

First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

HOUSE ENROLLED ACT No. 2043

AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 1. The following definitions apply in this chapter:

(1) "Employee" means:

(A) an elected or appointed officer or official, or a full-time employee;

(B) if the individual is employed by a school corporation, a full-time or part-time employee;

(C) for a local unit public employer, a full-time or part-time employee or a person who provides personal services to the unit under contract during the contract period; or

(D) a senior judge appointed under IC 33-2-1-8;

whose services have continued without interruption at least thirty (30) days.

(2) "Group insurance" means any of the kinds of insurance fulfilling the definitions and requirements of group insurance contained in IC 27-1.

(3) "Insurance" means insurance upon or in relation to human life in all its forms, including life insurance, health insurance, disability insurance, accident insurance, hospitalization insurance,

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surgery insurance, medical insurance, and supplemental medical insurance.

(4) "Local unit" includes a city, town, county, township, or school corporation.

(5) "New traditional plan" means a self-insurance program established under section 7(b) of this chapter to provide health care coverage.

(6) "Public employer" means the state or a local unit, including any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.

~~(6)~~ (7) "Public employer" does not include a state educational institution (as defined under IC 20-12-0.5-1).

~~(7)~~ (8) "Retired employee" means:

(A) in the case of a public employer that participates in the public employees' retirement fund, a former employee who qualifies for a benefit under IC 5-10.3-8;

(B) in the case of a public employer that participates in the teachers' retirement fund under IC 21-6.1, a former employee who qualifies for a benefit under IC 21-6.1-5; and

(C) in the case of any other public employer, a former employee who meets the requirements established by the public employer for participation in a group insurance plan for retired employees.

~~(8)~~ (9) "Retirement date" means the date that the employee has chosen to receive retirement benefits from the employees' retirement fund.

SECTION 2. IC 5-10-8-6.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 6.5. (a) A member of the general assembly may elect to participate in either:**

(1) the plan of self-insurance established by the state police department under section 6 of this chapter;

(2) the plan of self-insurance established by the state personnel department under section 7 of this chapter; or

(3) a prepaid health care delivery plan established under section 7 of this chapter.

(b) A former member of the general assembly who meets the criteria for participation in a group health insurance program provided under section 8(e) or 8.1 of this chapter may elect to participate in either:



(1) the plan of self-insurance established by the state police department under section 6 of this chapter; or

(2) a group health insurance program provided under section 8(e) or 8.1 of this chapter.

(c) A member of the general assembly or former member of the general assembly who chooses a plan described in subsection (a)(1) or (b)(1) shall pay any amount of both the employer and the employee share of the cost of the coverage that exceeds the cost of the coverage under the new traditional plan.

SECTION 3. IC 5-10-8-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 8. (a) This section applies only to the state and its employees who are not covered by a plan established under section 6 of this chapter.

(b) After June 30, 1986, the state shall provide a group health insurance plan to each retired employee:

(1) whose retirement date is:

(A) after June 29, 1986, for a retired employee who was a member of the field examiners' retirement fund;

(B) after May 31, 1986, for a retired employee who was a member of the Indiana state teachers' retirement fund; or

(C) after June 30, 1986, for a retired employee not covered by clause (A) or (B);

(2) who will have reached fifty-five (55) years of age on or before the employee's retirement date but who will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

(3) who will have completed twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which shall have been completed immediately preceding the retirement; and

(4) who will have completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's retirement date.

(c) The state shall provide a group health insurance program to each retired employee:

(1) who is a retired judge;

(2) whose retirement date is after June 30, 1990;

(3) who is at least sixty-two (62) years of age;

(4) who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

(5) who has at least eight (8) years of service credit as a participant in the Indiana judges' retirement fund, with at least

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eight (8) years of that service credit completed immediately preceding the judge's retirement.

(d) The state shall provide a group health insurance program to each retired employee:

- (1) who is a retired participant under the prosecuting attorneys retirement fund;
- (2) whose retirement date is after January 1, 1990;
- (3) who is at least sixty-two (62) years of age;
- (4) who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
- (5) who has at least ten (10) years of service credit as a participant in the prosecuting attorneys retirement fund, with at least ten (10) years of that service credit completed immediately preceding the participant's retirement.

