CONFERENCE COMMITTEE REPORT
DIGEST FOR EHB 1678

Citations Affected: IC 4-22-2-37.1; IC 6-7-1; IC 6-3.1; IC 12-7-2; IC 12-15; IC 12-16; IC 12-17.6-3; IC 16-18-2-331.8; IC 16-46-13; IC 27-8; IC 27-13-7-3; IC 34-30-2-45.7; IC 12-15-15-9.8; IC 12-15-20.7-3; IC 12-16-2.5-6.5; IC 12-16-8.5; IC 12-16-12.5.

Synopsis: Health matters. Conference committee report for EHB 1678. Provides for a tax credit related to small employer qualified wellness programs. Increases the cigarette tax by 44 cents per pack to fund various health related expenses. Allows an employer to take a tax credit for making a health benefit plan available to the employer's employees for the first two taxable years that the employer makes the health benefit plan available. Increases the income limit for Medicaid eligibility for pregnant women. Makes funding changes to the hospital care for the indigent program, the municipal disproportionate share program, and the Medicaid indigent care trust fund. Provides for continuous eligibility of a child under Medicaid and the children's health insurance program (CHIP) until the child becomes three years of age. Establishes the Indiana check-up plan (plan) and the Indiana check-up plan trust fund. Specifies requirements for the plan, including coverage, financial assistance, eligibility and enrollment, contracting, financial obligations, and funding requirements. Increases the CHIP eligibility family income limit. Requires the state department of health to establish standards for and certify a small employer qualified wellness program. Requires health insurers and health maintenance organizations to cover children up to 24 years old upon request. Allows certain small employers to join together to purchase group health insurance and allows the insurance commissioner and the office of the secretary of family and social services to develop a program to provide for such purchases. Requires the Indiana comprehensive health insurance association to administer plan benefits for high risk individuals insured under the plan. Requires application for necessary federal Medicaid approvals, including approval for presumptive eligibility for certain pregnant women and implementation of the plan. Establishes a plan task force. Requires the health finance commission to study and report concerning several issues. Makes appropriations. Makes conforming and technical changes. **(This conference committee report retains the contents of EHB 1678 as printed on March 23, 2007, and adds the contents described above.)**

Effective: Upon passage; January 1, 2007 (retroactive); July 1, 2007; August 1, 2007.

CONFERENCE COMMITTEE REPORT

MADAM PRESIDENT:

Your Conference Committee appointed to confer with a like committee from the House upon Engrossed Senate Amendments to Engrossed House Bill No. 1678 respectfully reports that said two committees have conferred and agreed as follows to wit:

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

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning health and to make an appropriation.

Delete everything after the enacting clause and insert the following:

SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.47-2006, SECTION 2, AS AMENDED BY P.L.91-2006, SECTION 2, AND AS AMENDED BY P.L.123-2006, SECTION 12, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 37.1. (a) This section applies to a rulemaking action resulting in any of the following rules:

(1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.

(2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.

(3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.

(4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.

(5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107 and declared necessary to meet an emergency.

(6) A rule required under IC 24-4.5-1-106 that is adopted by the department of financial institutions and declared necessary to meet an emergency under IC 24-4.5-6-107.
(7) A rule adopted by the Indiana utility regulatory commission to address an emergency under IC 8-1-2-113.
(8) An emergency rule adopted by the state lottery commission under IC 4-30-3-9.
(9) A rule adopted under IC 16-19-3-5 that the executive board of the state department of health declares is necessary to meet an emergency.
(10) An emergency rule adopted by the Indiana finance authority under IC 8-21-12.
(11) An emergency rule adopted by the insurance commissioner under IC 27-1-23-7.
(12) An emergency rule adopted by the Indiana horse racing commission under IC 4-31-3-9.
(13) An emergency rule adopted by the air pollution control board, the solid waste management board, or the water pollution control board under IC 13-15-4-10(4) or to comply with a deadline required by federal law, provided:
(A) the variance procedures are included in the rules; and
(B) permits or licenses granted during the period the emergency rule is in effect are reviewed after the emergency rule expires.
(14) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.
(15) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.
(16) An emergency rule adopted by the Indiana gaming commission under *IC 4-32.2-3-3(b),* IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.
(17) An emergency rule adopted by the alcohol and tobacco commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.
(18) An emergency rule adopted by the department of financial institutions under IC 28-15-11.
(19) An emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.
(20) An emergency rule adopted by the office of the children's health insurance program under IC 12-17.6-2-11.
(21) An emergency rule adopted by the office of Medicaid policy and planning under IC 12-15-41-15 **or IC 12-15-44-19(b).**
(22) An emergency rule adopted by the Indiana state board of animal health under IC 15-2.1-18-21.
(23) An emergency rule adopted by the board of directors of the Indiana education savings authority under IC 21-9-4-7.
(24) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-34 **(repealed).**
(25) An emergency rule adopted by the department of local government finance under IC 6-1.1-4-33 **(repealed).**
(26) An emergency rule adopted by the boiler and pressure vessel

rules board under IC 22-13-2-8(c).

(27) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-37(l) **(repealed)** or an emergency rule adopted by the department of local government finance under IC 6-1.1-4-36(j) **(repealed)** or IC 6-1.1-22.5-20.

(28) An emergency rule adopted by the board of the Indiana economic development corporation under IC 5-28-5-8.

(29) A rule adopted by the department of financial institutions under IC 34-55-10-2.5.

