program under IC 12-15.

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

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

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

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

19 (t) "Medically necessary" means health care services that the  
20 association has determined:

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

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

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

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

29 (v) "Policy" means a contract, policy, or plan of health  
30 insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 49 (1) Enter into contracts as are necessary or proper to carry out this  
50 chapter, **subject to the approval of the commissioner.**
- 51 (2) Sue or be sued, including taking any legal actions necessary

- 1 or proper for recovery of any assessments for, on behalf of, or  
 2 against participating carriers.
- 3 (3) Take legal action necessary to avoid the payment of improper  
 4 claims against the association or the coverage provided by or  
 5 through the association.
- 6 (4) Establish a medical review committee to determine the  
 7 reasonably appropriate level and extent of health care services in  
 8 each instance.
- 9 (5) Establish appropriate rates, scales of rates, rate classifications  
 10 and rating adjustments, such rates not to be unreasonable in  
 11 relation to the coverage provided and the reasonable operational  
 12 expenses of the association.
- 13 (6) Pool risks among members.
- 14 (7) Issue policies of insurance on an indemnity or provision of  
 15 service basis providing the coverage required by this chapter.
- 16 (8) Administer separate pools, separate accounts, or other plans  
 17 or arrangements considered appropriate for separate members or  
 18 groups of members.
- 19 (9) Operate and administer any combination of plans, pools, or  
 20 other mechanisms considered appropriate to best accomplish the  
 21 fair and equitable operation of the association.
- 22 (10) Appoint from among members appropriate legal, actuarial,  
 23 and other committees as necessary to provide technical assistance  
 24 in the operation of the association, policy and other contract  
 25 design, and any other function within the authority of the  
 26 association.
- 27 (11) Hire an independent consultant.
- 28 (12) Develop a method of advising applicants of the availability  
 29 of other coverages outside the association and may promulgate a  
 30 list of health conditions the existence of which would deem an  
 31 applicant eligible without demonstrating a rejection of coverage  
 32 by one (1) carrier.
- 33 (13) Provide for the use of managed care plans for insureds,  
 34 including the use of:
- 35 (A) health maintenance organizations; and  
 36 (B) preferred provider plans.
- 37 (14) Solicit bids directly from providers for coverage under this  
 38 chapter.
- 39 (f) Rates for coverages issued by the association may not be  
 40 unreasonable in relation to the benefits provided, the risk experience,  
 41 and the reasonable expenses of providing the coverage. Separate scales  
 42 of premium rates based on age apply for individual risks. Premium  
 43 rates must take into consideration the extra morbidity and  
 44 administration expenses, if any, for risks insured in the association. The  
 45 rates for a given classification may not be more than one hundred fifty  
 46 percent (150%) of the average premium rate for that class charged by  
 47 the five (5) carriers with the largest premium volume in the state during  
 48 the preceding calendar year. In determining the average rate of the five  
 49 (5) largest carriers, the rates charged by the carriers shall be actuarially  
 50 adjusted to determine the rate that would have been charged for  
 51 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  
39 filed with and approved by the commissioner before their use.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 7 (1) a court has ordered that health insurance coverage be provided  
 8 for ~~a~~ **the** spouse or ~~a~~ minor or dependent child of an eligible  
 9 employee under the eligible employee's insurance plan; and  
 10 (2) the request for enrollment is made not more than thirty (30)  
 11 days after the issuance of the court order.

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

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

- 28 (1) Nonpayment of required premiums.  
 29 (2) Fraud or misrepresentation of the small employer, or with  
 30 respect to coverage of an insured individual, fraud or  
 31 misrepresentation by the insured individual or the individual's  
 32 representative.  
 33 ~~(3) Noncompliance with the plan's provisions:~~  
 34 ~~(4) The number of individuals covered under the plan is less than~~  
 35 ~~the number of percentage of eligible individuals required by~~  
 36 ~~percentage requirements under the plan:~~  
 37 ~~(5) The small employer is no longer actively engaged in the~~  
 38 ~~business in which the small employer was engaged on the~~  
 39 ~~effective date of the plan:~~  
 40 **(3) The small employer has failed to comply with a material**  
 41 **plan provision relating to employer contribution or group**  
 42 **participation rules.**  
 43 **(4) In the case of a small employer insurer that offers**  
 44 **coverage in a market through a network plan, there is no**  
 45 **longer any insured individual in connection with the plan who**  
 46 **lives, resides, or works:**  
 47 **(A) in the service area of the small employer insurer; or**  
 48 **(B) in the area for which the issuer is authorized to do**  
 49 **business.**  
 50 **(5) In the case of coverage that is made available through one**  
 51 **(1) or more bona fide associations, the membership of the**

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

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

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

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

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

19 **(i) the claims experience of the small employer groups;**  
 20 **or**

21 **(ii) any health status related factor relating to any**  
 22 **eligible employee or dependent of an eligible employee**  
 23 **who is covered or who may become eligible for the**  
 24 **coverage.**

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

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

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

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

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

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

50 (2) A hospital or medical service plan contract.

