



January 14, 2000

# HOUSE BILL No. 1189

DIGEST OF HB 1189 (Updated January 12, 2000 2:41 PM - DI 97)

**Citations Affected:** IC 16-21; IC 22-2; IC 25-1; IC 27-1; IC 27-4; IC 27-7; IC 27-8; IC 27-13; IC 34-30; noncode.

**Synopsis:** Various insurance matters. Provides that a hospital and a physician must ensure compliance with a hold harmless clause in a health maintenance organization (HMO) provider contract. Allows a wage assignment for the purpose of paying a premium on a policy of insurance. Increases penalties for unfair methods of competition and unfair or deceptive acts or practices in the business of insurance. Provides requirements for cancellation or nonrenewal of residential insurance policies. Requires an insurer to notify a residential policyholder regarding coverage for flood damage. Requires an insurer to provide certain information with a premium rate change filing when a policy of accident and sickness insurance form is no longer actively marketed. Requires an insurer to issue a confirmation number when health care services are preauthorized. Requires an insurer to establish and maintain an internal grievance procedure and an external grievance review procedure. Amends the Indiana HMO law concerning: (1) assumption of a corporate name; (2) reinsurance; (3) powers of domestic HMOs; (4) annual and other filings; (5) uncovered health care expenditures; (6) receivership; and (7) voluntary dissolution.

**Effective:** July 1, 2000.

**Fry, Smith M**

January 10, 2000, read first time and referred to Committee on Insurance, Corporations and Small Business.  
January 13, 2000, amended, reported — Do Pass.

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January 14, 2000

Second Regular Session 111th General Assembly (2000)

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 1999 General Assembly.

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## HOUSE BILL No. 1189



A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

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

- 1 SECTION 1. IC 16-21-2-5, AS AMENDED BY P.L.162-1999,
- 2 SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 3 JULY 1, 2000]: Sec. 5. The governing board of the hospital is the
- 4 supreme authority in the hospital and is responsible for the following:
- 5 (1) The management, operation, and control of the hospital,
- 6 **including compliance with IC 27-13-15-3.**
- 7 (2) The appointment, reappointment, and assignment of privileges
- 8 to members of the medical staff, with the advice and
- 9 recommendations of the medical staff, consistent with the
- 10 individual training, experience, and other qualifications of the
- 11 medical staff.
- 12 (3) Establishing requirements for appointments to and continued
- 13 service on the hospital's medical staff, consistent with the
- 14 appointee's individual training, experience, and other
- 15 qualifications, including the following requirements:
- 16 (A) Proof that a medical staff member has qualified as a health
- 17 care provider under IC 16-18-2-163(a).

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- 1 (B) The performance of patient care and related duties in a
- 2 manner that is not disruptive to the delivery of quality medical
- 3 care in the hospital setting.
- 4 (C) Standards of quality medical care that recognize the
- 5 efficient and effective utilization of hospital resources,
- 6 developed by the medical staff.
- 7 (4) Upon recommendation of the medical staff, establishing
- 8 protocols within the requirements of this chapter and 410
- 9 IAC 5-1.2-1 for the admission, treatment, and care of patients
- 10 with extended lengths of stay.

11 SECTION 2. IC 22-2-6-2 IS AMENDED TO READ AS FOLLOWS  
 12 [EFFECTIVE JULY 1, 2000]: Sec. 2. (a) Any assignment of the wages  
 13 of an employee is valid only if all of the following conditions are  
 14 satisfied:

- 15 (1) The assignment is:
- 16 (A) in writing;
- 17 (B) signed by the employee personally;
- 18 (C) by its terms revocable at any time by the employee upon
- 19 written notice to the employer; and
- 20 (D) agreed to in writing by the employer.
- 21 (2) An executed copy of the assignment is delivered to the
- 22 employer within ten (10) days after its execution.
- 23 (3) The assignment is made for a purpose described in subsection
- 24 (b).

25 (b) A wage assignment under this section may be made for the  
 26 purpose of paying any of the following:

- 27 (1) Premium on a policy of insurance. ~~obtained for the employee~~
- 28 ~~by the employer.~~
- 29 (2) Pledge or contribution of the employee to a charitable or
- 30 nonprofit organization.
- 31 (3) Purchase price of bonds or securities, issued or guaranteed by
- 32 the United States.
- 33 (4) Purchase price of shares of stock, or fractional interests
- 34 therein, of the employing company, or of a company owning the
- 35 majority of the issued and outstanding stock of the employing
- 36 company, whether purchased from such company, in the open
- 37 market or otherwise. However, if such shares are to be purchased
- 38 on installments pursuant to a written purchase agreement, the
- 39 employee has the right under the purchase agreement at any time
- 40 before completing purchase of such shares to cancel said
- 41 agreement and to have repaid promptly the amount of all
- 42 installment payments which theretofore have been made.

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- 1 (5) Dues to become owing by the employee to a labor
- 2 organization of which the employee is a member.
- 3 (6) Purchase price of merchandise sold by the employer to the
- 4 employee, at the written request of the employee.
- 5 (7) Amount of a loan made to the employee by the employer and
- 6 evidenced by a written instrument executed by the employee.
- 7 (8) Contributions, assessments, or dues of the employee to a
- 8 hospital service or a surgical or medical expense plan or to an
- 9 employees' association, trust, or plan existing for the purpose of
- 10 paying pensions or other benefits to said employee or to others
- 11 designated by the employee.
- 12 (9) Payment to any credit union, nonprofit organizations, or
- 13 associations of employees of such employer organized under any
- 14 law of this state or of the United States.
- 15 (10) Payment to any person or organization regulated under the
- 16 Uniform Consumer Credit Code (IC 24-4.5) for deposit or credit
- 17 to the employee's account by electronic transfer or as otherwise
- 18 designated by the employee.
- 19 (11) Premiums on policies of insurance and annuities purchased
- 20 by the employee on the employee's life.
- 21 (12) The purchase price of shares or fractional interest in shares
- 22 in one (1) or more mutual funds.
- 23 SECTION 3. IC 25-1-9-4, AS AMENDED BY P.L.22-1999,
- 24 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 25 JULY 1, 2000]: Sec. 4. (a) A practitioner shall conduct the
- 26 practitioner's practice in accordance with the standards established by
- 27 the board regulating the profession in question and is subject to the
- 28 exercise of the disciplinary sanctions under section 9 of this chapter if,
- 29 after a hearing, the board finds:
- 30 (1) a practitioner has:
- 31 (A) engaged in or knowingly cooperated in fraud or material
- 32 deception in order to obtain a license to practice;
- 33 (B) engaged in fraud or material deception in the course of
- 34 professional services or activities; or
- 35 (C) advertised services in a false or misleading manner;
- 36 (2) a practitioner has been convicted of a crime that has a direct
- 37 bearing on the practitioner's ability to continue to practice
- 38 competently;
- 39 (3) a practitioner has knowingly violated any state statute or rule,
- 40 or federal statute or regulation, regulating the profession in
- 41 question;
- 42 (4) a practitioner has continued to practice although the

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1 practitioner has become unfit to practice due to:

2 (A) professional incompetence that:

3 (i) may include the undertaking of professional activities  
4 that the practitioner is not qualified by training or experience  
5 to undertake; and

6 (ii) does not include activities performed under  
7 IC 16-21-2-9;

8 (B) failure to keep abreast of current professional theory or  
9 practice;

10 (C) physical or mental disability; or

11 (D) addiction to, abuse of, or severe dependency upon alcohol  
12 or other drugs that endanger the public by impairing a  
13 practitioner's ability to practice safely;

14 (5) a practitioner has engaged in a course of lewd or immoral  
15 conduct in connection with the delivery of services to the public;

16 (6) a practitioner has allowed the practitioner's name or a license  
17 issued under this chapter to be used in connection with an  
18 individual who renders services beyond the scope of that  
19 individual's training, experience, or competence;

20 (7) a practitioner has had disciplinary action taken against the  
21 practitioner or the practitioner's license to practice in any other  
22 state or jurisdiction on grounds similar to those under this  
23 chapter;

24 (8) a practitioner has diverted:

25 (A) a legend drug (as defined in IC 16-18-2-199); or

26 (B) any other drug or device issued under a drug order (as  
27 defined in IC 16-42-19-3) for another person;

28 (9) a practitioner, except as otherwise provided by law, has  
29 knowingly prescribed, sold, or administered any drug classified  
30 as a narcotic, addicting, or dangerous drug to a habitue or addict;

31 **or**

32 (10) a practitioner has failed to comply with an order imposing a  
33 sanction under section 9 of this chapter; **or**

34 **(11) a practitioner who is a participating provider of a health  
35 maintenance organization has collected or attempted to  
36 collect from a subscriber or enrollee of the health  
37 maintenance organization any sums that are owed by the  
38 health maintenance organization.**

39 (b) A certified copy of the record of disciplinary action is conclusive  
40 evidence of the other jurisdiction's disciplinary action under subsection  
41 (a)(7).

42 SECTION 4. IC 27-1-23-1 IS AMENDED TO READ AS

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1 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. As used in this  
 2 chapter, the following terms shall have the respective meanings set  
 3 forth in this section, unless the context shall otherwise require:

4 (a) An "acquiring party" is the specific person by whom an  
 5 acquisition of control of a domestic insurer or of any corporation  
 6 controlling a domestic insurer is to be effected, and each person who  
 7 directly, or indirectly through one (1) or more intermediaries, controls  
 8 the person specified.

9 (b) An "affiliate" of, or person "affiliated" with, a specific person,  
 10 is a person that directly, or indirectly through one (1) or more  
 11 intermediaries, controls, or is controlled by, or is under common  
 12 control with, the person specified.

13 (c) A "beneficial owner" of a voting security includes any person  
 14 who, directly or indirectly, through any contract, arrangement,  
 15 understanding, relationship, revocable or irrevocable proxy, or  
 16 otherwise has or shares:

17 (1) voting power including the power to vote, or to direct the  
 18 voting of, the security; or

19 (2) investment power which includes the power to dispose, or to  
 20 direct the disposition, of the security.

21 (d) "Commissioner" means the insurance commissioner of this state.

22 (e) "Control" (including the terms "controlling", "controlled by", and  
 23 "under common control with") means the possession, direct or indirect,  
 24 of the power to direct or cause the direction of the management and  
 25 policies of a person, whether through the beneficial ownership of  
 26 voting securities, by contract other than a commercial contract for  
 27 goods or nonmanagement services, or otherwise, unless the power is  
 28 the result of an official position or corporate office. Control shall be  
 29 presumed to exist if any person beneficially owns ten percent (10%) or  
 30 more of the voting securities of any other person. The commissioner  
 31 may determine this presumption has been rebutted only by a showing  
 32 made in the manner provided by section 3(k) of this chapter that  
 33 control does not exist in fact, after giving all interested persons notice  
 34 and an opportunity to be heard. Control shall be presumed again to  
 35 exist upon the acquisition of beneficial ownership of each additional  
 36 five percent (5%) or more of the voting securities of the other person.  
 37 The commissioner may determine, after furnishing all persons in  
 38 interest notice and opportunity to be heard, that control exists in fact,  
 39 notwithstanding the absence of a presumption to that effect.