(30) A rule adopted by the Indiana finance authority:

(A) under IC 8-15.5-7 approving user fees (as defined in IC 8-15.5-2-10) provided for in a public-private agreement under IC 8-15.5;

(B) under IC 8-15-2-17.2(a)(10):

(i) establishing enforcement procedures; and

(ii) making assessments for failure to pay required tolls;

(C) under IC 8-15-2-14(a)(3) authorizing the use of and establishing procedures for the implementation of the collection of user fees by electronic or other nonmanual means; or

(D) to make other changes to existing rules related to a toll road project to accommodate the provisions of a public-private agreement under IC 8-15.5.

(b) The following do not apply to rules described in subsection (a):

(1) Sections 24 through 36 of this chapter.

(2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The publisher shall determine the ~~*number of copies*~~ *format* of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the ~~*secretary of state*~~ *publisher* for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The ~~*secretary of state*~~ *publisher* shall determine the ~~*number of copies*~~ *format* of the rule and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the ~~*secretary of state*~~ *publisher* shall:

(1) accept the rule for filing; and

(2) ~~*file stamp and indicate*~~ *electronically record* the date and time that the rule is accepted. ~~*on every duplicate original copy submitted.*~~

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

(1) The effective date of the statute delegating authority to the agency to adopt the rule.

(2) The date and time that the rule is accepted for filing under

subsection (e).

(3) The effective date stated by the adopting agency in the rule.

(4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, IC 22-8-1.1-16.1, and IC 22-13-2-8(c), and except as provided in subsections (j), ~~and~~ (k), *and (l),* a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(13), (a)(24), (a)(25), or (a)(27), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. The extension period for a rule adopted under subsection (a)(28) may not exceed the period for which the original rule was in effect. A rule adopted under subsection (a)(13) may be extended for two (2) extension periods. Subject to subsection (j), a rule adopted under subsection (a)(24), (a)(25), or (a)(27) may be extended for an unlimited number of extension periods. Except for a rule adopted under subsection (a)(13), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

(1) sections 24 through 36 of this chapter; or

(2) IC 13-14-9;

as applicable.

(h) A rule described in subsection (a)(6), (a)(8), (a)(12), or (a)(29) expires on the earlier of the following dates:

(1) The expiration date stated by the adopting agency in the rule.

(2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

(i) This section may not be used to readopt a rule under IC 4-22-2.5.

(j) A rule described in subsection (a)(24) or (a)(25) expires not later than January 1, 2006.

(k) A rule described in subsection (a)(28) expires on the expiration date stated by the board of the Indiana economic development corporation in the rule.

(l) A rule described in subsection (a)(30) expires on the expiration date stated by the Indiana finance authority in the rule.

SECTION 2. IC 6-7-1-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 12. (a) The following taxes are imposed, and shall be collected and paid as provided in this chapter, upon the sale, exchange, bartering, furnishing, giving away, or otherwise disposing of cigarettes within the state of Indiana:

(1) On cigarettes weighing not more than three (3) pounds per thousand (1,000), a tax at the rate of ~~two~~ **four** and ~~seven~~ **nine** hundred seventy-five thousandths ~~of a cent ($0.02775)~~ **cents ($0.04975)** per individual cigarette.

(2) On cigarettes weighing more than three (3) pounds per thousand (1,000), a tax at the rate of ~~three~~ **six** and six ~~thousand eight~~ hundred ~~eighty-one~~ **twelve** ~~ten-thousandths of a cent ($0.036881)~~ **thousandths cents ($0.06612)** per individual cigarette, except that if any cigarettes weighing more than three (3) pounds per thousand (1,000) shall be more than six and

one-half (6 1/2) inches in length, they shall be taxable at the rate provided in subdivision (1), counting each two and three-fourths (2 3/4) inches (or fraction thereof) as a separate cigarette.

(b) Upon all cigarette papers, wrappers, or tubes, made or prepared for the purpose of making cigarettes, which are sold, exchanged, bartered, given away, or otherwise disposed of within the state of Indiana (other than to a manufacturer of cigarettes for use by him in the manufacture of cigarettes), the following taxes are imposed, and shall be collected and paid as provided in this chapter:

(1) On fifty (50) papers or less, a tax of one-half cent ($0.005).

(2) On more than fifty (50) papers but not more than one hundred (100) papers, a tax of one cent ($0.01).

(3) On more than one hundred (100) papers, one-half cent ($0.005) for each fifty (50) papers or fractional part thereof.

(4) On tubes, one cent ($0.01) for each fifty (50) tubes or fractional part thereof.

SECTION 3. IC 6-7-1-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) Distributors who hold certificates and retailers shall be agents of the state in the collection of the taxes imposed by this chapter and the amount of the tax levied, assessed, and imposed by this chapter on cigarettes sold, exchanged, bartered, furnished, given away, or otherwise disposed of by distributors or to retailers. Distributors who hold certificates shall be agents of the department to affix the required stamps and shall be entitled to purchase the stamps from the department at a discount of ~~one and two-tenths percent (1.2%) of the amount of the tax stamps purchased,~~ **one and two-tenths cents ($0.012) per individual package of cigarettes** as compensation for their labor and expense.

(b) The department may permit distributors who hold certificates and who are admitted to do business in Indiana to pay for revenue stamps within thirty (30) days after the date of purchase. However, the privilege is extended upon the express condition that:

(1) except as provided in subsection (c), a bond or letter of credit satisfactory to the department, in an amount not less than the sales price of the stamps, is filed with the department; and

(2) proof of payment is made of all local property, state income, and excise taxes for which any such distributor may be liable. The bond or letter of credit, conditioned to secure payment for the stamps, shall be executed by the distributor as principal and by a corporation duly authorized to engage in business as a surety company or financial institution in Indiana.