(e) The state shall make available a group health insurance program to each former member of the general assembly or surviving spouse of each former member, if the former member:

- (1) is no longer a member of the general assembly;
- (2) is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq. or, in the case of a surviving spouse, the surviving spouse is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395, et. seq.; and
- (3) has at least ten (10) years of service credit as a member in the general assembly. ~~with at least eight (8) years of that service credit completed immediately preceding the member's retirement or death.~~

A former member or surviving spouse of a former member who obtains insurance under this section is responsible for paying both the employer and the employee share of the cost of the coverage.

(f) The group health insurance program required under subsections (b) through (e) must be equal to that offered active employees. The retired employee may participate in the group health insurance program if the retired employee pays an amount equal to the employer's and the employee's premium for the group health insurance for an active employee and if the retired employee within ninety (90) days after the employee's retirement date files a written request for insurance coverage with the employer. However, the employer may elect to pay any part of the retired employee's premium.

(g) A retired employee's eligibility to continue insurance under this section ends when the employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health insurance program. A retired employee

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who is eligible for insurance coverage under this section may elect to have the employee's spouse covered under the health insurance program at the time the employee retires. If a retired employee's spouse pays the amount the retired employee would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired employee. The surviving spouse's eligibility ends on the earliest of the following:

- (1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
- (2) When the employer terminates the health insurance program.
- (3) Two (2) years after the date of the employee's death.
- (4) The date of the spouse's remarriage.

(h) This subsection does not apply to an employee who is entitled to group insurance coverage under IC 20-6.1-6-1(c). An employee who is on leave without pay is entitled to participate for ninety (90) days in any health insurance program maintained by the employer for active employees if the employee pays an amount equal to the total of the employer's and the employee's premiums for the insurance.

(i) An employer may provide group health insurance for retired employees or their spouses not covered by this section and may provide group health insurance that contains provisions more favorable to retired employees and their spouses than required by this section. A public employer may provide group health insurance to an employee who is on leave without pay for a longer period than required by subsection (h).

SECTION 4. IC 5-10-8-8.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 8.1. (a) This section applies only to the state and former legislators, instead of section 8 of this chapter.

(b) As used in this section, "legislator" means a member of the general assembly.

(c) After June 30, 1988, the state shall provide to each retired legislator:

- (1) whose retirement date is after June 30, 1988;
- (2) ~~who will have reached fifty-five (55) years of age on or before the legislator's retirement date~~ but who is not participating in a group health insurance coverage plan:
 - (A) including Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; but
 - (B) not including a group health insurance plan provided by the state **or a health insurance plan provided under**

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IC 27-8-10;

- (3) who served as a legislator for at least
 (A) ~~fifteen (15)~~ **ten (10)** years; and
 (B) ~~ten (10) years immediately preceding the legislator's retirement date;~~ and
 (4) who participated in a group health insurance plan provided by the state on the legislator's retirement date;
 a group health insurance program that is equal to that offered active employees.

(d) A retired legislator who qualifies under subsection (c) may participate in the group health insurance program if the retired legislator:

- (1) pays an amount equal to the employer's and employee's premium for the group health insurance for an active employee; and
 (2) within ninety (90) days after the legislator's retirement date files a written request for insurance coverage with the employer.

(e) A retired legislator's eligibility to continue insurance under this section ends when the member becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health insurance program.

(f) A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's spouse covered under the health insurance program at the time the legislator retires. If a retired legislator's spouse pays the amount the retired legislator would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The spouse's eligibility ends on the earliest of the following:

- (1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
 (2) When the employer terminates the health insurance program.
 (3) The date of the spouse's remarriage.

(g) The surviving spouse of a legislator who dies or has died in office may elect to participate in the group health insurance program if all of the following apply:

- (1) The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the day of the legislator's death.
 (2) The surviving spouse files a written request for insurance

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coverage with the employer.