40 (f) "Department" means the department of insurance created by  
 41 IC 27-1-1-1.

42 (g) A "domestic insurer" is an insurer organized under the laws of

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1 this state.

2 (h) "Earned surplus" means an amount equal to the unassigned  
3 funds of an insurer as set forth in the most recent annual statement of  
4 an insurer that is submitted to the commissioner, excluding surplus  
5 arising from unrealized capital gains or revaluation of assets.

6 (i) An "insurance holding company system" consists of two (2) or  
7 more affiliated persons, one (1) or more of which is an insurer.

8 (j) "Insurer" has the same meaning as set forth in IC 27-1-2-3,  
9 except that it does not include:

10 (1) agencies, authorities, or instrumentalities of the United States,  
11 its possessions and territories, the Commonwealth of Puerto Rico,  
12 the District of Columbia, or a state or political subdivision of a  
13 state;

14 (2) fraternal benefit societies; or

15 (3) nonprofit medical and hospital service associations.

16 **The term includes a health maintenance organization (as defined**  
17 **in IC 27-13-1-19) and a limited service health maintenance**  
18 **organization (as defined in IC 27-13-1-27).**

19 (k) A "person" is an individual, a corporation, a limited liability  
20 company, a partnership, an association, a joint stock company, a trust,  
21 an unincorporated organization, any similar entity or any combination  
22 of the foregoing acting in concert, but shall not include any securities  
23 broker performing no more than the usual and customary broker's  
24 function.

25 (l) A "policyholder" of a domestic insurer includes any person who  
26 owns an insurance policy or annuity contract issued by the domestic  
27 insurer, any person reinsured by the domestic insurer under a  
28 reinsurance contract or treaty between the person and the domestic  
29 insurer, and any health maintenance organization with which the  
30 domestic insurer has contracted to provide services or protection  
31 against the cost of care.

32 (m) A "subsidiary" of a specified person is an affiliate controlled by  
33 that person directly or indirectly through one or more intermediaries.

34 (n) "Surplus" means the total of gross paid in and contributed  
35 surplus, special surplus funds, and unassigned surplus, less treasury  
36 stock at cost.

37 (o) "Voting security" includes any security convertible into or  
38 evidencing a right to acquire a voting security.

39 SECTION 5. IC 27-4-1-4 IS AMENDED TO READ AS FOLLOWS  
40 [EFFECTIVE JULY 1, 2000]: Sec. 4. The following are hereby defined  
41 as unfair methods of competition and unfair and deceptive acts and  
42 practices in the business of insurance:

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- 1 (1) Making, issuing, circulating, or causing to be made, issued, or  
2 circulated, any estimate, illustration, circular, or statement:  
3 (A) misrepresenting the terms of any policy issued or to be  
4 issued or the benefits or advantages promised thereby or the  
5 dividends or share of the surplus to be received thereon;  
6 (B) making any false or misleading statement as to the  
7 dividends or share of surplus previously paid on similar  
8 policies;  
9 (C) making any misleading representation or any  
10 misrepresentation as to the financial condition of any insurer,  
11 or as to the legal reserve system upon which any life insurer  
12 operates;  
13 (D) using any name or title of any policy or class of policies  
14 misrepresenting the true nature thereof; or  
15 (E) making any misrepresentation to any policyholder insured  
16 in any company for the purpose of inducing or tending to  
17 induce such policyholder to lapse, forfeit, or surrender his  
18 insurance.
- 19 (2) Making, publishing, disseminating, circulating, or placing  
20 before the public, or causing, directly or indirectly, to be made,  
21 published, disseminated, circulated, or placed before the public,  
22 in a newspaper, magazine, or other publication, or in the form of  
23 a notice, circular, pamphlet, letter, or poster, or over any radio or  
24 television station, or in any other way, an advertisement,  
25 announcement, or statement containing any assertion,  
26 representation, or statement with respect to any person in the  
27 conduct of his insurance business, which is untrue, deceptive, or  
28 misleading.
- 29 (3) Making, publishing, disseminating, or circulating, directly or  
30 indirectly, or aiding, abetting, or encouraging the making,  
31 publishing, disseminating, or circulating of any oral or written  
32 statement or any pamphlet, circular, article, or literature which is  
33 false, or maliciously critical of or derogatory to the financial  
34 condition of an insurer, and which is calculated to injure any  
35 person engaged in the business of insurance.
- 36 (4) Entering into any agreement to commit, or individually or by  
37 a concerted action committing any act of boycott, coercion, or  
38 intimidation resulting or tending to result in unreasonable  
39 restraint of, or a monopoly in, the business of insurance.
- 40 (5) Filing with any supervisory or other public official, or making,  
41 publishing, disseminating, circulating, or delivering to any person,  
42 or placing before the public, or causing directly or indirectly, to

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1 be made, published, disseminated, circulated, delivered to any  
 2 person, or placed before the public, any false statement of  
 3 financial condition of an insurer with intent to deceive. Making  
 4 any false entry in any book, report, or statement of any insurer  
 5 with intent to deceive any agent or examiner lawfully appointed  
 6 to examine into its condition or into any of its affairs, or any  
 7 public official to which such insurer is required by law to report,  
 8 or which has authority by law to examine into its condition or into  
 9 any of its affairs, or, with like intent, willfully omitting to make a  
 10 true entry of any material fact pertaining to the business of such  
 11 insurer in any book, report, or statement of such insurer.

12 (6) Issuing or delivering or permitting agents, officers, or  
 13 employees to issue or deliver, agency company stock or other  
 14 capital stock, or benefit certificates or shares in any common law  
 15 corporation, or securities or any special or advisory board  
 16 contracts or other contracts of any kind promising returns and  
 17 profits as an inducement to insurance.

18 (7) Making or permitting any of the following:

19 (A) Unfair discrimination between individuals of the same  
 20 class and equal expectation of life in the rates or assessments  
 21 charged for any contract of life insurance or of life annuity or  
 22 in the dividends or other benefits payable thereon, or in any  
 23 other of the terms and conditions of such contract; however, in  
 24 determining the class, consideration may be given to the  
 25 nature of the risk, plan of insurance, the actual or expected  
 26 expense of conducting the business, or any other relevant  
 27 factor.

28 (B) Unfair discrimination between individuals of the same  
 29 class involving essentially the same hazards in the amount of  
 30 premium, policy fees, assessments, or rates charged or made  
 31 for any policy or contract of accident or health insurance or in  
 32 the benefits payable thereunder, or in any of the terms or  
 33 conditions of such contract, or in any other manner whatever;  
 34 however, in determining the class, consideration may be given  
 35 to the nature of the risk, the plan of insurance, the actual or  
 36 expected expense of conducting the business, or any other  
 37 relevant factor.

38 (C) Excessive or inadequate charges for premiums, policy  
 39 fees, assessments, or rates, or making or permitting any unfair  
 40 discrimination between persons of the same class involving  
 41 essentially the same hazards, in the amount of premiums,  
 42 policy fees, assessments, or rates charged or made for:



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1 (i) policies or contracts of reinsurance or joint reinsurance,  
2 or abstract and title insurance;

3 (ii) policies or contracts of insurance against loss or damage  
4 to aircraft, or against liability arising out of the ownership,  
5 maintenance, or use of any aircraft, or of vessels or craft,  
6 their cargoes, marine builders' risks, marine protection and  
7 indemnity, or other risks commonly insured under marine,  
8 as distinguished from inland marine, insurance; or

9 (iii) policies or contracts of any other kind or kinds of  
10 insurance whatsoever.

11 However, nothing contained in clause (C) shall be construed to  
12 apply to any of the kinds of insurance referred to in clauses (A)  
13 and (B) nor to reinsurance in relation to such kinds of insurance.  
14 Nothing in clause (A), (B), or (C) shall be construed as making or  
15 permitting any excessive, inadequate, or unfairly discriminatory  
16 charge or rate or any charge or rate determined by the department  
17 or commissioner to meet the requirements of any other insurance  
18 rate regulatory law of this state.

19 (8) Except as otherwise expressly provided by law, knowingly  
20 permitting or offering to make or making any contract or policy  
21 of insurance of any kind or kinds whatsoever, including but not in  
22 limitation, life annuities, or agreement as to such contract or  
23 policy other than as plainly expressed in such contract or policy  
24 issued thereon, or paying or allowing, or giving or offering to pay,  
25 allow, or give, directly or indirectly, as inducement to such  
26 insurance, or annuity, any rebate of premiums payable on the  
27 contract, or any special favor or advantage in the dividends,  
28 savings, or other benefits thereon, or any valuable consideration  
29 or inducement whatever not specified in the contract or policy; or  
30 giving, or selling, or purchasing or offering to give, sell, or  
31 purchase as inducement to such insurance or annuity or in  
32 connection therewith, any stocks, bonds, or other securities of any  
33 insurance company or other corporation, association, limited  
34 liability company, or partnership, or any dividends, savings, or  
35 profits accrued thereon, or anything of value whatsoever not  
36 specified in the contract. Nothing in this subdivision and  
37 subdivision (7) shall be construed as including within the  
38 definition of discrimination or rebates any of the following  
39 practices:

40 (A) Paying bonuses to policyholders or otherwise abating their  
41 premiums in whole or in part out of surplus accumulated from  
42 nonparticipating insurance, so long as any such bonuses or

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abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year.

(D) Paying by an insurer or agent thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed agent thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, agent, or solicitor duly licensed under the laws of this state, but such broker, agent, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance agent or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of its or his right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of agents or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10).

The enumeration in this chapter of specific unfair methods of

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1 competition and unfair or deceptive acts and practices in the  
 2 business of insurance is not exclusive or restrictive or intended to  
 3 limit the powers of the commissioner or department or of any  
 4 court of review under section 8 of this chapter.

5 (12) Requiring as a condition precedent to the sale of real or  
 6 personal property under any contract of sale, conditional sales  
 7 contract, or other similar instrument or upon the security of a  
 8 chattel mortgage, that the buyer of such property negotiate any  
 9 policy of insurance covering such property through a particular  
 10 insurance company, agent, or broker or brokers. However, this  
 11 subdivision shall not prevent the exercise by any seller of such  
 12 property or the one making a loan thereon, of his, her, or its right  
 13 to approve or disapprove of the insurance company selected by  
 14 the buyer to underwrite the insurance.

15 (13) Issuing, offering, or participating in a plan to issue or offer,  
 16 any policy or certificate of insurance of any kind or character as  
 17 an inducement to the purchase of any property, real, personal, or  
 18 mixed, or services of any kind, where a charge to the insured is  
 19 not made for and on account of such policy or certificate of  
 20 insurance. However, this subdivision shall not apply to any of the  
 21 following:

22 (A) Insurance issued to credit unions or members of credit  
 23 unions in connection with the purchase of shares in such credit  
 24 unions.

25 (B) Insurance employed as a means of guaranteeing the  
 26 performance of goods and designed to benefit the purchasers  
 27 or users of such goods.

28 (C) Title insurance.