51 (3) A health maintenance organization subscriber contract.

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

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

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

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

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

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

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

41 Page 1, delete lines 1 through 5.

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

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

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

48 Page 2, between lines 30 and 31, begin a new paragraph and insert:  
 49 "SECTION 22. IC 27-13-7-3, AS ADDED BY P.L.26-1994,  
 50 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 51 JULY 1, 1998]: Sec. 3. (a) A contract referred to in section 1 of this

- 1 chapter must clearly state the following:
- 2 (1) The name and address of the health maintenance organization.
- 3 (2) Eligibility requirements.
- 4 (3) Benefits and services within the service area.
- 5 (4) Emergency care benefits and services.
- 6 (5) Any out-of-area benefits and services.
- 7 (6) Copayments, deductibles, and other out-of-pocket costs.
- 8 (7) Limitations and exclusions.
- 9 (8) Enrollee termination provisions.
- 10 (9) Any enrollee reinstatement provisions.
- 11 (10) Claims procedures.
- 12 (11) Enrollee grievance procedures.
- 13 (12) Continuation of coverage provisions.
- 14 (13) Conversion provisions.
- 15 (14) Extension of benefit provisions.
- 16 (15) Coordination of benefit provisions.
- 17 (16) Any subrogation provisions.
- 18 (17) A description of the service area.
- 19 (18) The entire contract provisions.
- 20 (19) The term of the coverage provided by the contract.
- 21 (20) Any right of cancellation of the group or individual contract
- 22 holder.
- 23 (21) Right of renewal provisions.
- 24 (22) Provisions regarding reinstatement of a group or an
- 25 individual contract holder.
- 26 (23) Grace period provisions.
- 27 (24) A provision on conformity with state law.
- 28 **(25) A provision or provisions that comply with the:**
- 29 **(A) guaranteed renewability; and**
- 30 **(B) group portability;**
- 31 **requirements of the federal Health Insurance Portability and**
- 32 **Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).**
- 33 (b) For purposes of subsection (a), an evidence of coverage which
- 34 is filed with a contract may be considered part of the contract.
- 35 SECTION 23. IC 27-13-29-1, AS AMENDED BY P.L.255-1995,
- 36 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 37 JULY 1, 1998]: Sec. 1. (a) Except as provided in subsection (b) or as
- 38 otherwise provided in this article or IC 27:
- 39 (1) IC 27; and
- 40 (2) the provisions of IC 16 regulating hospitals;
- 41 do not apply to any health maintenance organization or limited service
- 42 health maintenance organization **(as defined in IC 27-13-34-4)** that is
- 43 granted a certificate of authority under this article. However, this
- 44 section does not apply to an insurer or a hospital that is licensed under
- 45 Indiana law, except with respect to the health maintenance organization
- 46 activities of the hospital or insurer that are authorized and regulated
- 47 under this article.
- 48 (b) Every:
- 49 **(1) health maintenance organization; and**
- 50 **(2) limited service health maintenance organization (as**
- 51 **defined in IC 27-13-34-4);**

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

6 SECTION 24. IC 27-8-15-34 IS REPEALED [EFFECTIVE APRIL  
7 1, 1998].

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

12 (b) **The commissioner shall appoint, not later than September**  
13 **1, 1998, the members of the Indiana Comprehensive Health**  
14 **Insurance Association board of directors as required under**  
15 **IC 27-8-10-2.1(b), as amended by this act, for terms commencing**  
16 **on September 1, 1998.**

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

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

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

25 Renumber all SECTIONS consecutively.

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

**Conference Committee Report**  
**on**  
**House Bill 1286**

**S**igned by:

\_\_\_\_\_  
Senator

\_\_\_\_\_  
Representative Fry

\_\_\_\_\_  
Senator

\_\_\_\_\_  
Representative Torr

**Senate Conferees**

**House Conferees**