(c) If a distributor has at least five (5) consecutive years of good credit standing with the state, the distributor shall not be required to post a bond or letter of credit under subsection (b).

SECTION 4. IC 6-7-1-28.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE AUGUST 1, 2007]: Sec. 28.1. The taxes, registration fees, fines, or penalties collected under this chapter shall be deposited in the following manner:

(1) ~~Six~~ **Four** and ~~six-tenths~~ **twenty-two hundredths** percent ~~(6.6%)~~ **(4.22%)** of the money shall be deposited in a fund to be known as the cigarette tax fund.

(2) ~~Ninety-four hundredths~~ **Six-tenths** percent ~~(0.94%)~~ **(0.6%)** of the money shall be deposited in a fund to be known as the mental health centers fund.

(3) ~~Eighty-three~~ **Fifty-three** and ~~ninety-seven~~ **sixty-eight** hundredths percent ~~(83.97%)~~ **(53.68%)** of the money shall be deposited in the state general fund.

(4) ~~Eight~~ **Five** and ~~forty-nine~~ **forty-three** hundredths percent ~~(8.49%)~~ **(5.43%)** of the money shall be deposited into the pension relief fund established in IC 5-10.3-11.

(5) Twenty-seven and five hundredths percent (27.05%) of the money shall be deposited in the Indiana check-up plan trust fund established by IC 12-15-44-17.

(6) Two and forty-six hundredths percent (2.46%) of the money shall be deposited in the state general fund for the purpose of paying appropriations for Medicaid—Current Obligations, for provider reimbursements.

(7) Four and one-tenth percent (4.1%) of the money shall be deposited in the state general fund for the purpose of paying any appropriation for a health initiative.

(8) Two and forty-six hundredths percent (2.46%) of the money shall be deposited in the state general fund for the purpose of reimbursing the state general fund for a tax credit provided under IC 6-3.1-31.

The money in the cigarette tax fund, the mental health centers fund, **the Indiana check-up plan trust fund,** or the pension relief fund at the end of a fiscal year does not revert to the state general fund. However, if in any fiscal year, the amount allocated to a fund under subdivision (1) or (2) is less than the amount received in fiscal year 1977, then that fund shall be credited with the difference between the amount allocated and the amount received in fiscal year 1977, and the allocation for the fiscal year to the fund under subdivision (3) shall be reduced by the amount of that difference. **Money deposited under subdivisions (6) through (8) may not be used for any purpose other than the purpose stated in the subdivision.**

SECTION 5. IC 6-3.1-31 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2007 (RETROACTIVE)]:

Chapter 31. Credit for Offering Health Benefit Plans

Sec. 1. This chapter applies to an employer that does not offer coverage for health care services under a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

Sec. 2. As used in this chapter, "eligible taxpayer" means a taxpayer that did not provide health insurance to the taxpayer's employees in the taxable year immediately preceding the first taxable year for which the taxpayer claims a credit under this chapter.

Sec. 3. As used in this chapter, "full-time employee" means an employee who is normally scheduled to work at least thirty (30) hours each week.

Sec. 4. (a) As used in this chapter, "health benefit plan" means

coverage for health care services provided under:

(1) an insurance policy that provides one (1) or more of the types of insurance described in Class 1(b) or Class 2(a) of IC 27-1-5-1; or

(2) a contract with a health maintenance organization for coverage of basic health care services under IC 27-13;

that satisfies the requirements of Section 125 of the Internal Revenue Code.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

Sec. 5. As used in this chapter, "pass through entity" means a:

(1) corporation that is exempt from the adjusted gross income tax under IC 6-3-2-2.8(2);

(2) partnership;

(3) limited liability company; or

(4) limited liability partnership.

Sec. 6. As used in this chapter, "state tax liability" means a taxpayer's total tax liability that is incurred under:

(1) IC 6-3-1 through IC 6-3-7 (adjusted gross income tax);

(2) IC 6-5.5 (financial institutions tax); and

(3) IC 27-1-18-2 (insurance premiums tax);

as computed after the application of the credits that under IC 6-3.1-1-2 are to be applied before the credit provided by this chapter.

Sec. 7. As used in this chapter, "taxpayer" means an individual or entity that has state tax liability.

Sec. 8. (a) An eligible taxpayer that, after December 31, 2006, makes health insurance available to the eligible taxpayer's employees and their dependents through at least one (1) health benefit plan is entitled to a credit against the taxpayer's state tax liability for the first two (2) taxable years in which the taxpayer makes the health benefit plan available if the following requirements are met:

(1) An employee's participation in the health benefit plan is at the employee's election.

(2) If an employee chooses to participate in the health benefit plan, the employee may pay the employee's share of the cost

of the plan using a wage assignment authorized under IC 22-2-6-2.

(b) The credit allowed in each of the first two (2) taxable years described in subsection (a) equals the lesser of:

(1) two thousand five hundred dollars ($2,500); or

(2) fifty dollars ($50) multiplied by the number of employees enrolled in the health benefit plan during the taxable year.

Sec. 9. (a) An employer may pay or provide reimbursement for all or part of the cost of a health benefit plan made available under section 8 of this chapter.

(b) An employer that pays or provides reimbursement under subsection (a) shall pay or provide reimbursement on an equal basis for all full-time employees who elect to participate in the health benefit plan.

Sec. 10. (a) If the amount determined under section 8 of this chapter for a taxpayer in a taxable year exceeds the taxpayer's state tax liability for that taxable year, the taxpayer may carry the excess over to the following taxable years. The amount of the credit carryover from a taxable year shall be reduced to the extent that the carryover is used by the taxpayer to obtain a credit under this chapter for any subsequent taxable year. A taxpayer is not entitled to a carryback.