(3) The surviving spouse pays an amount equal to the employer's and employee's premium for the group health insurance for an active employee.

(h) The eligibility of the surviving spouse of a legislator to purchase group health insurance under subsection (g) ends on the earliest of the following:

- (1) When the employer terminates the health insurance program.
- (2) The date of the spouse's remarriage.
- (3) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

SECTION 5. IC 27-1-15.5-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2000]: Sec. 19. (a) To qualify as a registered insurance agent program of study required under section 4(e) of this chapter, the program of study must meet all of the following criteria:

- (1) Be conducted **or developed** by:
 - (A) an insurance trade association;
 - (B) an accredited college or university;
 - (C) an educational organization certified by the insurance agent education advisory council; or
 - (D) an insurance company licensed to do business in Indiana.
- (2) Provide for **self-study or** instruction provided by an approved instructor in a structured setting as follows:
 - (A) For life insurance agents, a minimum of twenty-four (24) hours of instruction **in a structured setting or comparable self-study** on:
 - (i) ethical practices in the marketing and selling of insurance;
 - (ii) requirements of the insurance laws and administrative rules of the state; and
 - (iii) principles of life insurance.
 - (B) For health insurance agents, a minimum of twenty-four (24) hours of instruction **in a structured setting or comparable self-study** on:
 - (i) ethical practices in the marketing and selling of insurance;
 - (ii) requirements of the insurance laws and administrative rules of the state; and
 - (iii) principles of health insurance.
 - (C) For life and health insurance agents, a minimum of forty (40) hours of instruction **in a structured setting or**

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comparable self-study on:

- (i) ethical practices in the marketing and selling of insurance;
- (ii) requirements of the insurance laws and administrative rules of the state;
- (iii) principles of life insurance; and
- (iv) principles of health insurance.

(D) For property and casualty insurance agents, a minimum of forty (40) hours of instruction **in a structured setting or comparable self-study on:**

- (i) ethical practices in the marketing and selling of insurance;
- (ii) requirements of the insurance laws and administrative rules of the state;
- (iii) principles of property insurance; and
- (iv) principles of liability insurance.

(3) **Instruction provided in a structured setting must** be given only by individuals who meet the qualifications required by the commissioner. The commissioner, after consulting with the insurance agent education advisory council, shall adopt rules prescribing the criteria to be met by a person in order to render instruction in a registered insurance agent program of study.

(b) The commissioner shall adopt rules under IC 4-22-2 prescribing the subject matter that a program of study must possess to qualify for registration under this section.

(c) The commissioner may make recommendations for improvements in course materials as considered necessary by the commissioner.

(d) The commissioner shall certify a program of study meeting the requirements of this section as a registered insurance agent program of study.

(e) The commissioner may, after notice and opportunity for a hearing, withdraw the registration of a program of study which does not maintain reasonable standards as determined by the commissioner for the protection of the public.

(f) Programs of study certified under this section must submit current course materials to the commissioner upon request but no less frequently than every three (3) years.

SECTION 6. IC 27-6-8-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 6. (a) The board of directors of the association shall consist of nine (9) member insurers one (1) of whom shall be selected by or from among each of the following groups

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representative of member insurers, such selection to be subject to the approval of the commissioner:

~~(i)~~ **(1)** One (1) person representing the American Insurance Association.

~~(ii)~~ **(2)** One (1) person representing the Alliance of American Insurers.

~~(iii)~~ **(3)** One (1) person representing the National Association of Independent Insurers.

~~(iv)~~ **(4)** One (1) person representing the National Association of Mutual Insurance Companies.

~~(v)~~ **(5)** One (1) person representing the Insurance Institute of Indiana.

~~(vi)~~ One ~~(1)~~ person representing the domestic stock companies.

(6) Three (3) persons representing the:

(A) domestic stock companies;

(B) domestic mutual companies; or

(C) domestic reciprocal insurers;

with not more than two (2) persons representing any category.

~~(vii)~~ One ~~(1)~~ person representing the domestic mutual companies.

~~(viii)~~ One ~~(1)~~ person representing the domestic reciprocal insurers.

