

**CONFERENCE COMMITTEE REPORT
DIGEST FOR HB 1396**

Citations Affected: IC 27-8; P.L.147-1997; noncode.

Synopsis: Mental health. Provides that for purposes of analyzing health care service claims, to recode means to change a code used on a claim for covered services to a different classification code. Requires the administrator or insurer to notify the provider and insured that the insurer or administrator has recoded the claim and to provide certain additional specified information. Adds a dependent child's incapability to self-sustain employment because of mental illness to the reasons that continue hospital and medical coverage to a child under certain insurance policies. Allows an individual who meets certain requirements to be granted a mental health counselor's license. (This conference committee report amends mental health counselor licensure requirements, adds the language from the most recent version of HB 1287 and February 26, 1999, version of ESB 289, and amends a Medicaid outpatient mental health reimbursement rule cite.)

Effective: Upon passage; July 1, 1999.

CONFERENCE COMMITTEE REPORT

MR. PRESIDENT:

Your Conference Committee appointed to confer with a like committee from the House upon Engrossed Senate Amendments to Engrossed House Bill No. 1396 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 Delete the title and insert the following:
- 2 A BILL FOR AN ACT to amend the Indiana Code concerning
- 3 human services.
- 4 Page 1, between the enacting clause and line 1, begin a new
- 5 paragraph and insert:
- 6 "SECTION 1. IC 27-1-25-1 IS AMENDED TO READ AS
- 7 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 1. As used in this
- 8 chapter:
- 9 (a) "Administrator", **except as provided in section 7.5 of this**
- 10 **chapter**, means a person who collects charges or premiums from, or
- 11 who adjusts or settles claims on, residents of Indiana in connection
- 12 with life or health coverage or annuities, whether provided for by an
- 13 insurer or a self-funded plan. The term "administrator" does not include
- 14 the following persons:
- 15 (1) An employer for its employees or for the employees of a
- 16 subsidiary or affiliated corporation of the employer.
- 17 (2) A union for its members.
- 18 (3) An insurer, including:
- 19 (A) an insurer operating a health maintenance organization or
- 20 a limited service health maintenance organization; and
- 21 (B) the sales representative of an insurer operating a health
- 22 maintenance organization or a limited service health
- 23 maintenance organization when that sales representative is
- 24 licensed in Indiana and when it is engaged in the performance
- 25 of its duties as the sales representative.
- 26 (4) A life or health insurance agent licensed under IC 27-1-15.5
- 27 whose activities are limited exclusively to the sale of insurance.

- 1 (5) A creditor for its debtors regarding insurance covering a debt
2 between them.
- 3 (6) A trust established under 29 U.S.C. 186 and the trustees,
4 agents, and employees acting pursuant to that trust.
- 5 (7) A trust that is exempt from taxation under Section 501(a) of
6 the Internal Revenue Code and:
- 7 (A) the trustees and employees acting pursuant to that trust; or
8 (B) a custodian and the agents and employees of the custodian
9 acting pursuant to a custodian account that meets the
10 requirements of Section 401(f) of the Internal Revenue Code.
- 11 (8) A financial institution that is subject to supervision or
12 examination by federal or state banking authorities.
- 13 (9) A credit card issuing company that advances for and collects
14 premiums or charges from its credit cardholders as long as that
15 company does not adjust or settle claims.
- 16 (10) An individual who adjusts or settles claims in the normal
17 course of his practice or employment as an attorney at law, and
18 who does not collect charges or premiums in connection with life
19 or health insurance coverage or annuities.
- 20 (11) A health maintenance organization that has a certificate of
21 authority issued under IC 27-13.
- 22 (12) A limited service health maintenance organization that has
23 a certificate of authority issued under IC 27-13.
- 24 (b) "Certificate of registration" refers to the certificate required by
25 section 11 of this chapter.
- 26 (c) "Commissioner" refers to the commissioner of insurance.
- 27 (d) "Financial institution" means a bank, savings association, credit
28 union, or any other institution regulated under IC 28 or federal law.
- 29 (e) "Insurer" means a person who obtains a certificate of authority
30 under IC 27-1-3-20.
- 31 (f) "Person" means an individual, a corporation, a partnership, a
32 limited liability company, or an unincorporated association.
- 33 (g) "Self-funded plan" means a plan for providing benefits for life,
34 health, or annuity coverage by a person who is not an insurer.
- 35 SECTION 2. IC 27-1-25-7.5 IS ADDED TO THE INDIANA CODE
36 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
37 1, 1999]: **Sec. 7.5. (a) As used in this section, "administrator"**
38 **means a person that administers claims for health care services**
39 **under an insurance policy.**
- 40 (b) **As used in this section, "health care services" has the**
41 **meaning set forth in IC 27-8-11-1.**
- 42 (c) **As used in this section, "insurance policy" means a policy**
43 **that provides the kind or kinds of insurance described in Class 1(b)**
44 **or Class 2(a) of IC 27-1-5-1 on an individual, group, franchise, or**
45 **blanket basis or through a preferred provider plan (as defined in**
46 **IC 27-8-11-1).**
- 47 (d) **As used in this section, "insured" means an individual**
48 **entitled to coverage under an insurance policy.**
- 49 (e) **As used in this section, "recode" means to change a code**
50 **used by a provider of health care services on a claim for covered**
51 **services provided to an insured to a different classification code**