(b) A taxpayer is not entitled to a refund of any unused credit.

Sec. 11. If a pass through entity does not have state income tax liability against which the tax credit may be applied, a shareholder or partner of the pass through entity is entitled to a tax credit equal to:

(1) the tax credit determined for the pass through entity for the taxable year; multiplied by

(2) the percentage of the pass through entity's distributive income to which the shareholder or partner is entitled.

Sec. 12. To receive the credit provided by this chapter, a taxpayer must claim the credit on the taxpayer's state tax return or returns in the manner prescribed by the department. The taxpayer must submit to the department all information that the department determines is necessary to calculate the credit provided by this chapter and to determine the taxpayer's eligibility for the credit.

Sec. 13. (a) A taxpayer claiming a credit under this chapter shall continue to make health insurance available to the taxpayer's employees through a health benefit plan for at least twenty-four (24) consecutive months beginning on the day after the last day of the taxable year in which the taxpayer first offers the health benefit plan.

(b) If the taxpayer terminates the health benefit plan before the expiration of the period required under subsection (a), the taxpayer shall repay the department the amount of the credit received under section 8 of this chapter.

SECTION 6. IC 6-3.1-31.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2007](RETROACTIVE)]:

Chapter 31.2. Small Employer Qualified Wellness Program Tax Credit

Sec. 1. As used in this chapter, "pass through entity" means:

(1) a corporation that is exempt from the adjusted gross income tax under IC 6-3-2-2.8(2);

(2) a partnership;

(3) a limited liability company; or

(4) a limited liability partnership.

Sec. 2. As used in this chapter, "qualified wellness program" means a wellness program that is certified by the state department of health under IC 16-46-13.

Sec. 3. (a) As used in this chapter, "small employer" means an employer that:

(1) is actively engaged in business;

(2) on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than one hundred (100) eligible employees, the majority of whom work in Indiana.

(b) In determining the number of eligible employees for purposes of subsection (a), employers that are affiliated employers or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Sec. 4. As used in this chapter, "state tax liability" means a taxpayer's total tax liability that is incurred under:

(1) IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax);

(2) IC 6-5.5 (the financial institutions tax); and

(3) IC 27-1-18-2 (the insurance premiums tax);

as computed after the application of the credits that under IC 6-3.1-1-2 are to be applied before the credit provided by this chapter.

Sec. 5. As used in this chapter, "taxpayer" means a small employer that has any state tax liability.

Sec. 6. A taxpayer is entitled to a credit against the taxpayer's state tax liability for a taxable year in an amount equal to fifty percent (50%) of the costs incurred by the taxpayer during the taxable year for providing a qualified wellness program for the taxpayer's employees during the taxable year.

Sec. 7. If a pass through entity is entitled to a credit under section 6 of this chapter but does not have state tax liability against which the tax credit may be applied, a shareholder, partner, or member of the pass through entity is entitled to a tax credit equal to:

(1) the tax credit determined for the pass through entity for the taxable year; multiplied by

(2) the percentage of the pass through entity's distributive income to which the shareholder, partner, or member is entitled.

Sec. 8. (a) If the credit provided by this chapter exceeds the taxpayer's state tax liability for the taxable year for which the credit is first claimed, the excess may be carried forward to succeeding taxable years and used as a credit against the

taxpayer's state tax liability during those taxable years. Each time that the credit is carried forward to a succeeding taxable year, the credit is to be reduced by the amount that was used as a credit during the immediately preceding taxable year.

(b) A taxpayer is not entitled to any carryback or refund of any unused credit.

Sec. 9. To receive the credit provided by this chapter, a taxpayer must:

(1) submit to the department with the taxpayer's state tax return or returns a copy of the certificate received from the state department of health under IC 16-46-13; and

(2) claim the credit on the taxpayer's state tax return or returns in the manner prescribed by the department.

The taxpayer shall submit to the department all information that the department determines is necessary for the calculation of the credit provided by this chapter.

Sec. 10. Beginning in 2009, the department shall, not later than December 31 of each odd-numbered year, report to the legislative council in an electronic format under IC 5-14-6 concerning use of the credit provided by this chapter. A report required by this section must include:

(1) the number of taxpayers claiming and receiving the credit;

(2) any reports of abuse of the credit; and

(3) other information the department considers necessary concerning the use and effectiveness of the credit;

during the preceding reporting period.

SECTION 7. IC 12-7-2-140.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 140.5. "Plan", for purposes of IC 12-15-44, has the meaning set forth in IC 12-15-44-1.**

SECTION 8. IC 12-7-2-144.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 144.3. "Preventative care services", for purposes of IC 12-15-44, has the meaning set forth in IC 12-15-44-2.**

SECTION 9. IC 12-15-2-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 13. (a) A pregnant woman:

(1) who is not described in 42 U.S.C. 1396a(a)(10)(A)(i); and

(2) whose family income does not exceed the income level established in subsection (b);

is eligible to receive Medicaid.

(b) A pregnant woman described in this section is eligible to receive Medicaid, subject to subsections (c) and (d) and 42 U.S.C. 1396a et seq., if her family income does not exceed ~~one~~ **two** hundred ~~fifty~~ percent ~~(150%)~~ **(200%)** of the federal income poverty level for the same size family.

(c) Medicaid made available to a pregnant woman described in this section is limited to medical assistance for services related to pregnancy, including prenatal, delivery, and postpartum services, and to other conditions that may complicate pregnancy.

(d) Medicaid is available to a pregnant woman described in this section for the duration of the pregnancy and for the sixty (60) day postpartum period that begins on the last day of the pregnancy, without regard to any change in income of the family of which she is a member during that time.