29 (D) Insurance written in connection with an indebtedness and  
 30 intended as a means of repaying such indebtedness in the  
 31 event of the death or disability of the insured.

32 (E) Insurance provided by or through motorists service clubs  
 33 or associations.

34 (F) Insurance that is provided to the purchaser or holder of an  
 35 air transportation ticket and that:

36 (i) insures against death or nonfatal injury that occurs during  
 37 the flight to which the ticket relates;

38 (ii) insures against personal injury or property damage that  
 39 occurs during travel to or from the airport in a common  
 40 carrier immediately before or after the flight;

41 (iii) insures against baggage loss during the flight to which  
 42 the ticket relates; or



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(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the state department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25 or IC 27-1-22-26 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-1-15.5-3(h).

(23) Violating IC 27-8-26 concerning genetic screening or testing.

**(24) Violating IC 27-8-17.5 concerning preauthorization.**

SECTION 6. IC 27-4-1-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 6. (a) If after a hearing under IC 4-21.5-3, the commissioner determines that ~~the~~ **a person has engaged in a** method of competition, ~~or the~~ act, or practice ~~in question~~ **is defined described** in section 4 of this chapter and that the person complained of ~~has engaged in such method of competition; act, or practice in violation or 8~~ of this chapter, ~~he shall reduce his findings to writing and shall~~ **or has otherwise violated this chapter, the commissioner may** issue and cause to be served on the person charged

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1 with the violation an order requiring such person to cease and desist  
 2 from such method of competition, act, or practice, and the  
 3 commissioner may at his discretion order one (1) or more of the  
 4 following:

5 (1) Payment of a civil penalty of not more than ~~twenty-five~~ **forty**  
 6 thousand dollars ~~(\$25,000)~~ **(\$50,000)** for each act or violation but  
 7 not to exceed an aggregate penalty of ~~one~~ **five** hundred thousand  
 8 dollars ~~(\$100,000)~~ **(\$500,000)** in any twelve (12) month period  
 9 unless the person knew or reasonably should have known that he  
 10 was in violation of this chapter, in which case the penalty may be  
 11 not more than ~~fifty~~ **one hundred** thousand dollars ~~(\$50,000)~~  
 12 **(\$100,000)** for each act or violation but not to exceed an  
 13 aggregate penalty of ~~two hundred thousand~~ **one million** dollars  
 14 ~~(\$200,000)~~ **(\$1,000,000)** in any twelve (12) month period.

15 (2) **Restitution or other remedial measures as determined**  
 16 **necessary by the commissioner to correct the violation.**

17 (3) Suspension or revocation of the person's license, or certificate  
 18 of authority, if he knew or reasonably should have known he was  
 19 in violation of this chapter.

20 (b) All civil penalties imposed and collected under this section shall  
 21 be deposited in the state general fund.

22 SECTION 7. IC 27-7-12 IS ADDED TO THE INDIANA CODE AS  
 23 A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY  
 24 1, 2000]:

25 **Chapter 12. Termination of Residential Policies**

26 **Sec. 1. (a) This chapter applies to policies of insurance covering**  
 27 **risks to property located in Indiana that take effect or are renewed**  
 28 **after June 30, 2000, and that insure loss of or damage to:**

29 (1) real property consisting of not more than four (4)  
 30 residential units, one (1) of which is the principal place of  
 31 residence of the named insured; or

32 (2) personal property in which the named insured has an  
 33 insurable interest where the personal property is:

34 (A) used for personal, family, or household purposes; and

35 (B) within a residential dwelling.

36 (b) This chapter does not apply to the following:

37 (1) A policy of inland marine insurance.

38 (2) The cancellation or nonrenewal of an automobile  
 39 insurance policy under IC 27-7-6.

40 (3) The cancellation or nonrenewal of a commercial property  
 41 and casualty insurance policy under IC 27-1-31-2.5.

42 **Sec. 2. (a) As used in this chapter, "cancellation" or "cancelled"**



1 means a termination of property insurance coverage that occurs  
2 during the policy term.

3 (b) As used in this chapter, "nonpayment of premium" means  
4 the failure of the named insured to discharge any obligation in  
5 connection with the payment of premiums on policies of insurance  
6 subject to this chapter, regardless of whether the payments are  
7 directly payable to the insurer or its agent or indirectly payable  
8 under a premium finance plan or extension of credit. The term  
9 includes the failure to pay dues or fees where payment of the dues  
10 or fees is a prerequisite to obtaining or continuing property  
11 insurance coverage.

12 (c) As used in this chapter, "nonrenewal" or "nonrenewed"  
13 means a termination of property insurance coverage that occurs at  
14 the end of the policy term.

15 (d) As used in this chapter, "renewal" or "to renew" means the  
16 issuance and delivery by an insurer at the end of a policy period of  
17 a policy superseding a policy previously issued and delivered by the  
18 same insurer, or the issuance and delivery of a certificate or notice  
19 extending the term of an existing policy beyond its policy period or  
20 term.

21 (e) As used in this chapter, "termination" means a cancellation  
22 or nonrenewal and includes the transfer of a policy between  
23 insurers within the same insurance group. The term does not  
24 include:

- 25 (1) the requirement of a reasonable deductible;
- 26 (2) reasonable changes in the amount of insurance; or
- 27 (3) reasonable reductions in policy limits or coverage;

28 if the requirements or changes are directly related to the hazard  
29 involved and are made on the renewal date for the policy.

30 **Sec. 3. (a) Notice of cancellation of property insurance coverage**  
31 **by an insurer must:**

- 32 (1) be in writing;
- 33 (2) be delivered or mailed to the named insured at the last  
34 known address of the named insured;
- 35 (3) state the effective date of the cancellation; and
- 36 (4) be accompanied by a written explanation of the specific  
37 reasons for the cancellation.

38 (b) An insurer shall provide written notice of cancellation to the  
39 named insured at least:

- 40 (1) twenty (20) days before canceling a policy, if the  
41 cancellation occurs more than sixty (60) days after the date of  
42 issuance of the policy;



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1 (2) ten (10) days before canceling a policy, if the cancellation  
2 is for nonpayment of a premium; and

3 (3) ten (10) days before canceling a policy, if the cancellation  
4 occurs sixty (60) days or less after the date of issuance of the  
5 policy.

6 (c) If the policy was procured by an agent licensed in Indiana,  
7 the insurer shall deliver or mail notice of cancellation to the agent  
8 not less than ten (10) days before the insurer delivers or mails the  
9 notice to the named insured, unless the obligation to notify the  
10 agent is waived in writing by the agent.

11 Sec. 4. (a) Notice of nonrenewal by an insurer must:

12 (1) be in writing;

13 (2) be delivered or mailed to the named insured at the last  
14 known address of the named insured;

15 (3) state the insurer's intention not to renew the policy upon  
16 expiration of the current policy period; and

17 (4) be accompanied by a written explanation of the specific  
18 reasons for the nonrenewal.

19 (b) If the policy was procured by an agent licensed in Indiana,  
20 the insurer shall deliver or mail notice of nonrenewal to the agent  
21 not less than ten (10) days before the insurer delivers or mails the  
22 notice to the named insured, unless the obligation to notify the  
23 agent is waived in writing by the agent.

24 (c) If an insurer mails or delivers to an insured a renewal notice,  
25 bill, certificate, or policy indicating the insurer's willingness to  
26 renew a policy and the insured does not respond, the insurer is not  
27 required to provide to the insured notice of intention not to renew.

28 Sec. 5. (a) The explanation that is required under sections 3 and  
29 4 of this chapter must be sufficiently clear and specific so that a  
30 reasonable layperson can identify the basis for the insurer's  
31 decision without further inquiry. Generalized terms used in the  
32 explanation, including, but not limited to:

33 (1) "personal habits";

34 (2) "living conditions";

35 (3) "poor morals"; or

36 (4) "unsatisfactory credit history";

37 are not sufficient to meet the requirements of this subsection.

38 (b) If notice is not provided under section 4 of this chapter,  
39 coverage is considered to be renewed for the ensuing policy period  
40 upon payment of the appropriate premiums under the same terms  
41 and conditions, and subject to section 6 of this chapter, until the  
42 named insured has accepted replacement coverage with another



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insurer or until the named insured has agreed to the nonrenewal.

**Sec. 6.** After coverage has been in effect for more than sixty (60) days or after the effective date of a renewal policy, a notice of cancellation shall not be issued unless cancellation is based on at least one (1) of the following:

- (1) Nonpayment of a premium.
- (2) Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.
- (3) Discovery of willful or reckless acts or omissions on the part of the named insured that increase a hazard insured against.
- (4) The occurrence of a change in the risk that substantially increases a hazard insured against after insurance coverage has been issued or renewed.
- (5) A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to an insured property or the occupancy of the property that substantially increases any hazard insured against.
- (6) A determination by the commissioner of the department of insurance that the continuation of the policy would place the insurer in violation of the insurance laws of Indiana.
- (7) Real property taxes owing on the insured property have been delinquent for two (2) or more years and continue to be delinquent at the time notice of cancellation is issued.

**Sec. 7.** Termination of property insurance coverage by an insurer is prohibited if the termination is based on any of the following:

- (1) Upon the race, religion, nationality, ethnic group, age, sex, or marital status of the applicant or named insured.
- (2) Solely upon the lawful occupation or profession of the applicant or named insured. However, this provision does not apply to an insurer that limits its market to one (1) lawful occupation or profession or to several related lawful occupations or professions.
- (3) Upon the age or location of the residence of the applicant or named insured, unless that decision is for a business purpose that is not a mere pretext for a decision based on factors prohibited in this chapter or any other provision of this title.
- (4) Upon the fact that another insurer previously declined to

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insure the applicant or terminated an existing policy in which the applicant was the named insured.

(5) Upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

Sec. 8. (a) The following persons are immune from civil liability for any communication giving notice of or specifying the reasons for a termination or for any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for a termination under this chapter:

- (1) Employees of the department of insurance.
- (2) An insurer or its authorized representative, agent, or employee.
- (3) A licensed insurance agent.
- (4) A person furnishing information to an insurer as to reasons for a termination.

(b) This section does not apply to statements made in bad faith with malice in fact.

SECTION 8. IC 27-7-13 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]:

**Chapter 13. Required Notice of Flood Coverage in a Residential Policy**

Sec. 1. (a) This chapter applies to policies of insurance covering risks to property located in Indiana that are issued or renewed after December 31, 2000, and that insure loss of or damage to:

- (1) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or
- (2) personal property in which the named insured has an insurable interest where the personal property is:
  - (A) used for personal, family, or household purposes; and
  - (B) within a residential dwelling.

(b) This chapter does not apply to the following:

- (1) A policy of inland marine insurance.
- (2) An automobile insurance policy under IC 27-7-6.
- (3) A commercial property and casualty insurance policy under IC 27-1-31.