1 using the most current edition of either of the following:

2 (1) International Classification of Diseases.

3 (2) Current Procedural Terminology.

4 (f) An administrator may not recode a claim unless the
5 administrator provides written notice to the insured and the
6 provider that the administrator has recoded the claim together
7 with:

8 (1) the insurer's explanation of benefits to the insured; and

9 (2) an explanation of remittance to the provider of the health
10 care services.

11 (g) The notification required under subsection (f) must include
12 at least the following:

13 (1) An appropriate ANSI code or other reason code, or both,
14 along with a specific description of the reasons for recoding
15 the claim.

16 (2) A toll free number that the provider or the insured may
17 use to contact the administrator to obtain additional
18 information.

19 (3) The procedure that a provider may use to submit a request
20 for a review of the initial decision to recode a claim.

21 (4) A list of additional information that the provider must
22 submit in a request for a review of the initial decision to
23 recode a claim.

24 SECTION 3. IC 27-8-5-2 IS AMENDED TO READ AS FOLLOWS
25 [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) No individual policy of
26 accident and sickness insurance shall be delivered or issued for
27 delivery to any person in this state unless **it complies with each of the**
28 **following:**

29 (1) The entire money and other considerations ~~therefor~~ **for the**
30 **policy** are expressed ~~therein~~; **in the policy.**

31 (2) The time at which the insurance takes effect and terminates is
32 expressed ~~therein~~; **in the policy.**

33 (3) ~~it~~ **The policy** purports to insure only one (1) person, except
34 that a policy may insure, originally or by subsequent amendment,
35 upon the application of any member of a family who shall be
36 deemed the policyholder and who is at least eighteen (18) years
37 of age, any two (2) or more eligible members of that family,
38 including husband, wife, dependent children or any children
39 under a specified age, which shall not exceed nineteen (19) years,
40 and any other person dependent upon the policyholder.

41 (4) The style, arrangement, and overall appearance of the policy
42 give no undue prominence to any portion of the text, and unless
43 every printed portion of the text of the policy and of any
44 ~~indorsements~~ **endorsements** or attached papers is plainly printed
45 in ~~light-faced~~ **lightface** type of a style in general use, the size of
46 which shall be uniform and not less than ten point with a
47 lower-case unspaced alphabet length not less than one hundred
48 and twenty point (the "text" shall include all printed matter except
49 the name and address of the insurer, name or title of the policy,
50 the brief description if any, and captions and subcaptions).

51 (5) The exceptions and reductions of indemnity are set forth in the

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

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

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

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

27 ~~(a)~~ **(A)** incapable of self-sustaining employment by reason of
 28 mental retardation **or mental** or physical disability; and

29 ~~(b)~~ **(B)** chiefly dependent upon the policyholder for support
 30 and maintenance.

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

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

47 (b) If any policy is issued by an insurer domiciled in this state for
 48 delivery to a person residing in another state, and if the official having
 49 responsibility for the administration of the insurance laws of such other
 50 state shall have advised the commissioner that any such policy is not
 51 subject to approval or disapproval by such official, the commissioner

1 may by ruling require that such policy meet the standards set forth in
2 subsection (a) ~~of this section~~ and in section 3 of this chapter.

3 SECTION 4. IC 27-8-5-19 IS AMENDED TO READ AS
4 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 19. (a) As used in this
5 chapter, "late enrollee" has the meaning set forth in 26 U.S.C.
6 9801(b)(3).

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

10 (1) the provisions described in subsection (c); or

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

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

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

15 than the provisions set forth in subsection (c).