(e) The office may apply a resource standard in determining the eligibility of a pregnant woman described in this section.

SECTION 10. IC 12-15-2-15.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 15.8. After an individual who is less than three (3) years of age is determined to be eligible for Medicaid under section 14 of this chapter, the individual is not required to submit eligibility information more frequently than once in a twelve (12) month period until the child becomes three (3) years of age.**

SECTION 11. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount ~~equal to~~ **not to exceed** one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding

payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in ~~proportion to~~ **an amount not to exceed** each hospital's Medicaid shortfall as defined in subsection (f).

(c) Subject to subsection (e), reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. ~~Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the state fiscal year's end.~~ A hospital is not eligible for a payment described in this subsection unless an intergovernmental transfer **or certification of expenditures** is made under subsection (d).

(d) Subject to subsection (e):

(1) ~~a hospital may make an intergovernmental transfer under this subsection, or~~ an intergovernmental transfer may be made **by or** on behalf of the hospital; **or**

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of subsection (b). In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ **this section.** The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

(e) A hospital ~~making~~ **that makes a certification of expenditures or makes or has** an intergovernmental transfer **made on the hospital's behalf** under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital **or another entity** to make an intergovernmental transfer **or certification of expenditures** are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under ~~STEP SEVEN of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP SEVEN of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated

under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 12. IC 12-15-15-1.3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.3. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office under Medicare payment principles for the outpatient hospital services described in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount ~~equal to~~ **not to exceed** one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in ~~proportion to~~ **an amount not to exceed** each hospital's Medicaid shortfall as defined in subsection (f).

(c) ~~Subject to subsection (e), the reimbursement for a state fiscal year under this section consists of payments made before December 31 following the end of the state fiscal year.~~ A hospital is not eligible for a payment described in this ~~subsection~~ **section** unless:

(1) an intergovernmental transfer is made ~~under subsection (d).~~ **by the hospital or on behalf of the hospital; or**

(2) the hospital or another entity certifies the hospital's expenditures as eligible for federal financial participation.

(d) Subject to subsection (e):

(1) ~~a hospital may make an intergovernmental transfer under this subsection, or~~ an intergovernmental transfer may be made **by or** on behalf of the hospital; **or**

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of~~ subsection (b). ~~In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

(e) A hospital ~~making~~ **that makes a certification of expenditures or makes or has** an intergovernmental transfer **made on the hospital's behalf** under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid by the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital **or other entity** to make an intergovernmental transfer **or certification of expenditures** are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under

~~STEP SEVEN of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP SEVEN of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals must be made. A partial distribution may be calculated by the office based upon estimates and trends.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the outpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the outpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 13. IC 12-15-15-1.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.5. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21;

(2) is not a unit of state or local government; and

(3) is not owned or operated by a unit of state or local government.

(b) For a state fiscal year ending after June 30, 2003, **and before July 1, 2007,** in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals described in subsection (a), excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payment, the first ten million dollars ($10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than ~~seventy~~ **sixty** thousand ~~(70,000)~~ **(60,000)** Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services. **For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state and paid Medicaid fee for service and managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office.**

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals:

(i) on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days; or

(ii) other payment methodology **determined by the office and** approved by the Centers for Medicare and Medicaid

Services.

~~(D) For purposes of the clauses (A), (B) and (C), a hospital's Medicaid inpatient days are based on the Medicaid inpatient days allowed for the hospital by the office for purposes of the office's most recent determination of eligibility for the Medicaid disproportionate payment program under IC 12-15-16.~~

(c) ~~Reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the end of the state fiscal year.~~ **As used in this subsection, "Medicaid supplemental payments" means Medicaid payments for hospitals that are in addition to Medicaid fee-for-service payments, Medicaid risk-based managed care payments, and Medicaid disproportionate share payments, and that are included in the Medicaid state plan, including Medicaid safety-net payments, and payments made under sections 1.1, 1.3, 1.5, 9, and 9.5 of this chapter. For a state fiscal year ending after June 30, 2007, in addition to the reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:**

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services reimbursable under this article and under the state Medicaid plan that were provided during the state fiscal year for all hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified in STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to all hospitals described in subsection (a). A calculation under this STEP excludes a payment made under the following:

(A) IC 12-15-16.

(B) IC 12-15-17.

(C) IC 12-15-19.

STEP THREE: The office shall calculate, under Medicare payment principles, a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) As used in this clause, "Medicaid inpatient days" are the hospital's in-state paid Medicaid fee for service and risk-based managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office. Subject to the availability of funds transferred to the Medicaid indigent care trust fund

under STEP FOUR of IC 12-16-7.5-4.5(c) and remaining in the Medicaid indigent care trust fund under IC 12-15-20-2(8)(G) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis, based on the hospitals' Medicaid inpatient days or in accordance with another payment methodology determined by the office and approved by the Centers for Medicare and Medicaid Services.

(B) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid as described in clauses (C) and (D) to a hospital that is described in subsection (a) and that is described as eligible under this clause. A hospital is eligible for a payment under clause (C) only if the hospital:

(i) has less than sixty thousand (60,000) Medicaid inpatient days annually;

(ii) was eligible for Medicaid disproportionate share hospital payments in the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and

(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The payment amount under clause (C) for an eligible hospital is subject to the availability of the non-federal share of the hospital's payment being provided by the hospital or on behalf of the hospital.

(C) For state fiscal years ending after June 30, 2007, but before July 1, 2009, payments to eligible hospitals described in clause (B) shall be made as follows:

(i) The payment to an eligible hospital that merged two (2) hospitals under a single Medicaid provider number effective January 1, 2004, shall equal one hundred percent (100%) of the hospital's hospital-specific limit for the state fiscal year ending June 30, 2005, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.