Sec. 2. If a policy of insurance described in section 1 of this chapter does not provide coverage for flood damage:

- (1) the policy must have prominently printed on the policy jacket a notice stating; or

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1           **(2) the policyholder must be given written notice when the**  
2           **policy is issued or renewed;**  
3           **that flood damage is not covered under the policy.**

4           SECTION 9. IC 27-8-5-1 IS AMENDED TO READ AS FOLLOWS  
5 [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) The term "policy of accident  
6 and sickness insurance", as used in this chapter, includes any policy or  
7 contract covering one (1) or more of the kinds of insurance described  
8 in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the  
9 individual basis under this section and sections 2 through 9 of this  
10 chapter, on the group basis under this section and sections 16 through  
11 19 of this chapter, on the franchise basis under this section and section  
12 11 of this chapter, or on a blanket basis under section 15 of this chapter  
13 and (except as otherwise expressly provided in this chapter) shall be  
14 exclusively governed by this chapter.

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

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

29           (d) The commissioner may, within thirty (30) days after the filing of  
30 any form under subsection (b), disapprove the form:

31           (1) if, in the case of an individual accident and sickness form, the  
32 benefits provided therein are unreasonable in relation to the  
33 premium charged; or

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

38           (e) If the commissioner notifies the insurer that filed a form that the  
39 form does not comply with this section, it is unlawful thereafter for the  
40 insurer to issue the form or use it in connection with any policy. In the  
41 notice given under this subsection, the commissioner shall specify the  
42 reasons for his disapproval and state that a hearing will be granted

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

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

14 **(h) If a policy of accident and sickness insurance form is no**  
 15 **longer actively marketed, a filing to increase a premium rate on the**  
 16 **form must include a:**

17 (1) **statement indicating whether a similar form is actively**  
 18 **marketed; and**

19 (2) **comparison of the original to the similar forms, including**  
 20 **benefits, services, terms, and premium rates.**

21 **The commissioner may disapprove a premium rate increase if the**  
 22 **requested rate for the form that is no longer actively marketed**  
 23 **significantly exceeds rates for actively marketed individual policy**  
 24 **forms that provide similar benefits.**

25 SECTION 10. IC 27-8-5-1.5 IS ADDED TO THE INDIANA CODE  
 26 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
 27 1, 2000]: **Sec. 1.5. If:**

28 (1) **a policy of accident and sickness insurance form is no**  
 29 **longer actively marketed by an insurer; and**

30 (2) **not more than two hundred (200) claims are filed**  
 31 **nationally in a twelve (12) month period for a block of**  
 32 **business in force under the form;**

33 **the insurer shall, for rating and monitoring purposes, combine**  
 34 **individual policies in force under the form with other blocks of**  
 35 **business of the same type that offer similar benefits and rates.**

36 SECTION 11. IC 27-8-17.5 IS ADDED TO THE INDIANA CODE  
 37 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
 38 JULY 1, 2000]:

39 **Chapter 17.5. Preauthorization**

40 **Sec. 1. As used in this chapter, "covered individual" means an**  
 41 **individual who is entitled to coverage under a health insurance**  
 42 **plan.**

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1           **Sec. 2.** As used in this chapter, "health care services" has the  
2 meaning set forth in IC 27-8-11-1.

3           **Sec. 3.** As used in this chapter, "health insurance plan" means  
4 coverage provided under any of the following:

- 5           (1) A hospital or medical expense incurred policy or  
6 certificate.
- 7           (2) A health maintenance organization subscriber contract.
- 8           (3) An employer based health insurance arrangement.
- 9           (4) An individual health insurance policy.
- 10          (5) A policy issued by the Indiana comprehensive health  
11 insurance association under IC 27-8-10.
- 12          (6) An employee welfare benefit plan (as defined in 29 U.S.C.  
13 1002) that is self-funded.
- 14          (7) A conversion policy issued under IC 27-8-15-31 or  
15 IC 27-8-15-31.1.

16           **Sec. 4.** As used in this chapter, "insurer" means any person that  
17 provides coverage for health care services in Indiana. The term  
18 includes the following:

- 19           (1) A licensed insurance company.
- 20           (2) A health maintenance organization or limited service  
21 health maintenance organization.
- 22           (3) A state employee health benefit plan under IC 5-10-8-7.
- 23           (4) Any other person that provides coverage for health care  
24 services through a health insurance plan regulated under  
25 IC 27.

26           **Sec. 5.** An insurer shall issue a confirmation number to a  
27 covered individual when the insurer authorizes the provision of  
28 health care services:

- 29           (1) directly;
- 30           (2) through a participating provider; or
- 31           (3) through any other authorized representative of the  
32 insurer.

33           **Sec. 6.** If an insurer or an insurer's authorized representative  
34 authorizes the provision of health care services, the insurer shall  
35 not retract the authorization after the health care services have  
36 been provided or reduce payment for an item or service furnished  
37 in reliance on such authorization unless the:

- 38           (1) authorization is based on a material misrepresentation or  
39 omission regarding the covered individual's health condition  
40 or cause of the health condition;
- 41           (2) health insurance plan terminates before the health care  
42 services are provided; or



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1           (3) covered individual's coverage under the health insurance  
 2           plan terminates before the health care services are provided.  
 3           **Sec. 7. If a dispute arises between an insurer and the provider**  
 4           **of an authorized health care service concerning whether the health**  
 5           **care service was provided in the manner or type authorized by the**  
 6           **insurer, the insurer shall hold the covered individual harmless**  
 7           **from any claims made by the provider concerning the service.**  
 8           **Failure to hold the covered individual harmless under this section**  
 9           **is a violation of IC 27-4-1-4. This section does not apply to any**  
 10           **copayment, coinsurance, or deductible payable by a covered**  
 11           **individual under the health insurance plan.**

12           SECTION 12. IC 27-8-28 IS ADDED TO THE INDIANA CODE  
 13           AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
 14           JULY 1, 2000]:

15           **Chapter 28. Internal Grievance Procedures**

16           **Sec. 1. (a) As used in this chapter, "accident and sickness**  
 17           **insurance policy" means an insurance policy that:**

- 18                   (1) provides one (1) or more of the kinds of insurance  
 19                   described in class 1(b) and 2(a) of IC 27-1-5-1; and  
 20                   (2) is issued on an individual or group basis.

21           **(b) The term does not include the following:**

- 22                   (1) Accident only, credit, dental, vision, Medicare supplement,  
 23                   long term care, or disability income insurance.  
 24                   (2) Coverage issued as a supplement to liability insurance.  
 25                   (3) Automobile medical payment insurance.  
 26                   (4) A specified disease policy issued as an individual policy.  
 27                   (5) A limited benefit health insurance policy issued as an  
 28                   individual policy.  
 29                   (6) A short term insurance plan that:  
 30                           (A) may not be renewed; and  
 31                           (B) has a duration of not more than six (6) months.  
 32                   (7) A policy that provides a stipulated daily, weekly, or  
 33                   monthly payment to an insured during hospital confinement  
 34                   without regard to the actual expense of the confinement.  
 35                   (8) Worker's compensation or similar insurance.

36           **Sec. 2. As used in this chapter, "commissioner" refers to the**  
 37           **commissioner of the Indiana department of insurance.**

38           **Sec. 3. As used in this chapter, "covered individual" means an**  
 39           **individual who is covered under an accident and sickness insurance**  
 40           **policy.**

41           **Sec. 4. As used in this chapter, "department" refers to the**  
 42           **Indiana department of insurance.**



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1           **Sec. 5. As used in this chapter, "grievance" means any**  
 2 **dissatisfaction expressed by or on behalf of a covered individual**  
 3 **regarding the:**

4           **(1) availability, delivery, appropriateness, or quality of health**  
 5 **care services;**

6           **(2) handling or payment of claims for health care services; or**

7           **(3) matters pertaining to the contractual relationship**  
 8 **between:**

9           **(A) a covered individual and an insurer; or**

10           **(B) a group policyholder and an insurer;**

11 **and for which the covered individual has a reasonable expectation**  
 12 **that action will be taken to resolve or reconsider the matter that is**  
 13 **the subject of dissatisfaction.**

14           **Sec. 6. As used in this chapter, "grievance procedure" means a**  
 15 **written procedure established and maintained by an insurer for**  
 16 **filing, investigating, and resolving grievances and appeals.**

17           **Sec. 7. As used in this chapter, "insured" means:**

18           **(1) an individual whose employment status or other status**  
 19 **except family dependency is the basis for coverage under a**  
 20 **group accident and sickness insurance policy; or**

21           **(2) in the case of an individual accident and sickness insurance**  
 22 **policy, the individual in whose name the policy is issued.**

23           **Sec. 8. As used in this chapter, "insurer" means any person who**  
 24 **delivers or issues for delivery an accident and sickness insurance**  
 25 **policy or certificate in Indiana.**

26           **Sec. 9. (a) An insurer shall establish and maintain a grievance**  
 27 **procedure that complies with the requirements of this chapter for**  
 28 **the resolution of grievances initiated by a covered individual.**

29           **(b) The grievance procedure of an insurer complies with the**  
 30 **requirements of this chapter if:**

31           **(1) the insurer certifies in writing to the department that the**  
 32 **insurer has complied with grievance and appeals procedures**  
 33 **established by the Health Care Financing Administration of**  
 34 **the United States Department of Health and Human Services;**  
 35 **and**

36           **(2) the department certifies that the grievance and appeals**  
 37 **procedures established by the Health Care Financing**  
 38 **Administration of the United States Department of Health**  
 39 **and Human Services are substantially similar to the grievance**  
 40 **and appeals procedures under this chapter.**

41           **(c) Subsection (b) does not:**

42           **(1) limit the authority of the department;**



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- 1 (2) limit the responsibility of an insurer;
- 2 (3) release an insurer from the prohibition under section 16 of
- 3 this chapter; or
- 4 (4) require an insurer to use a grievance and appeals
- 5 procedure established by the Health Care Financing
- 6 Administration of the United States Department of Health
- 7 and Human Services.

8 **Sec. 10.** The commissioner may examine the grievance  
9 procedure of any insurer.

10 **Sec. 11.** An insurer shall maintain all grievance records received  
11 by the insurer after the most recent examination of the insurer's  
12 grievance procedure by the commissioner.

13 **Sec. 12.** (a) An insurer shall provide timely, adequate, and  
14 appropriate notice to each insured of:

- 15 (1) the grievance procedure required under this chapter;
- 16 (2) the external review process required under IC 27-8-29;
- 17 (3) information on how to file:
  - 18 (A) a grievance under this chapter; and
  - 19 (B) a request for an external review under IC 27-8-29; and
- 20 (4) a toll free telephone number through which a covered  
21 individual may contact the insurer at no cost to the covered  
22 individual to obtain information and to file grievances.

23 (b) An insurer shall prominently display on all notices to  
24 covered individuals the toll free telephone number and the address  
25 at which a grievance or request for external review may be filed.

26 **Sec. 13.** (a) A covered individual may file a grievance orally or  
27 in writing.

28 (b) An insurer shall make available to covered individuals a toll  
29 free telephone number through which a grievance may be filed.  
30 The toll free number must:

- 31 (1) be staffed by a qualified representative of the insurer;
- 32 (2) be available for at least forty (40) normal business hours  
33 per week; and
- 34 (3) accept grievances in the languages of the major population  
35 groups served by the insurer.