~~(ix)~~ **(7)** One (1) person representing independent unaffiliated stock, fire, and casualty companies to be appointed by the commissioner.

(b) Not more than one (1) member insurer in a group of insurers under the same management or ownership shall serve as a director at the same time.

(c) Directors shall serve such terms as shall be established in the plan of operation.

(d) Vacancies on the board shall be filled for the remaining period of the term in the same manner as the initial selection.

(e) If no directors are selected by March 1, 1972, the commissioner may appoint the initial members of the board of directors.

(f) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(g) Directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

SECTION 7. IC 27-6-10-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 7. Credit for reinsurance shall be allowed ~~a~~ **to any** domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded

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only when:

- (1) the reinsurer meets the requirements of:
 - (1) (A) section 8 of this chapter;
 - (2) (B) section 9 of this chapter;
 - (3) (C) sections 10 and 12 of this chapter;
 - (4) (D) sections 11 and 12 of this chapter; or
 - (5) (E) section 13 of this chapter; and

(2) **the reinsurance contract provides in substance that, in the event of the insolvency of the ceding insurer, the reinsurance is payable under a contract reinsured by the assuming insurer on the basis of reported claims allowed in the liquidation proceedings, subject to court approval, without diminution because of the insolvency of the ceding insurer. Payments under this subdivision must be made directly to the ceding insurer or to the ceding insurer's domiciliary liquidator except as provided in IC 27-9-3-30.1. The reinsurance agreement may provide that the domiciliary liquidator of an insolvent ceding insurer shall give written notice to an assuming insurer of the pendency of a claim against the ceding insurer on the contract reinsured within a reasonable time after the claim is filed in the liquidation proceeding. During the pendency of the claim, any assuming insurer may investigate the claim and interpose in the proceeding where the claim is to be adjudicated, at the assuming insurer's expense, any defenses that the assuming insurer considers available to the ceding insurer or the liquidator. If two (2) or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to the claim, the expense must be apportioned under the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer.**

SECTION 8. IC 27-7-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) The insurer shall make available, in each automobile liability or motor vehicle liability policy of insurance which is delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state, insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person and for injury to or destruction of property to others arising from the ownership, maintenance, or use of a motor vehicle, or in a supplement to such a policy, the following types of coverage:

- (1) in limits for bodily injury or death and for injury to or

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destruction of property not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death, and for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured motor vehicles for injury to or destruction of property resulting therefrom; or

(2) in limits for bodily injury or death not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy provisions who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom.

The uninsured and underinsured motorist coverages must be provided by insurers for either a single premium or for separate premiums, in limits at least equal to the limits of liability specified in the bodily injury liability provisions of an insured's policy, unless such coverages have been rejected in writing by the insured. However, underinsured motorist coverage must be made available in limits of not less than fifty thousand dollars (\$50,000). At the insurer's option, the bodily injury liability provisions of the insured's policy may be required to be equal to the insured's underinsured motorist coverage. Insurers may not sell or provide underinsured motorist coverage in an amount less than fifty thousand dollars (\$50,000). Insurers must make underinsured motorist coverage available to all existing policyholders on the date of the first renewal of existing policies that occurs on or after January 1, 1995, and on any policies newly issued or delivered on or after January 1, 1995. Uninsured motorist coverage or underinsured motorist coverage may be offered by an insurer in an amount exceeding the limits of liability specified in the bodily injury and property damage liability provisions of the insured's policy.

(b) ~~The~~ **Any** named insured of an automobile or motor vehicle liability policy has the right, **on behalf of all other named insureds and all other insureds**, in writing, to:

- (1) reject both the uninsured motorist coverage and the underinsured motorist coverage provided for in this section; or
- (2) reject either the uninsured motorist coverage alone or the underinsured motorist coverage alone, if the insurer provides the

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coverage not rejected separately from the coverage rejected. No insured may have uninsured motorist property damage liability insurance coverage under this section unless the insured also has uninsured motorist bodily injury liability insurance coverage under this section. Following rejection of either or both uninsured motorist coverage or underinsured motorist coverage, unless later requested in writing, the insurer need not offer uninsured motorist coverage or underinsured motorist coverage in or supplemental to a renewal **or replacement** policy ~~in connection with a policy previously~~ issued to the same insured **by the same insurer or a subsidiary or an affiliate of the originally issuing insurer.** Renewals of policies issued or delivered in this state which have undergone interim policy endorsement or amendment do not constitute newly issued or delivered policies for which the insurer is required to provide the coverages described in this section.