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

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

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

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

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

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

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

- 1 beneficiary or personal representative.
- 2 (4) A provision setting forth the conditions, if any, under which
3 the insurer reserves the right to require a person eligible for
4 insurance to furnish evidence of individual insurability
5 satisfactory to the insurer as a condition to part or all of the
6 person's coverage.
- 7 (5) A provision specifying any additional exclusions or limitations
8 applicable under the policy with respect to a disease or physical
9 condition of a person that existed before the effective date of the
10 person's coverage under the policy and that is not otherwise
11 excluded from the person's coverage by name or specific
12 description effective on the date of the person's loss. An exclusion
13 or limitation that must be specified in a provision under this
14 subdivision:
- 15 (A) may apply only to a disease or physical condition for
16 which medical advice, diagnosis, care, or treatment was
17 received by the person, or recommended to the person, during
18 the six (6) months before the enrollment date of the person's
19 coverage; and
- 20 (B) may not apply to a loss incurred or disability beginning
21 after the earlier of:
- 22 (i) the end of a continuous period of twelve (12) months
23 beginning on or after the enrollment date of the person's
24 coverage; or
- 25 (ii) the end of a continuous period of eighteen (18) months
26 beginning on the enrollment date of the person's coverage if
27 the person is a late enrollee.
- 28 (6) If premiums or benefits under the policy vary according to a
29 person's age, a provision specifying an equitable adjustment of:
- 30 (A) premiums;
- 31 (B) benefits; or
- 32 (C) both premiums and benefits;
- 33 to be made if the age of a covered person has been misstated. A
34 provision under this subdivision must contain a clear statement of
35 the method of adjustment to be used.
- 36 (7) A provision that the insurer will issue to the policyholder, for
37 delivery to each person insured, a certificate setting forth a
38 statement that:
- 39 (A) explains the insurance protection to which the person
40 insured is entitled;
- 41 (B) indicates to whom the insurance benefits are payable; and
- 42 (C) explains any family member's or dependent's coverage
43 under the policy.
- 44 (8) A provision stating that written notice of a claim must be
45 given to the insurer within twenty (20) days after the occurrence
46 or commencement of any loss covered by the policy, but that a
47 failure to give notice within the twenty (20) day period does not
48 invalidate or reduce any claim if it can be shown that it was not
49 reasonably possible to give notice within that period and that
50 notice was given as soon as was reasonably possible.
- 51 (9) A provision stating that:

- 1 (A) the insurer will furnish to the person making a claim, or to
2 the policyholder for delivery to the person making a claim,
3 forms usually furnished by the insurer for filing proof of loss;
4 and
5 (B) if the forms are not furnished within fifteen (15) days after
6 the insurer received notice of a claim, the person making the
7 claim will be deemed to have complied with the requirements
8 of the policy as to proof of loss upon submitting, within the
9 time fixed in the policy for filing proof of loss, written proof
10 covering the occurrence, character, and extent of the loss for
11 which the claim is made.
- 12 (10) A provision stating that:
- 13 (A) in the case of a claim for loss of time for disability, written
14 proof of the loss must be furnished to the insurer within ninety
15 (90) days after the commencement of the period for which the
16 insurer is liable, and that subsequent written proofs of the
17 continuance of the disability must be furnished to the insurer
18 at reasonable intervals as may be required by the insurer;
- 19 (B) in the case of a claim for any other loss, written proof of
20 the loss must be furnished to the insurer within ninety (90)
21 days after the date of the loss; and
- 22 (C) the failure to furnish proof within the time required under
23 clause (A) or (B) does not invalidate or reduce any claim if it
24 was not reasonably possible to furnish proof within that time,
25 and if proof is furnished as soon as reasonably possible but
26 (except in case of the absence of legal capacity of the
27 claimant) no later than one (1) year from the time proof is
28 otherwise required under the policy.
- 29 (11) A provision that:
- 30 (A) all benefits payable under the policy (other than benefits
31 for loss of time) will be paid within forty-five (45) days after
32 the insurer receives all information required to determine
33 liability under the terms of the policy; and
- 34 (B) subject to due proof of loss, all accrued benefits under the
35 policy for loss of time will be paid not less frequently than
36 monthly during the continuance of the period for which the
37 insurer is liable, and any balance remaining unpaid at the
38 termination of the period for which the insurer is liable will be
39 paid as soon as possible after receipt of the proof of loss.
- 40 (12) A provision that benefits for loss of life of the person insured
41 are payable to the beneficiary designated by the person insured.
42 However, if the policy contains conditions pertaining to family
43 status, the beneficiary may be the family member specified by the
44 policy terms. In either case, payment of benefits for loss of life is
45 subject to the provisions of the policy if no designated or
46 specified beneficiary is living at the death of the person insured.
47 All other benefits of the policy are payable to the person insured.
48 The policy may also provide that if any benefit is payable to the
49 estate of a person, or to a person who is a minor or otherwise not
50 competent to give a valid release, the insurer may pay the benefit,
51 up to an amount of five thousand dollars (\$5,000), to any relative

1 by blood or connection by marriage of the person who is deemed
2 by the insurer to be equitably entitled to the benefit.