36 (c) A grievance is considered to be filed on the first date it is  
37 received, either by telephone or in writing.

38 **Sec. 14.** (a) An insurer shall establish procedures to assist  
39 covered individuals in filing grievances.

40 (b) A covered individual may designate a representative to file  
41 a grievance for the covered individual and to represent the covered  
42 individual in a grievance under this chapter.

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1           **Sec. 15. (a) An insurer shall establish written policies and**  
 2 **procedures for the timely resolution of grievances filed under this**  
 3 **chapter. The policies and procedures must include the following:**

4           **(1) An acknowledgment of the grievance, orally or in writing,**  
 5 **to the covered individual within three (3) business days.**

6           **(2) Documentation of the substance of the grievance and any**  
 7 **actions taken.**

8           **(3) An investigation of the substance of the grievance,**  
 9 **including any aspects involving clinical care.**

10           **(4) Notification to the covered individual of the disposition of**  
 11 **the grievance and the right to appeal.**

12           **(5) Standards for timeliness in:**

13           **(A) responding to grievances; and**

14           **(B) providing notice to covered individuals of:**

15           **(i) the disposition of the grievance; and**

16           **(ii) the right to appeal;**

17 **that accommodates the clinical urgency of the situation.**

18           **(b) An insurer shall appoint at least one (1) individual to resolve**  
 19 **a grievance.**

20           **(c) A grievance must be resolved as expeditiously as possible,**  
 21 **but not more than twenty (20) business days after the grievance is**  
 22 **filed. If an insurer is unable to make a decision regarding the**  
 23 **grievance within the twenty (20) day period due to circumstances**  
 24 **beyond the insurer's control, the insurer shall:**

25           **(1) notify, before the twentieth business day, the covered**  
 26 **individual in writing of the reason for the delay; and**

27           **(2) issue a written decision regarding the grievance within an**  
 28 **additional ten (10) business days.**

29           **(d) An insurer shall notify a covered individual in writing of the**  
 30 **resolution of a grievance within five (5) business days after**  
 31 **completing an investigation. The grievance resolution notice must**  
 32 **include the following:**

33           **(1) The decision reached by the insurer.**

34           **(2) The reasons, policies, and procedures that are the basis of**  
 35 **the decision.**

36           **(3) Notice of the covered individual's right to appeal the**  
 37 **decision.**

38           **(4) The department, address, and telephone number through**  
 39 **which a covered individual may contact a qualified**  
 40 **representative to obtain additional information about the**  
 41 **decision or the right to appeal.**

42           **Sec. 16. (a) An insurer shall establish written policies and**



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1 procedures for the timely resolution of appeals of grievance  
 2 decisions. The procedures for registering and responding to oral  
 3 and written appeals of grievance decisions must include the  
 4 following:

5 (1) Written or oral acknowledgment of the appeal not more  
 6 than three (3) business days after the appeal is filed.

7 (2) Documentation of the substance of the appeal and the  
 8 actions taken.

9 (3) Investigation of the substance of the appeal, including any  
 10 aspects of clinical care involved.

11 (4) Notification to the covered individual:

12 (A) of the disposition of an appeal; and

13 (B) that the covered individual may have the right to  
 14 further remedies allowed by law.

15 (5) Standards for timeliness in:

16 (A) responding to an appeal; and

17 (B) providing notice to covered individuals of:

18 (i) the disposition of an appeal; and

19 (ii) the right to initiate an external appeal;

20 that accommodate the clinical urgency of the situation.

21 (b) Except for grievances that have previously been appealed  
 22 under IC 27-8-17, in the case of an appeal regarding the proposal,  
 23 denial, or delivery of a health care procedure, treatment, or  
 24 service, an insurer shall appoint a panel of one (1) or more  
 25 qualified individuals to resolve an appeal. The panel must include  
 26 one (1) or more individuals who:

27 (1) have knowledge in the medical condition, procedure, or  
 28 treatment at issue;

29 (2) are licensed in the same profession as the provider who  
 30 proposed, denied, or delivered the health care procedure,  
 31 treatment, or service;

32 (3) are not involved in the matter giving rise to the appeal or  
 33 in the initial investigation of the grievance; and

34 (4) do not have a direct business relationship with the covered  
 35 individual or the health care provider who previously  
 36 recommended the health care procedure, treatment, or  
 37 service giving rise to the grievance.

38 (c) An appeal of a grievance decision must be resolved as  
 39 expeditiously as possible reflecting the clinical urgency of the  
 40 situation. However, an appeal must be resolved not later than  
 41 forty-five (45) days after the appeal is filed.

42 (d) An insurer shall allow a covered individual the opportunity



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to:

- (1) appear in person before; or
- (2) if unable to appear in person, otherwise appropriately communicate with;

the panel appointed under subsection (b).

(e) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance within five (5) business days after completing the investigation. The grievance resolution notice must include the following:

- (1) The decision reached by the insurer.
- (2) The reasons, policies, and procedures that are the basis of the decision.
- (3) Notice of the covered individual's right to further remedies allowed by law, including the right to review by an independent review organization under IC 27-8-29.
- (4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an appeal.

Sec. 17. An insurer may not take action against a provider solely on the basis that the provider represents a covered individual in a grievance filed under this chapter.

Sec. 18. (a) An insurer shall each year file with the commissioner a description of the grievance procedure of the insurer established under this chapter, including:

- (1) the total number of grievances handled through the procedure during the preceding calendar year;
- (2) a compilation of the causes underlying those grievances; and
- (3) a summary of the final disposition of those grievances.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

- (1) make the information required to be filed under this section available to the public; and
- (2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

Sec. 19. The department may adopt rules under IC 4-22-2 to implement this chapter.

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1 SECTION 13. IC 27-8-29 AS ADDED TO THE INDIANA CODE  
 2 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
 3 JULY 1, 2000]:

4 **Chapter 29. External Review of Grievances**

5 **Sec. 1.** As used in this chapter, "accident and sickness insurance  
 6 policy" has the meaning set forth in IC 27-8-28-1.

7 **Sec. 2.** As used in this chapter, "commissioner" refers to the  
 8 commissioner of the Indiana department of insurance.

9 **Sec. 3.** As used in this chapter, "covered individual" has the  
 10 meaning set forth in IC 27-8-28-3.

11 **Sec. 4.** As used in this chapter, "department" refers to the  
 12 Indiana department of insurance.

13 **Sec. 5.** As used in this chapter, "grievance" has the meaning set  
 14 forth in IC 27-8-28-5.

15 **Sec. 6.** As used in this chapter, "grievance procedure" has the  
 16 meaning set forth in IC 27-8-28-6.

17 **Sec. 7.** As used in this chapter, "insured" has the meaning set  
 18 forth in IC 27-8-28-7.

19 **Sec. 8.** As used in this chapter, "insurer" has the meaning set  
 20 forth in IC 27-8-28-8.

21 **Sec. 9.** An insurer shall establish and maintain an external  
 22 grievance procedure for the resolution of grievances regarding:

- 23 (1) an adverse utilization review determination (as defined in  
 24 IC 27-8-17-8);  
 25 (2) an adverse determination of medical necessity; or  
 26 (3) a determination that a proposed service is experimental or  
 27 investigational;

28 made by an insurer or an agent of an insurer regarding a service  
 29 proposed by the treating physician.

30 **Sec. 10.** (a) An external grievance procedure established under  
 31 section 9 of this chapter must:

- 32 (1) allow a covered individual or a covered individual's  
 33 representative to file a written request with the insurer for an  
 34 appeal of the insurer's grievance resolution under  
 35 IC 27-8-28-16 not more than forty-five (45) days after the  
 36 covered individual is notified of the resolution; and

37 (2) provide for:

- 38 (A) an expedited appeal for a grievance related to an  
 39 illness, disease, condition, injury, or a disability that would  
 40 seriously jeopardize the covered individual's:

41 (i) life or health; or

42 (ii) ability to reach and maintain maximum function; or



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**(B) a standard appeal for a grievance not described in clause (A).**

**A covered individual may file not more than one (1) appeal of an insurer's grievance resolution under this chapter.**

**(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:**

- (1) select a different independent review organization for each appeal filed under this chapter from the list of independent review organizations that are certified by the department under section 16 of this chapter; and**
- (2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.**

**(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an appeal.**

**(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:**

- (1) The insurer.**
- (2) Any officer, director, or management employee of the insurer.**
- (3) The physician or the physician's medical group that is proposing the service.**
- (4) The facility at which the service would be provided.**
- (5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.**

**However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.**

**(e) A covered individual may be required to pay not more than twenty-five dollars (\$25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the insurer.**

**Sec. 11. (a) A covered individual who files an appeal under this**

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- 1 chapter shall:
- 2 (1) not be subject to retaliation for exercising the covered
- 3 individual's right to an appeal under this chapter;
- 4 (2) be permitted to utilize the assistance of other individuals,
- 5 including physicians, attorneys, friends, and family members
- 6 throughout the review process;
- 7 (3) be permitted to submit additional information relating to
- 8 the proposed service throughout the review process; and
- 9 (4) cooperate with the independent review organization by:
- 10 (A) providing any requested medical information; or
- 11 (B) authorizing the release of necessary medical
- 12 information.
- 13 (b) An insurer shall cooperate with an independent review
- 14 organization selected under section 10(b) of this chapter by
- 15 promptly providing any information requested by the independent
- 16 review organization.
- 17 **Sec. 12. (a) An independent review organization shall:**
- 18 (1) for an expedited appeal filed under section 10(a)(2)(A) of
- 19 this chapter, within seventy-two (72) hours after the appeal is
- 20 filed; or
- 21 (2) for a standard appeal filed under section 10(a)(2)(B) of this
- 22 chapter, within fifteen (15) business days after the appeal is
- 23 filed;
- 24 make a determination to uphold or reverse the insurer's grievance
- 25 resolution under IC 27-8-28-16 based on information gathered
- 26 from the covered individual or the covered individual's designee,
- 27 the insurer, and the treating physician, and any additional
- 28 information that the independent review organization considers
- 29 necessary and appropriate.
- 30 (b) When making the determination under this section, the
- 31 independent review organization shall apply:
- 32 (1) standards of decision making that are based on objective
- 33 clinical evidence; and
- 34 (2) the terms of the covered individual's accident and sickness
- 35 insurance policy.
- 36 (c) The independent review organization shall notify the insurer
- 37 and the covered individual of the determination made under this
- 38 section:
- 39 (1) for an expedited appeal filed under section 10(a)(2)(A) of
- 40 this chapter, within twenty-four (24) hours after making the
- 41 determination; and
- 42 (2) for a standard appeal filed under section 10(a)(2)(B) of this



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1 chapter, within seventy-two (72) hours after making the  
2 determination.

3 **Sec. 13.** A determination made under section 12 of this chapter  
4 is binding on the insurer.