SECTION 9. IC 27-8-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless **it complies with each of the following:**

- (1) The entire money and other considerations ~~therefor for the policy~~ are expressed ~~therein; in the policy.~~
- (2) The time at which the insurance takes effect and terminates is expressed ~~therein; in the policy.~~
- (3) ~~it~~ **The policy** purports to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age, which shall not exceed nineteen (19) years, and any other person dependent upon the policyholder.
- (4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any ~~endorsements~~ **endorsements** or attached papers is plainly printed in ~~light-faced~~ **lightface** type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

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(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form **of the policy**, including riders and ~~indorsements~~, **endorsements**, shall be identified by a form number in the lower left-hand corner of the first page ~~thereof~~; **of the policy**.

(7) ~~it~~ **The policy** contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner. ~~and~~

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both:

- (~~a~~) **(A)** incapable of self-sustaining employment by reason of mental retardation **or mental** or physical disability; and
- (~~b~~) **(B)** chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a mentally retarded **or mentally** or physically disabled child where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In



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any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent.

This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) ~~of this section~~ and in section 3 of this chapter.

SECTION 10. IC 27-8-5-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

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

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

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

- (1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.
- (2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating

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to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

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

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

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

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

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

- (A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person, or recommended to the person, during the six (6) months before the enrollment date of the person's coverage; and
- (B) may not apply to a loss incurred or disability beginning after the earlier of:
 - (i) the end of a continuous period of twelve (12) months beginning on or after the enrollment date of the person's

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coverage; or

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

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and (B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

~~(7)~~ (7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

- (A) premiums;
- (B) benefits; or
- (C) both premiums and benefits;

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

~~(8)~~ (8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement that:

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

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(B) indicates to whom the insurance benefits are payable; and
 (C) explains any family member's or dependent's coverage under the policy.

~~(8)~~ (9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

~~(9)~~ (10) A provision stating that:

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

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

~~(10)~~ (11) A provision stating that:

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

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

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

~~(11)~~ (12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid within forty-five (45) days after

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the insurer receives all information required to determine liability under the terms of the policy; and

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

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

~~(13)~~ **(14)** A provision that the insurer has the right and must be allowed the opportunity to:

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

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

~~(14)~~ **(15)** A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy, and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

~~(15)~~ **(16)** In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

~~(16)~~ **(17)** If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon

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the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

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

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

~~(17)~~ **(18)** A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), ~~(c)(7)~~, **(c)(8)**, and ~~(c)(12)~~ **(c)(13)** do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

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

SECTION 11. IC 27-8-10-5.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or

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

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

- (1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;
- (2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or
- (3) the person is a federally eligible individual.

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

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

- (1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and
- (2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

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

- (1) incapable of self-sustaining employment by reason of mental retardation **or mental** or physical disability; and
- (2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by

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the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

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

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage.

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

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

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

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

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

SECTION 12. IC 27-9-3-30.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 30.1. (a) Reinsurance must be payable under a contract reinsured by an assuming insurer on the basis of reported claims allowed in the liquidation proceedings,**

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subject to court approval, without diminution because of the insolvency of the ceding insurer. Payments must be made directly to the ceding insurer or to the ceding insurer's domiciliary liquidator except when:

- (1) the contract or other written agreement specifically provides another payee of the reinsurance in the event of the insolvency of the ceding insurer; or
- (2) before the initiation of the insolvency proceedings, the assuming insurer, with the consent of the direct insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to policy payees and in substitution for the obligations of the ceding insurer to the payees.