(ii) The payment to an eligible hospital described in clause (B) other than a hospital described in item (i) shall equal one hundred percent (100%) of the hospital's hospital specific limit for the state fiscal year ending June 30, 2004, when the payment is combined with any

Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.

(D) For state fiscal years beginning after June 30, 2009, payments to an eligible hospital described in clause (B) shall be made in a manner determined by the office.

(E) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A), and clauses (C) or (D), the remaining amount may be paid as described in clause (F) to a hospital described in subsection (a) that is described as eligible under this clause. A hospital is eligible for a payment for a state fiscal year under clause (F) if the hospital:

(i) is eligible to receive Medicaid disproportionate share payments for the state fiscal year for which the Medicaid disproportionate share payment is attributable under IC 12-15-19-2.1, for a state fiscal year ending after June 30, 2007; and

(ii) does not receive a payment under clauses (C) or (D) for the state fiscal year.

A payment to a hospital under this clause is subject to the availability of non-federal matching funds.

(F) Payments to eligible hospitals described in clause (E) shall be made:

(i) to best use federal matching funds available for hospitals that are eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(ii) by using a methodology that allocates available funding under this clause, Medicaid supplemental payments, and payments under IC 12-15-19-2.1, in a manner in which all hospitals eligible under clause (E) receive payments in a manner that takes into account the situation of eligible hospitals that have historically qualified for Medicaid disproportionate share payments and ensures that payments for eligible hospitals are equitable.

(G) If the Centers for Medicare and Medicaid Services does not approve the payment methodologies in clauses (A) through (F), the office may implement alternative payment methodologies, that are eligible for federal financial participation, to implement a program consistent with the payments for hospitals described in clauses (A) through (F).

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of ~~subsection~~ **subsections** (b) **or (c).** The distribution to other hospitals under STEP FIVE of subsection (b) **or (c)** may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the

office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) **or (c)** pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends calculated by the office.

SECTION 14. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2007,** a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b).~~ **IC 12-16-7.5-4.5.**

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of~~

~~IC 12-16-7.5-4.5(b).~~ **IC 12-16-7.5-4.5.** Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b).~~ **IC 12-16-7.5-4.5.**

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under subsection (c) **and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.~~ **IC 12-16-7.5-4.5.**

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

~~(i)~~ **(j)** For purposes of ~~this section:~~ **subsection (c):**

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

SECTION 15. IC 12-15-15-9.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **but before July 1, 2007,** a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under ~~this section:~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under subsection (c) **or (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is derived from funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** and not expended under section 9 of this chapter. ~~To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE.~~

~~(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed; and~~

~~(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.~~

~~The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.~~

~~(f)~~ **(g)** Except as provided in subsection ~~(g),~~ **(h),** the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

~~(g)~~ **(h)** If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

~~(h)~~ **(i)** Any funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** remaining after payments are made under this section shall be used as provided in ~~IC 12-15-20-2(8)(D).~~ **IC 12-15-20-2(8).**

(i) For purposes of ~~this section.~~ **subsection (c):**

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 16. IC 12-15-15-9.6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.6. **For state fiscal years beginning after June 30, 2007,** the total amount of payments to hospitals under sections 9 and 9.5 of this chapter may not exceed the amount ~~transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).~~ **paid to hospitals under sections 9 and 9.5 of this chapter for the state fiscal year ending June 30, 2007.**

SECTION 17. IC 12-15-15-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21; and

(2) qualifies as a provider under **IC 12-15-16, IC 12-15-17, or IC 12-15-19 of** the Medicaid disproportionate share provider program.

(b) The office may, after consulting with affected providers, do one (1) or more of the following:

~~(1) Expand the payment program established under section 1.1(b) of this chapter to include all hospitals described in subsection (a).~~

~~(2)~~ **(1)** Establish a nominal charge hospital payment program.

~~(3)~~ **(2)** Establish any other permissible payment program.

(c) A program expanded or established under this section is subject to the availability of:

(1) intergovernmental transfers; ~~or~~

(2) funds certified as being eligible for federal financial participation; **or**

(3) other permissible sources of non-federal share dollars.

(d) The office may not implement a program under this section until the federal Centers for Medicare and Medicaid Services approves the provisions regarding the program in the amended state plan for medical assistance.

(e) The office may determine not to continue to implement a program established under this section if federal financial participation is not available.

SECTION 18. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;

(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments ~~net of intergovernmental transfers made by or on behalf of~~ **for** qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

~~(d) The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~

~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).~~

SECTION 19. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits, **including intergovernmental transfers of funds and certifications of expenditures,** to permit the office to make the state's share of the required disproportionate share payments.

(b) **For state fiscal years beginning after June 30, 2006,** if:

(1) sufficient deposits have not been received; **or**

(2) the statewide Medicaid disproportionate share allocation is insufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' hospital-specific limits;

the office shall reduce disproportionate share payments **made under IC 12-15-19-2.1 and Medicaid safety-net payments made in accordance with the Medicaid state plan** to ~~all~~ eligible institutions ~~by the same percentage.~~ **using an equitable methodology consistent with subsection (c).**

(c) For state fiscal years beginning after June 30, 2006, payments reduced under this section shall, in accordance with the Medicaid state plan, be made:

(1) to best utilize federal matching funds available for hospitals eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(2) by utilizing a methodology that allocates available funding under this subdivision, and Medicaid supplemental payments as defined in IC 12-15-15-1.5, in a manner that all hospitals eligible for Medicaid disproportionate share payments under

IC 12-15-19-2.1 receive payments using a methodology that:

(A) takes into account the situation of the eligible hospitals that have historically qualified for Medicaid disproportionate share payments; and

(B) ensures that payments for eligible hospitals are equitable.