5 **Sec. 14. (a)** If at any time during an external review performed  
6 under this chapter, the covered individual submits information to  
7 the insurer that is relevant to the insurer's resolution under  
8 IC 27-8-28-16 and was not considered by the insurer under  
9 IC 27-8-28:

10 (1) the insurer shall reconsider the resolution under  
11 IC 27-8-28-16; and

12 (2) the independent review organization shall cease the  
13 external review process until the reconsideration under  
14 subsection (b) is completed.

15 (b) An insurer to which information is submitted under  
16 subsection (a) shall reconsider the resolution under IC 27-8-28-16  
17 based on the information and notify the covered individual of the  
18 insurer's decision:

19 (1) within seventy-two (72) hours after the information is  
20 submitted for a reconsideration related to an illness, disease,  
21 condition, injury, or disability that would seriously jeopardize  
22 the covered individual's:

23 (A) life or health; or

24 (B) ability to reach and maintain maximum function; or

25 (2) within fifteen (15) days after the information is submitted  
26 for a reconsideration not described in subdivision (1).

27 (c) If the decision reached under subsection (b) is adverse to the  
28 covered individual, the covered individual may request that the  
29 independent review organization resume the external review under  
30 this chapter.

31 **Sec. 15.** This chapter does not add to or otherwise change the  
32 terms of coverage included in a policy, certificate, or contract  
33 under which a covered individual receives health care benefits  
34 under IC 27-8.

35 **Sec. 16. (a)** The department shall establish and maintain a  
36 process for annual certification of independent review  
37 organizations.

38 (b) The department shall certify a number of independent  
39 review organizations determined by the department to be sufficient  
40 to fulfill the purposes of this chapter.

41 (c) An independent review organization shall meet the following  
42 minimum requirements for certification by the department:

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1 (1) Medical review professionals assigned by the independent  
 2 review organization to perform external grievance reviews  
 3 under this chapter:

4 (A) must be board certified in the specialty in which a  
 5 covered individual's proposed service would be provided;

6 (B) must be knowledgeable about a proposed service  
 7 through actual clinical experience;

8 (C) must hold an unlimited license to practice in a state of  
 9 the United States; and

10 (D) must not have any history of disciplinary actions or  
 11 sanctions, including:

12 (i) loss of staff privileges; or

13 (ii) restriction on participation;

14 taken or pending by any hospital, government, or  
 15 regulatory body.

16 (2) The independent review organization must have a quality  
 17 assurance mechanism to ensure the:

18 (A) timeliness and quality of reviews;

19 (B) qualifications and independence of medical review  
 20 professionals;

21 (C) confidentiality of medical records and other review  
 22 materials; and

23 (D) satisfaction of covered individuals with the procedures  
 24 utilized by the independent review organization, including  
 25 the use of covered individual satisfaction surveys.

26 (3) The independent review organization must file with the  
 27 department the following information on or before March 1  
 28 of each year:

29 (A) The number and percentage of determinations made in  
 30 favor of covered individuals.

31 (B) The number and percentage of determinations made in  
 32 favor of insurers.

33 (C) The average time to process a determination.

34 (D) Any other information required by the department.

35 The information required under this subdivision must be  
 36 specified for each insurer for which the independent review  
 37 organization performed reviews during the reporting year.

38 (4) Any additional requirements established by the  
 39 department.

40 (d) The department may not certify an independent review  
 41 organization that is one (1) of the following:

42 (1) A professional or trade association of health care

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1 providers or a subsidiary or an affiliate of a professional or  
2 trade association of health care providers.

3 (2) An insurer, health maintenance organization, or health  
4 plan association, or a subsidiary or an affiliate of an insurer,  
5 health maintenance organization, or health plan association.

6 (e) The department may suspend or revoke an independent  
7 review organization's certification if the department finds that the  
8 independent review organization is not in substantial compliance  
9 with the certification requirements under this section.

10 (f) The department shall make available to insurers a list of all  
11 certified independent review organizations.

12 (g) The department shall make the information provided to the  
13 department under subsection (c)(3) available to the public in a  
14 format that does not identify individual covered individuals.

15 Sec. 17. Except as provided in section 16(g) of this chapter,  
16 documents and other information created or received by the  
17 independent review organization or the medical review  
18 professional in connection with an external review under this  
19 chapter:

20 (1) are not public records;

21 (2) may not be disclosed under IC 5-14-3; and

22 (3) must be treated in accordance with confidentiality  
23 requirements of state and federal law.

24 Sec. 18. (a) An insurer shall each year file with the  
25 commissioner a description of the grievance procedure of the  
26 insurer established under this chapter, including:

27 (1) the total number of external grievances handled through  
28 the procedure during the preceding calendar year;

29 (2) a compilation of the causes underlying those grievances;  
30 and

31 (3) a summary of the final disposition of those grievances;  
32 for each independent review organization used by the insurer  
33 during the reporting year.

34 (b) The information required by subsection (a) must be filed  
35 with the commissioner on or before March 1 of each year. The  
36 commissioner shall:

37 (1) make the information required to be filed under this  
38 section available to the public; and

39 (2) prepare an annual compilation of the data required under  
40 subsection (a) that allows for comparative analysis.

41 (c) The commissioner may require any additional reports as are  
42 necessary and appropriate for the commissioner to carry out the

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1 commissioner's duties under this article.

2 **Sec. 19. (a) An independent review organization is immune from**  
3 **civil liability for actions taken in good faith in connection with an**  
4 **external review under this chapter.**

5 **(b) The work product or determination, or both, of an**  
6 **independent review organization under this chapter are admissible**  
7 **in a judicial or administrative proceeding. However, the work**  
8 **product or determination, or both, do not, without other**  
9 **supporting evidence, satisfy a party's burden of proof or**  
10 **persuasion concerning any material issue of fact or law.**

11 **Sec. 20. If a covered individual has the right to an external**  
12 **review of a grievance under Medicare, the covered individual may**  
13 **not request an external review of the same grievance under this**  
14 **chapter.**

15 **Sec. 21. The department may adopt rules under IC 4-22-2 to**  
16 **implement this chapter.**

17 SECTION 14. IC 27-13-2-3 IS AMENDED TO READ AS  
18 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 3. (a) A foreign  
19 corporation, other than a foreign corporation defined under  
20 IC 27-1-2-3, may obtain a certificate of authority if the foreign  
21 corporation:

22 (1) is authorized to do business in Indiana under IC 23-1-49 or  
23 IC 23-17-26; and

24 (2) complies with this article.

25 (b) A foreign corporation (as defined in IC 27-1-2-3) may obtain a  
26 certificate of authority if the foreign corporation complies with this  
27 article.

28 **(c) A foreign or alien health maintenance organization granted**  
29 **a certificate of authority under this section has the same but no**  
30 **greater rights and privileges than a domestic health maintenance**  
31 **organization.**

32 SECTION 15. IC 27-13-2-6 IS AMENDED TO READ AS  
33 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 6. (a) An applicant  
34 shall submit to the commissioner any modifications or amendments to  
35 the items of information required in an application under section 5 of  
36 this chapter.

37 (b) The commissioner may adopt rules under this section that  
38 provide that any modifications or amendments to the items of  
39 information in the application required of a health maintenance  
40 organization:

41 (1) must be submitted to the commissioner before the  
42 modification or amendment takes effect:



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- 1 (A) for the approval of the commissioner; or
- 2 (B) for the information of the commissioner only; or
- 3 (2) must be indicated by the health maintenance organization to
- 4 the commissioner at the time of the next succeeding site visit or
- 5 examination of the organization by the department of insurance.

6 (c) **A health maintenance organization shall file any assumed**  
 7 **corporate name with the department at least thirty (30) days**  
 8 **before assuming the name.**

9 SECTION 16. IC 27-13-2-9 IS ADDED TO THE INDIANA CODE  
 10 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
 11 1, 2000]: **Sec. 9. (a) A health maintenance organization established**  
 12 **under this article may not:**

13 (1) **use as a part of its corporate name the words "United**  
 14 **States", "Federal", "government", "official", or any word**  
 15 **that would imply that the company was an administrative**  
 16 **agency of the state of Indiana or of the United States, or is**  
 17 **subject to supervision of any department other than the**  
 18 **department of insurance; or**

19 (2) **take or assume a corporate name the same as, or**  
 20 **confusingly similar to, an existing name of any other**  
 21 **insurance company or other entity licensed or regulated**  
 22 **under IC 27, unless at the same time:**

23 (A) **the other company changes its corporate name or**  
 24 **withdraws from transacting business in Indiana; and**

25 (B) **the written consent of the other company, signed and**  
 26 **verified under oath by its secretary, is filed with the**  
 27 **department.**

28 (b) **This section does not affect the right of any health**  
 29 **maintenance organization that:**

30 (1) **exists under the laws of Indiana as of July 1, 2000;**

31 (2) **exists under the laws of Indiana as of July 1, 2000, and**  
 32 **thereafter reorganizes or reincorporates under this article; or**

33 (3) **is authorized to transact business in Indiana as of July 1,**  
 34 **2000;**

35 **to continue the use of its corporate name.**

36 SECTION 17. IC 27-13-4-1 IS AMENDED TO READ AS  
 37 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) Subject to section  
 38 3 of this chapter, the powers of a health maintenance organization  
 39 include the following:

40 (1) The purchase, lease, construction, renovation, operation, or  
 41 maintenance of:

42 (A) hospitals and medical facilities;

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- 1 (B) equipment for hospitals and medical facilities; and  
 2 (C) other property reasonably required for the principal office  
 3 of the health maintenance organization or for purposes  
 4 necessary in the transaction of the business of the organization.
- 5 (2) Engaging in transactions between affiliated entities, including  
 6 loans and the transfer of responsibility under any or all contracts:  
 7 (A) between affiliates; or  
 8 (B) between the health maintenance organization and the  
 9 parent organization of the health maintenance organization.
- 10 (3) The furnishing of health care services through:  
 11 (A) providers;  
 12 (B) provider associations; and  
 13 (C) agents for providers;  
 14 who are under contract with or are employed by the health  
 15 maintenance organization. The contracts with providers, provider  
 16 associations, or agents of providers may include fee for service,  
 17 cost plus, capitation, or other payment or risk-sharing  
 18 arrangements.
- 19 (4) Contracting with any person for the performance on behalf of  
 20 the health maintenance organization of certain functions,  
 21 including:  
 22 (A) marketing;  
 23 (B) enrollment; and  
 24 (C) administration.
- 25 (5) Contracting with:  
 26 (A) an insurance company licensed in Indiana;  
 27 (B) an authorized reinsurer; or  
 28 (C) a hospital authorized to conduct business in Indiana;  
 29 for the provision of insurance, indemnity, or reimbursement  
 30 against the cost of health care services provided by the health  
 31 maintenance organization.
- 32 (6) The offering of point-of-service products.
- 33 (7) The joint marketing of products with:  
 34 (A) an insurance company that is licensed in Indiana; or  
 35 (B) a hospital that is authorized to conduct business in Indiana;  
 36 if the company that is offering each product is clearly identified.
- 37 (8) Administration of the provision of health care services at the  
 38 expense of a self-funded plan.
- 39 (b) A health maintenance organization may offer any of the  
 40 following:  
 41 (1) Plans that include only basic health care services.  
 42 (2) Plans that include basic health care services and other health

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1 care services.  
2 (3) Plans that include health care services other than basic health  
3 care services so long as at least one (1) of the plans offered by the  
4 health maintenance organization includes basic health care  
5 services.