(b) During the pendency of a receivership proceeding, an assuming insurer, with the consent of the direct insured and the receiver, subject to court approval, may assume policy obligations of the ceding insurer as direct obligations of the assuming insurer to the policy payees and in substitution for the obligations of the ceding insurer to the payees.

SECTION 13. IC 27-13-36-2.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2.5. (a) A health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certification with respect to:

- (1) participation;
- (2) reimbursement;
- (3) indemnification; or
- (4) scope of care;

solely on the basis of the provider's license or certification.

(b) This section does not require a health maintenance organization to enter into a contract with a provider that would allow the provider to enter the health maintenance organization network.

SECTION 14. IC 34-18-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) As used in this section, "actuarial program" means a program used or created by the department to determine the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by a hospital. The program must be:

- (1) developed to calculate actuarial risk posed by a hospital, taking into consideration risk management programs used by the hospital;

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- (2) an efficient and accurate means of calculating a hospital's malpractice actuarial risk;
- (3) publicly identified by the department by July 1 of each year; and
- (4) made available to a hospital's malpractice insurance carrier for purposes of calculating the hospital's surcharge under subsection (g).

(b) Beginning July 1, 1999, the amount of the annual surcharge shall be one hundred percent (100%) of the cost to each health care provider for maintenance of financial responsibility. Beginning July 1, 2001, the annual surcharge shall be set by a rule adopted by the commissioner under IC 4-22-2.

(c) The amount of the surcharge shall be determined based upon actuarial principles and actuarial studies and must be adequate for the payment of claims and expenses from the patient's compensation fund.

(d) The surcharge **for qualified providers other than:**

- (1) physicians licensed under IC 25-22.5; and**
- (2) hospitals licensed under IC 16-21;**

may not exceed the actuarial risk posed to the patient's compensation fund under IC 34-18 (or IC 27-12 before its repeal) by qualified providers **other than physicians licensed under IC 25-22.5 and hospitals licensed under IC 16-21.**

(e) There is imposed a minimum annual surcharge of one hundred dollars (\$100).

(f) Notwithstanding subsections (b), (c), and (e), beginning July 1, 1999, the surcharge for a qualified provider who is licensed under IC 25-22.5 is calculated as follows:

(1) The commissioner shall contract with an actuary that has experience in calculating the actuarial risks posed by physicians. Not later than July 1 of each year, the actuary shall calculate the median of the premiums paid for malpractice liability policies to the three (3) malpractice insurance carriers in the state that have underwritten the most malpractice insurance policies for all physicians practicing in the same specialty class in Indiana during the previous twelve (12) month period. In calculating the median, the actuary shall consider the:

- (A) manual rates of the three (3) leading malpractice insurance carriers in the state; and
- (B) aggregate credits or debits to the manual rates given during the previous twelve (12) month period.

(2) After making the calculation described in subdivision (1), the actuary shall establish a uniform surcharge for all licensed

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physicians practicing in the same specialty class. This surcharge must be based on a percentage of the median calculated in subdivision (1) for all licensed physicians practicing in the same specialty class under rules adopted by the commissioner under IC 4-22-2. The surcharge:

(A) must be sufficient to cover; and

(B) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by physicians practicing in the specialty class.

(g) Beginning July 1, 1999, the surcharge for a hospital licensed under IC 16-21 that establishes financial responsibility under IC 34-18-4 after June 30, 1999, is established by the department through the use of an actuarial program. At the time financial responsibility is established for the hospital, the hospital shall pay the surcharge amount established for the hospital under this section. The surcharge:

(1) must be sufficient to cover; and

(2) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 by the hospital.

(h) An actuarial program used or developed under subsection (a) shall be treated as a public record under IC 5-14-3.

SECTION 15. IC 34-18-15-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of ~~one two~~ **two hundred fifty** thousand dollars (~~\$100,000~~), **(\$250,000)**, and the claimant is demanding an amount in excess of that amount, the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking:

(A) approval of an agreed settlement, if any; or

(B) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition with summons shall be served on the commissioner, the health care provider, and the health care provider's insurer, and must contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with

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the claimant from the patient's compensation fund, or the commissioner, the health care provider, or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after service of summons with copy of the petition attached to the summons.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider, and the commissioner.