(d) The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid disproportionate share allocation or the** amounts that can be financed with:

(1) ~~the state share that is in~~ the **amount transferred from the hospital care for the indigent trust** fund;

(2) other intergovernmental transfers;

(3) certifications of public expenditures; or

(4) any other permissible sources of non-federal match.

SECTION 20. IC 12-15-20-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. The Medicaid indigent care trust fund is established to pay the non-federal share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19-1.

(2) Subject to subdivision (8), disproportionate share payments to providers under IC 12-15-19-2.1.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14.

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

(5) Payments to hospitals under IC 12-15-15-9.

(6) Payments to hospitals under IC 12-15-15-9.5.

(7) Payments, funding, and transfers as otherwise provided in clauses (8)(D), ~~and~~ (8)(F), **and (8)(G).**

(8) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, the following apply:

(A) The entirety of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for state fiscal years ending on or before June 30, 2000, shall be used to fund the state's share of the disproportionate share payments to providers under IC 12-15-19-2.1.

(B) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year ending June 30, 2001, an amount equal to one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal year shall be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(C) Of the intergovernmental transfers deposited into the

Medicaid indigent care trust fund, for state fiscal years beginning July 1, 2001, and July 1, 2002, an amount equal to:

(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998; minus

(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under IC 12-15-15-9(d) for the state fiscal years beginning July 1, 2001, and July 1, 2002;

shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, must be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(D) ~~Of~~ The intergovernmental transfers, which shall include amounts transferred under ~~IC 12-16-7.5-4.5(b), STEP FOUR,~~ **IC 12-16-7.5-4.5,** deposited into the Medicaid indigent care trust fund **and the certifications of public expenditures deemed to be made to the medicaid indigent care trust fund,** for **the** state fiscal years ending after June 30, ~~2003,~~ **2005, but before July 1, 2007,** ~~an amount equal to:~~

~~(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, minus~~

~~(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year ending after June 30, 2003,~~

shall be used, ~~to fund the non-federal share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal years shall be used to fund, in descending order of priority, the non-federal share of payments to hospitals under IC 12-15-15-9, the non-federal share of payments to hospitals under IC 12-15-15-9.5, the amount to be transferred under clause (F), and the non-federal share of payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).~~ **in descending order of priority, as follows:**

(i) As provided in clause (B) of STEP THREE of IC 12-16-7.5-4.5(b)(1) and clause (B) of STEP THREE of IC 12-16-7.5-4.5(b)(2), to fund the amount to be transferred to the office.

(ii) As provided in clause (C) of STEP THREE of IC 12-16-7.5-4.5(b)(1) and clause (C) of STEP THREE of IC 12-16-7.5-4.5(b)(2), to fund the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5.

(iii) To fund the non-federal share of the payments made

under IC 12-15-15-1.1, IC 12-15-15-1.3, and IC 12-15-19-8.

(iv) As provided under clause (A) of STEP THREE of IC 12-16-7.5-4.5(b)(1) and clause (A) of STEP THREE of IC 12-16-7.5-4.5(b)(2), for the payment to be made under clause (A) of STEP FIVE of IC 12-15-15-1.5(b).

(v) As provided under STEP FOUR of IC 12-16-7.5-4.5(b)(1) and STEP FOUR of IC 12-16-7.5-4.5(b)(2), to fund the payments to be made under clause (B) of STEP FIVE of IC 12-15-15-1.5(b).

(vi) To fund, in an order of priority determined by the office to best use the available non-federal share, the programs listed in clause (H).

(E) **For state fiscal years ending after June 30, 2007,** the total amount of intergovernmental transfers used to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the amount ~~calculated under STEP TWO of the following formula: STEP ONE: Calculate the total amount of funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).~~

~~STEP TWO: Multiply the state Medicaid medical assistance percentage for the state fiscal year for which the payments under IC 12-15-15-9 and IC 12-15-15-9.5 are to be made by the amount calculated under STEP ONE.~~ **provided in clause (G)(ii).**

(F) As provided in clause (D), for **the following:**

(i) Each **state** fiscal year ending after June 30, 2003, **but before July 1, 2005,** an amount equal to the amount calculated under STEP THREE of the following formula shall be transferred to the office:

STEP ONE: Calculate the product of thirty-five million dollars ($35,000,000) multiplied by the federal medical assistance percentage for federal fiscal year 2003.

STEP TWO: Calculate the sum of the amounts, if any, reasonably estimated by the office to be transferred or otherwise made available to the office for the state fiscal year, and the amounts, if any, actually transferred or otherwise made available to the office for the state fiscal year, under arrangements whereby the office and a hospital licensed under IC 16-21-2 agree that an amount transferred or otherwise made available to the office by the hospital or on behalf of the hospital shall be included in the calculation under this STEP.

STEP THREE: Calculate the amount by which the product calculated under STEP ONE exceeds the sum calculated under STEP TWO.

(ii) The state fiscal years ending after June 30, 2005, but before July 1, 2007, an amount equal to thirty million dollars ($30,000,000) shall be transferred to the office.

(G) Subject to IC 12-15-20.7-2(b), for each state fiscal year ending after June 30, 2007, the total amount in the

Medicaid indigent care trust fund, including the amount of intergovernmental transfers of funds transferred, and the amounts of certifications of expenditures eligible for federal financial participation deemed to be transferred, to the Medicaid indigent care trust fund, shall be used to fund the following:

(i) Thirty million dollars ($30,000,000) transferred to the office for the Medicaid budget.