6 (c) **Notwithstanding subsection (a)(5), a health maintenance**  
7 **organization may not take credit for reinsurance unless the risk is**  
8 **ceded to a reinsurer qualified under IC 27-6-10.**

9 SECTION 18. IC 27-13-4-3 IS AMENDED TO READ AS  
10 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 3. (a) A **domestic**  
11 health maintenance organization must file notice with the  
12 commissioner, with supporting information that the commissioner  
13 deems adequate, before exercising any power granted in:

- 14 (1) section 1(a)(1); or
- 15 (2) section 1(a)(4);

16 of this chapter if the proposed transaction is equal to or greater than ten  
17 percent (10%) of the health maintenance organization's admitted assets.

18 (b) A **domestic** health maintenance organization must file notice  
19 with the commissioner, with the supporting information that the  
20 commissioner deems adequate, before exercising any power granted in  
21 section 1(a)(2), if the proposed transaction is equal to or greater than  
22 three percent (3%) of the health maintenance organization's admitted  
23 assets.

24 (c) The commissioner may disapprove an exercise of power referred  
25 to in a notice received under subsection (a) or (b) only if, in the opinion  
26 of the commissioner, the exercise of the power would:

- 27 (1) substantially and adversely affect the financial soundness of  
28 the health maintenance organization; and
- 29 (2) endanger the ability of the health maintenance organization to  
30 meet its obligations.

31 (d) If the commissioner does not disapprove an exercise of power  
32 referred to in a notice received under subsection (a) or (b) within thirty  
33 (30) days after the notice is filed with the commissioner, the exercise  
34 of power is considered approved.

35 (e) The commissioner may adopt rules under IC 4-22-2 exempting  
36 from the filing requirement of this section certain activities that have  
37 a minimal effect on:

- 38 (1) the financial soundness of the health maintenance  
39 organization; and
- 40 (2) the ability of the health maintenance organization to meet its  
41 obligations.

42 SECTION 19. IC 27-13-8-1.5 IS ADDED TO THE INDIANA

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1 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 2 [EFFECTIVE JULY 1, 2000]: **Sec. 1.5. (a) Each health maintenance**  
 3 **organization authorized to conduct business in Indiana and**  
 4 **required to file an annual statement with the department under**  
 5 **this chapter shall submit the health maintenance organization's**  
 6 **statement on the National Association of Insurance Commissioners**  
 7 **(NAIC) Annual Statement Blank prepared in accordance with**  
 8 **NAIC Annual Statement Instructions, and following practices and**  
 9 **procedures prescribed by the most recent NAIC Accounting**  
 10 **Practices and Procedures Manual.**

11 (b) To the extent that the NAIC Annual Statement Instructions  
 12 require disclosure under subsection (a) of compensation paid to or  
 13 on behalf of a health maintenance organization's officers, directors,  
 14 or employees, the information may be filed with the department as  
 15 an exhibit separate from the annual statement blank. The  
 16 compensation information described under this subsection shall be  
 17 maintained by the department as confidential and may not be  
 18 made public.

19 SECTION 20. IC 27-13-8-2, AS AMENDED BY P.L.133-1999,  
 20 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 21 JULY 1, 2000]: Sec. 2. (a) In addition to the report required by section  
 22 1 of this chapter, a health maintenance organization shall each year file  
 23 with the commissioner the following:

24 (1) Audited financial statements of the health maintenance  
 25 organization for the preceding calendar year **prepared in**  
 26 **conformity with statutory accounting practices prescribed or**  
 27 **otherwise permitted by the department.**

28 (2) A list of participating providers who provide health care  
 29 services to enrollees or subscribers of the health maintenance  
 30 organization.

31 (3) A description of the grievance procedure of the health  
 32 maintenance organization:

33 (A) established under IC 27-13-10, including:

34 (i) the total number of grievances handled through the  
 35 procedure during the preceding calendar year;

36 (ii) a compilation of the causes underlying those grievances;  
 37 and

38 (iii) a summary of the final disposition of those grievances;  
 39 and

40 (B) established under IC 27-13-10.1, including:

41 (i) the total number of external grievances handled through  
 42 the procedure during the preceding calendar year;



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- 1 (ii) a compilation of the causes underlying those grievances;
- 2 and
- 3 (iii) a summary of the final disposition of those grievances;
- 4 for each independent review organization used by the health
- 5 maintenance organization during the reporting year.
- 6 (4) The percentage of providers credentialed by the health
- 7 maintenance organization according to the most current standards
- 8 or guidelines, if any, developed by the National Committee on
- 9 Quality Assurance or a successor organization.
- 10 (5) The health maintenance organization's Health Plan Employer
- 11 Data and Information Set (HEDIS) data.
- 12 (b) The information required by subsection (a)(2) through (a)(4)
- 13 must be filed with the commissioner on or before March 1 of each year.
- 14 The audited financial statements required by subsection (a)(1) must be
- 15 filed with the commissioner on or before June 1 of each year. The
- 16 health maintenance organization's HEDIS data required by subsection
- 17 (a)(5) must be filed with the commissioner on or before July 1 of each
- 18 year. The commissioner shall:
- 19 (1) make the information required to be filed under this section
- 20 available to the public; and
- 21 (2) prepare an annual compilation of the data required under
- 22 subsection (a)(3) through (a)(5) that allows for comparative
- 23 analysis.
- 24 (c) **Upon a determination by a health maintenance**
- 25 **organization's auditor that the health maintenance organization:**
- 26 **(1) does not meet the requirements of IC 27-13-12-3; or**
- 27 **(2) is in the condition described in IC 27-13-24-1(a)(5);**
- 28 **the health maintenance organization shall notify the commissioner**
- 29 **within five (5) business days after the auditor's determination.**
- 30 (d) The commissioner may require any additional reports as are
- 31 necessary and appropriate for the commissioner to carry out the
- 32 commissioner's duties under this article.
- 33 SECTION 21. IC 27-13-8-4 IS ADDED TO THE INDIANA CODE
- 34 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
- 35 1, 2000]: **Sec. 4. (a) This section applies to a domestic health**
- 36 **maintenance organization that is authorized to transact business**
- 37 **in Indiana.**
- 38 (b) **As used in this section, "NAIC" refers to the National**
- 39 **Association of Insurance Commissioners.**
- 40 (c) **On or before March 1 of each year, a health maintenance**
- 41 **organization shall file with the National Association of Insurance**
- 42 **Commissioners and with the department a copy of the health**

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1 maintenance organization's annual statement convention blank  
 2 and additional filings prescribed by the commissioner for the  
 3 preceding year. A health maintenance organization shall also file  
 4 quarterly statements with the NAIC and with the department, on  
 5 or before May 15, August 15, and November 15 of each year, in a  
 6 form prescribed by the commissioner. The information filed with  
 7 the NAIC under this subsection:

8 (1) must be:

9 (A) in the same format; and

10 (B) of the same scope;

11 as is required by the commissioner under section 1 of this  
 12 chapter;

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

15 (3) must be filed electronically in accordance with NAIC  
 16 electronic filing specifications.

17 The commissioner may, for good cause shown, grant an exemption  
 18 from the requirement of this section to domestic health  
 19 maintenance organizations that operate only in Indiana. If a health  
 20 maintenance organization files any amendment or addendum to  
 21 the health maintenance organization's annual statement  
 22 convention blank or quarterly statement with the commissioner,  
 23 the health maintenance organization shall also file a copy of the  
 24 amendment or addendum with the NAIC. Annual and quarterly  
 25 financial statements are considered filed with the NAIC when  
 26 delivered to the address designated by the NAIC for the filings,  
 27 regardless of whether the filing is accompanied by any applicable  
 28 fee.

29 (d) The commissioner may, for good cause shown, grant a health  
 30 maintenance organization an extension of time for the filing  
 31 required by subsection (c).

32 (e) In the absence of actual malice:

33 (1) members of the NAIC;

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

36 (3) delegates of members of the NAIC;

37 (4) employees of the NAIC; and

38 (5) other persons responsible for collecting, reviewing,  
 39 analyzing, and disseminating information developed from the  
 40 filing of annual statement convention blanks under this  
 41 section;

42 shall be considered to be acting as agents of the commissioner



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1 under the authority of this section and are not subject to civil  
 2 liability for libel, slander, or any other cause of action by virtue of  
 3 the collection, review, analysis, or dissemination of the data and  
 4 information collected from the filings required by this section.

5 (f) The commissioner may suspend, revoke, or refuse to renew  
 6 the certificate of authority of a health maintenance organization  
 7 that fails to file the health maintenance organization's annual  
 8 statement convention blank or quarterly statements with the NAIC  
 9 or with the department within the time allowed by subsection (c)  
 10 or (d).

11 SECTION 22. IC 27-13-8-5 IS ADDED TO THE INDIANA CODE  
 12 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
 13 1, 2000]: **Sec. 5. (a) The commissioner may impose a civil penalty  
 14 of five hundred dollars (\$500), after notice and hearing under  
 15 IC 4-21.5-3, on a health maintenance organization that fails to file  
 16 an annual statement under this chapter.**

17 (b) A domestic health maintenance organization that fails to file  
 18 an audited annual financial statement under section 2(a)(1) of this  
 19 chapter before June 1 of each year without obtaining an extension  
 20 is subject to a civil penalty of fifty dollars (\$50) per day until the  
 21 report is received by the commissioner.

22 SECTION 23. IC 27-13-13-9 IS ADDED TO THE INDIANA  
 23 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 24 [EFFECTIVE JULY 1, 2000]: **Sec. 9. (a) As used in this section,  
 25 "uncovered health care expenditures" means the costs to a health  
 26 maintenance organization for health care services that:**

- 27 (1) are the obligation of the health maintenance organization;
- 28 (2) for which the enrollee may be liable in the event of the  
 29 health maintenance organization's insolvency; and
- 30 (3) for which no alternative arrangements have been made  
 31 that are acceptable to the commissioner.

32 (b) If uncovered health care expenditures exceed ten percent  
 33 (10%) of total health care expenditures, a health maintenance  
 34 organization shall deposit cash or securities that are acceptable to  
 35 the commissioner with:

- 36 (1) the commissioner; or
- 37 (2) an organization or trustee approved by the commissioner  
 38 through which a custodial or controlled account is  
 39 maintained.