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

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

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

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

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

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

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

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

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

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

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

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

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

9 SECTION 5. IC 27-8-10-5.1 IS AMENDED TO READ AS
10 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.1. (a) Except as
11 provided in subsections (b) and (c), a person is not eligible for an
12 association policy if, at the effective date of coverage, the person has
13 or is eligible for coverage under any insurance plan that equals or
14 exceeds the minimum requirements for accident and sickness insurance
15 policies issued in Indiana as set forth in IC 27. Coverage under any
16 association policy is in excess of, and may not duplicate, coverage
17 under any other form of health insurance.

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

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

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

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

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

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

- 49 (1) incapable of self-sustaining employment by reason of mental
50 retardation **or mental** or physical disability; and
- 51 (2) chiefly dependent upon the person in whose name the contract

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

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

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

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

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

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

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

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

42 SECTION 6. P.L.147-1997, SECTION 79, IS AMENDED TO
 43 READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: (a) The
 44 definitions under IC 25-23.6, as amended by this act, apply throughout
 45 this SECTION.

46 (b) The board shall exempt an individual from the requirement
 47 under IC 25-23.6, as amended by this act, and grant the individual a
 48 mental health counselor license if the individual meets the following
 49 requirements:

50 (1) Submits an application to the board before ~~July~~ **August 1,**
 51 1999.

- 1 (2) Has:
- 2 (A) **at least twenty (20) years of mental health counseling**
- 3 **experience in a joint commission accredited agency and**
- 4 **has a bachelor's degree; or**
- 5 (B) a master's or doctor's degree from an institution of higher
- 6 learning in at least one (1) of the following areas:
- 7 ~~(A)~~ (i) Counseling.
- 8 ~~(B)~~ (ii) Clinical or counseling psychology.
- 9 ~~(C)~~ (iii) Mental health.
- 10 ~~(D)~~ (iv) Applied human development.
- 11 (v) **Psychology.**
- 12 (3) Presents evidence that the applicant is credentialed by a
- 13 national organization that provides private credentialing in mental
- 14 health counseling.
- 15 (4) Presents evidence from employers or professional colleagues
- 16 that the applicant has at least five (5) years of mental health
- 17 counseling practice within the ten (10) years preceding the date
- 18 of application.
- 19 (5) Pays the fee required by the board.
- 20 (6) Has not had a license, certificate, or registration in mental
- 21 health counseling or a related profession suspended or revoked in
- 22 any jurisdiction.
- 23 (7) Has not been convicted of a crime that has a direct bearing on
- 24 the individual's ability to practice competently.
- 25 (8) Presents evidence that the applicant has completed at least two
- 26 thousand (2,000) hours of supervised client counseling before the
- 27 date of application.
- 28 (c) The board shall exempt an individual from the requirement
- 29 under IC 25-23.6, as amended by this act, and grant the individual a
- 30 marriage and family therapist license if the individual has a current
- 31 certificate as a marriage and family therapist under IC 25-23.6 or
- 32 obtains this certificate no later than June 30, 1999.
- 33 (d) The board shall exempt an individual from the requirement
- 34 under IC 25-23.6, as amended by this act, and grant the individual a
- 35 social worker license if the individual has a current certificate as a
- 36 social worker under IC 25-23.6-5 or obtains this certificate no later
- 37 than June 30, 1999.
- 38 (e) The board shall exempt an individual from the requirement
- 39 under IC 25-23.6, as amended by this act, and grant the individual a
- 40 clinical social worker license if the individual has a current certificate
- 41 as a clinical social worker issued under IC 25-23.6 or obtains this
- 42 certificate no later than June 30, 1999.
- 43 (f) Notwithstanding subsections (c), (d), and (e), if the board has:
- 44 (1) taken a disciplinary action against the certificate of a:
- 45 (A) certified marriage and family therapist;
- 46 (B) certified social worker; or
- 47 (C) certified clinical social worker;
- 48 before July 1, 1997; and
- 49 (2) imposed sanctions against an individual under subdivision (1);
- 50 and the sanctions imposed under subdivision (2) remain in place, the
- 51 board shall review the file of each individual described in this

1 subsection to determine whether to grant a license to the individual as
2 provided in this act. The board may grant a license with any restrictions
3 the board believes are appropriate to protect the public health.

4 (g) This SECTION expires ~~July~~ **December** 1, 1999."

5 Page 1, line 3, delete "405 IAC 5-20-8(1) and 405 IAC 5-21-1(c)"
6 and insert "**405 IAC 2-20 and 405 IAC 5-21**".

7 Renumber all SECTIONS consecutively.

(Reference is to EHB 1396 as printed April 6, 1999.)

Conference Committee Report
on
House Bill 1396

Signed by:

Senator Miller

Representative Crosby

Senator Breaux

Representative Budak

Senate Conferees

House Conferees