(5) At the hearing, the commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if the evidence is submitted on agreement without objections. If the commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, the court shall, after hearing any relevant evidence on the issue of claimant's damage submitted by any of the parties described in this section, determine the amount of claimant's damages, if any, in excess of the ~~one two~~ **fifty** thousand dollars ~~(\$100,000)~~ **(\$250,000)** already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and make a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested proceeding is appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties does not bar access to the patient's compensation fund unless the release specifically provides otherwise.

SECTION 16. IC 27-9-3-30 IS REPEALED [EFFECTIVE JULY 1, 1999].

SECTION 17. [EFFECTIVE JULY 1, 1999] (a) **The legislative council shall establish an interim study committee to do the following:**

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(1) Study the following issues related to the Indiana comprehensive health insurance association established under IC 27-8-10:

(A) Borrowing from financial institutions to provide working capital.

(B) Premium rates, including:

(i) a maximum premium rate or range for premium rates;

(ii) consideration of health maintenance organization premiums in rate determination;

(iii) annual premium rate determination and adjustment; and

(iv) a policy providing for reduced premium rates for insureds who have Medicare coverage.

(C) The effect of Medicaid eligibility on eligibility for coverage under an association policy.

(D) A maximum total annual assessment to members, the remainder of the cost to be paid by the state.

(E) Appeals procedures allowing members to:

(i) defer assessment payments for not more than one (1) year;

(ii) make assessment payments on a monthly or quarterly basis for cause; or

(iii) reduce or suspend an assessment if payment would cause the member's net worth or reserves to decrease below statutory requirements.

(F) Membership of self-insurance plans, including:

(i) conflicts with the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.); and

(ii) mechanisms for identifying self-insurance plans.

(G) Periodic audits to ensure that all entities that assume risk for accident or sickness of individuals in Indiana are members for purposes of the annual assessment.

(H) Penalties for late payment or nonpayment of assessments.

(I) Strategies to increase the base of insured individuals and decrease costs.

(J) Establishment of an independent administrative agency.

(2) Make recommendations to the legislative council regarding the issues specified in subdivision (1).

(b) The committee must have the following membership:

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(1) Two (2) members of the house of representatives to be appointed by the speaker of the house of representatives. Not more than one (1) member appointed under this subdivision may be affiliated with the same political party.

(2) Two (2) members of the senate to be appointed by the president pro tempore of the senate. Not more than one (1) member appointed under this subdivision may be affiliated with the same political party.

(3) One (1) member who is a member of the board of directors of the Indiana comprehensive health insurance association and is an Indiana comprehensive health insurance association policyholder to be appointed by the speaker of the house of representatives.

(4) One (1) member who is the chairman of the board of directors of the Indiana comprehensive health insurance association to be appointed by the president pro tempore of the senate.

(5) One (1) member who is a member of the board of directors of the Indiana comprehensive health insurance association and is a representative of the insurance industry to be appointed by the president pro tempore of the senate .

The chairman of the legislative council shall appoint the chairperson of the committee from the legislative members of the committee.

(c) The committee shall:

(1) operate under the direction and rules of the legislative council; and

(2) issue a final report when directed to do so by the legislative council.

(d) This SECTION expires November 1, 2000.

SECTION 18. [EFFECTIVE JULY 1, 1999] (a) Notwithstanding IC 5-10-8-8(f) and IC 5-10-8-8.1(d)(2), a retired legislator who:

(1) was not eligible for participation in a group health insurance plan under IC 5-10-8-8.1 when the legislator retired; and

(2) would be eligible for participation in a group health insurance plan under IC 5-10-8-8.1, as amended by this act, if the legislator retired after June 30, 1999;

may participate in a group health insurance plan under IC 5-10-8-8.1, as amended by this act, if the retired legislator files a written request for insurance coverage with the employer before October 1, 1999.

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(b) This SECTION expires January 1, 2001.
SECTION 19. An emergency is declared for this act.

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