40 (c) The deposit made under subsection (b) must have a fair  
 41 market value:

- 42 (1) calculated on the first day of each month; and



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1           **(2) maintained for the remainder of the month;**  
 2 **of not less than one hundred twenty percent (120%) of the health**  
 3 **maintenance organization's outstanding liability for uncovered**  
 4 **health care expenditures for enrollees in Indiana, including**  
 5 **incurred but not reported claims.**

6           **(d) The commissioner may require a health maintenance**  
 7 **organization to file periodic reports, including liability for**  
 8 **uncovered health care expenditures and audit opinions, that the**  
 9 **commissioner considers necessary to monitor compliance with this**  
 10 **section.**

11           SECTION 24. IC 27-13-15-2 IS AMENDED TO READ AS  
 12 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. If:

13           (1) the contract between a health maintenance organization and  
 14 a participating provider has not been reduced to writing as  
 15 required by this chapter; or

16           (2) the contract fails to contain the provision required by section  
 17 ~~1(2)~~ **1(a)(4)** of this chapter;

18 the participating provider may not collect or attempt to collect from the  
 19 subscriber or enrollee any sums that are owed by the health  
 20 maintenance organization.

21           SECTION 25. IC 27-13-15-3 IS AMENDED TO READ AS  
 22 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 3. **(a) A:**

23           (1) participating provider; or

24           (2) trustee, an agent, a representative, or an assignee of a  
 25 participating provider;

26 may not **bring or** maintain any legal action against a subscriber or an  
 27 enrollee of a health maintenance organization to collect sums owed by  
 28 the health maintenance organization.

29           **(b) If a participating provider of a health maintenance**  
 30 **organization brings or maintains a legal action against a subscriber**  
 31 **or enrollee for an amount owed to the participating provider by the**  
 32 **health maintenance organization, the participating provider is**  
 33 **liable to the subscriber or enrollee for costs and attorney's fees**  
 34 **incurred by the subscriber or enrollee in defending the legal action.**

35           SECTION 26. IC 27-13-18-1 IS AMENDED TO READ AS  
 36 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) In the event of  
 37 receivership of a health maintenance organization, the commissioner  
 38 may order all other carriers that participated in the enrollment process  
 39 of the group covered by the organization in receivership at the last  
 40 regular enrollment period of the group to offer the enrollees of the  
 41 organization in receivership an enrollment period of thirty (30) days  
 42 beginning on the date of receivership.



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1 (b) Each carrier referred to in subsection (a) shall offer the enrollees  
2 of the health maintenance organization in receivership:

- 3 (1) the same coverage;  
4 (2) under the same terms; and  
5 (3) at the same rates;

6 as the carrier had offered at the last regular enrollment period of the  
7 group. The coverage required under this chapter shall begin on the date  
8 of receivership and end on the date the contract period would have  
9 ended had the health maintenance organization not gone into  
10 receivership.

11 (c) **If there is no carrier referred to in subsection (a), or the**  
12 **commissioner determines that there is no carrier referred to in**  
13 **subsection (a) that has adequate or accessible resources, the**  
14 **commissioner shall equitably allocate the:**

- 15 (1) **group contracts of the health maintenance organization in**  
16 **receivership; and**  
17 (2) **individual contracts of the health maintenance**  
18 **organization in receivership belonging to enrollees who are**  
19 **unable to obtain other coverage;**

20 **among all health maintenance organizations operating within a**  
21 **portion of the service area of the health maintenance organization**  
22 **in receivership.**

23 (d) **A health maintenance organization to which the**  
24 **commissioner allocates a group contract under subsection (c)(1)**  
25 **shall offer to the group existing coverage that is most similar to the**  
26 **group's coverage with the health maintenance organization in**  
27 **receivership at rates consistent with the successor health**  
28 **maintenance organization's existing rating methodology.**

29 (e) **A health maintenance organization to which the**  
30 **commissioner allocates individual contracts under subsection (c)(2)**  
31 **shall offer to the enrollee existing individual or conversion**  
32 **coverage that is most similar to the enrollee's coverage with the**  
33 **health maintenance organization in receivership at rates consistent**  
34 **with the successor health maintenance organization's existing**  
35 **rating methodology. A successor health maintenance organization**  
36 **that does not offer direct individual enrollment may aggregate all**  
37 **allocated individual contracts into one (1) group for purposes of**  
38 **rating and coverage.**

39 SECTION 27. IC 27-13-22-1 IS AMENDED TO READ AS  
40 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) A licensed  
41 insurer or a hospital authorized to conduct business in Indiana may,  
42 ~~either directly or~~ through a subsidiary or an affiliate, organize and

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1 operate a health maintenance organization under this article.

2 **(b) This section does not apply to a health maintenance**  
 3 **organization granted a certificate of authority under this article**  
 4 **before July 1, 2000.**

5 SECTION 28. IC 27-13-23-8 IS ADDED TO THE INDIANA  
 6 CODE AS A NEW CHAPTER TO READ AS FOLLOWS  
 7 [EFFECTIVE JULY 1, 2000]: **Sec. 8. A health maintenance**  
 8 **organization shall file a copy of any examination report filed by the**  
 9 **insurance commissioner of another state during the preceding**  
 10 **calendar year with the annual statement required under**  
 11 **IC 27-13-8-1.**

12 SECTION 29. IC 27-13-32-1 IS AMENDED TO READ AS  
 13 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 1. (a) This section does  
 14 not apply to a health maintenance organization or a limited service  
 15 health maintenance organization that is a foreign corporation. ~~or is~~  
 16 ~~owned by a foreign corporation.~~

17 (b) As used in this section, "foreign corporation" means a  
 18 corporation organized or reorganized under the law of a state or  
 19 jurisdiction other than Indiana.

20 (c) A person may not acquire control, as that term is defined in  
 21 IC 27-1-23-1, of a health maintenance organization or a limited service  
 22 health maintenance organization unless:

23 (1) that person complies with the requirements of IC 27-1-23-2;  
 24 and

25 (2) the acquisition is approved by the commissioner under the  
 26 procedure set forth in IC 27-1-23-2.

27 SECTION 30. IC 27-13-32.5 IS ADDED TO THE INDIANA  
 28 CODE AS A NEW CHAPTER TO READ AS FOLLOWS  
 29 [EFFECTIVE JULY 1, 2000]:

30 **Chapter 32.5. Voluntary Dissolution**

31 **Sec. 1. Upon authorization of voluntary dissolution by the board**  
 32 **of directors and any shareholders entitled to vote in respect of the**  
 33 **voluntary dissolution, the board of directors shall:**

34 (1) cause a notice that the health maintenance organization is  
 35 about to be dissolved to be published at least once in a  
 36 newspaper of general circulation, printed and published in the  
 37 English language, in the county in which the principal office  
 38 of the health maintenance organization is located, and at least  
 39 once in a newspaper of general circulation, printed and  
 40 published in the English language in the city of Indianapolis,  
 41 Marion County, Indiana;

42 (2) cause a copy of the publication under subdivision (1) to be



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mailed to each subscriber;  
(3) file a copy of the publication under subdivision (1) with the department; and  
(4) file a certified copy of the articles of dissolution with the department and present to the department the certificate of authority issued or renewed under IC 27-13-3-1 for cancellation.

The department shall file the certified copy of the articles of dissolution, cancel the certificate of authority, endorse the cancellation on the certificate, and return the canceled certificate of authority to the health maintenance organization or its representatives.

**Sec. 2. The dissolution of a health maintenance organization under this chapter does not alter the rights of an enrollee under IC 27-13-7-13.**

SECTION 31. IC 27-13-34-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 7. (a) After December 31, 1994, a person, corporation, partnership, limited liability company, or other entity may not operate a limited service health maintenance organization in Indiana without obtaining and maintaining a certificate of authority from the commissioner under this chapter.

(b) A for-profit or nonprofit corporation organized under the laws of another state, other than a foreign corporation defined under IC 27-1-2-3, may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation is authorized to do business in Indiana under IC 23-1-49 or IC 23-17-26 and complies with this chapter.

(c) A foreign corporation (as defined in IC 27-1-2-3) may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation complies with this chapter.

**(d) A foreign or alien limited service health maintenance organization granted a certificate of authority under this chapter has the same but not greater rights and privileges than a domestic limited service health maintenance organization.**

SECTION 32. IC 34-30-2-114.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: **Sec. 114.5. IC 27-7-12-7 (Concerning communications regarding termination of a homeowner's insurance policy).**

SECTION 33. IC 34-30-2-116.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS

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1 [EFFECTIVE JULY 1, 2000]: **Sec. 116.7. IC 27-8-29-19 (Concerning**  
2 **independent review organizations).**  
3 SECTION 34. IC 34-30-2-119.3 IS ADDED TO THE INDIANA  
4 CODE AS A NEW SECTION TO READ AS FOLLOWS  
5 [EFFECTIVE JULY 1, 2000]: **Sec. 119.3. IC 27-13-8-4 (Concerning**  
6 **data and information collected from health maintenance**  
7 **organization filings).**  
8 SECTION 35. [EFFECTIVE JULY 1, 2000] (a) **Notwithstanding**  
9 **IC 27-8-28-18 and IC 27-8-29-18, both as added by this act, the**  
10 **information required under IC 27-8-28-18 and IC 27-8-29-18, both**  
11 **as added by this act, must be filed beginning March 1, 2002.**  
12 (b) **This SECTION expires June 30, 2004.**

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1189, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 2, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 2. IC 22-2-6-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 2. (a) Any assignment of the wages of an employee is valid only if all of the following conditions are satisfied:

- (1) The assignment is:
  - (A) in writing;
  - (B) signed by the employee personally;
  - (C) by its terms revocable at any time by the employee upon written notice to the employer; and
  - (D) agreed to in writing by the employer.
- (2) An executed copy of the assignment is delivered to the employer within ten (10) days after its execution.
- (3) The assignment is made for a purpose described in subsection (b).

(b) A wage assignment under this section may be made for the purpose of paying any of the following:

- (1) Premium on a policy of insurance. ~~obtained for the employee by the employer.~~
- (2) Pledge or contribution of the employee to a charitable or nonprofit organization.
- (3) Purchase price of bonds or securities, issued or guaranteed by the United States.
- (4) Purchase price of shares of stock, or fractional interests therein, of the employing company, or of a company owning the majority of the issued and outstanding stock of the employing company, whether purchased from such company, in the open market or otherwise. However, if such shares are to be purchased on installments pursuant to a written purchase agreement, the employee has the right under the purchase agreement at any time before completing purchase of such shares to cancel said agreement and to have repaid promptly the amount of all installment payments which theretofore have been made.
- (5) Dues to become owing by the employee to a labor organization of which the employee is a member.
- (6) Purchase price of merchandise sold by the employer to the employee, at the written request of the employee.

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(7) Amount of a loan made to the employee by the employer and evidenced by a written instrument executed by the employee.

(8) Contributions, assessments, or dues of the employee to a hospital service or a surgical or medical expense plan or to an employees' association, trust, or plan existing for the purpose of paying pensions or other benefits to said employee or to others designated by the employee.

(9) Payment to any credit union, nonprofit organizations, or associations of employees of such employer organized under any law of this state or of the United States.

(10) Payment to any person or organization regulated under the Uniform Consumer Credit Code (IC 24-4.5) for deposit or credit to the employee's account by electronic transfer or as otherwise designated by the employee.

(11) Premiums on policies of insurance and annuities purchased by the employee on the employee's life.

(12) The purchase price of shares or fractional interest in shares in one (1) or more mutual funds."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1189 as introduced.)

FRY, Chair

Committee Vote: yeas 13, nays 1.

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