(ii) An amount not to exceed the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(iii) An amount not to exceed the non-federal share of payments to hospitals made under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(iv) An amount not to exceed the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-8.

(v) An amount not to exceed the non-federal share of payments to hospitals under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(vi) An amount not to exceed the non-federal share of Medicaid safety-net payments.

(vii) An amount not to exceed the non-federal share of payments to hospitals made under clauses (C) or (D) of STEP FIVE of IC 12-15-15-1.5(c).

(viii) An amount not to exceed the non-federal share of payments to hospitals made under clause (F) of STEP FIVE of IC 12-15-15-1.5(c).

(ix) An amount not to exceed the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

(x) If additional funds are available after making payments under items (i) through (ix), to fund other Medicaid supplemental payments for hospitals approved by the office and included in the Medicaid state plan.

(H) For purposes of clause (D)(vi), the office shall fund the following:

(i) An amount equal to the non-federal share of the payments to the hospital that is eligible under this item, for payments made under clause (C) of STEP FIVE of IC 12-15-15-1.5(b) under an agreement with the office, Medicaid safety-net payments and any payment made under IC 12-15-19-2.1. The amount of the payments to the hospital under this item shall be equal to one hundred percent (100%) of the hospital's hospital-specific limit for state fiscal year 2005, when the payments are combined with payments made under IC 12-15-15-9, IC 12-15-15-9.5, and clause (B) of STEP FIVE of IC 12-15-15-1.5(b) for a state fiscal year. A hospital is eligible under this item if the hospital was eligible for Medicaid disproportionate share hospital

payments for the state fiscal year ending June 30, 1998, the hospital received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004, and the hospital merged two (2) hospitals under a single Medicaid provider number, effective January 1, 2004.

(ii) An amount equal to the non-federal share of payments to hospitals that are eligible under this item, for payments made under clause (C) of STEP FIVE of IC 12-15-15-1.5(b) under an agreement with the office, Medicaid safety-net payments, and any payment made under IC 12-15-19-2.1. The amount of payments to each hospital under this item shall be equal to one hundred percent (100%) of the hospital's hospital-specific limit for state fiscal year 2004, when the payments are combined with payments made to the hospital under IC 12-15-15-9, IC 12-15-15-9.5, and clause (B) of STEP FIVE of IC 12-15-15-1.5(b) for a state fiscal year. A hospital is eligible under this item if the hospital did not receive a payment under item (i), the hospital has less than sixty thousand (60,000) Medicaid inpatient days annually, the hospital either was eligible for Medicaid disproportionate share hospital payments for the state fiscal year ending June 30, 1998 or the hospital met the office's Medicaid disproportionate share payment criteria based on state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001, and the hospital received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

(iii) Subject to IC 12-15-19-6, an amount not less than the non-federal share of Medicaid safety-net payments in accordance with the Medicaid state plan.

(iv) An amount not less than the non-federal share of payments made under clause (C) of STEP FIVE of IC 12-15-15-1.5(b) under an agreement with the office to a hospital having sixty thousand (60,000) Medicaid inpatient days annually.

(v) An amount not less than the non-federal share of Medicaid disproportionate share payments for hospitals eligible under this item, and made under IC 12-15-19-6 and the approved Medicaid state plan. A hospital is eligible for a payment under this item if the hospital is eligible for payments under IC 12-15-19-2.1.

(vi) If additional funds remain after the payments made under (i) through (v), payments approved by the office and under the Medicaid state plan, to fund the non-federal share of other Medicaid supplemental payments for hospitals.

SECTION 21. IC 12-15-20.7-2 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. **(a)** For each state fiscal year **ending before July 1, 2005, and** subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(2) Second, payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).

(3) Third, Medicaid inpatient payments for safety-net hospitals and Medicaid outpatient payments for safety-net hospitals.

(4) Fourth, payments under IC 12-15-15-1.1 and 12-15-15-1.3.

(5) Fifth, payments under IC 12-15-19-8 for municipal disproportionate share hospitals.

(6) Sixth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(b).

(b) For each state fiscal year ending after June 30, 2007, the office shall make the payments for the programs identified in IC 12-15-20-2(8)(G) in the order of priority that best utilizes available non-federal share, Medicaid supplemental payments, and Medicaid disproportionate share payments, and may change the order or priority at any time as necessary for the proper administration of one (1) or more of the payment programs listed in IC 12-15-20-2(8)(G).

SECTION 22. IC 12-15-44 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 44. Indiana Check-Up Plan

Sec. 1. As used in this chapter, "plan" refers to the Indiana check-up plan established by section 3 of this chapter.

Sec. 2. As used in this chapter, "preventative care services" means care that is provided to an individual to prevent disease, diagnose disease, or promote good health.

Sec. 3. (a) The Indiana check-up plan is established.

(b) The office shall administer the plan.

(c) The department of insurance and the office of the secretary shall provide oversight of the marketing practices of the plan.

(d) The office shall promote the plan and provide information to potential eligible individuals who live in medically underserved rural areas of Indiana.

(e) The office shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Indiana in proportion to the number of individuals throughout Indiana who are eligible for participation in the plan.

(f) The office shall establish standards for consumer protection, including the following:

(1) Quality of care standards.

(2) A uniform process for participant grievances and appeals.

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

(g) A health care provider that provides care to an individual

who receives health insurance coverage under the plan shall participate in the Medicaid program under IC 12-15.

(h) The office of the secretary may refer an individual who:

(1) has applied for health insurance coverage under the plan; and

(2) is at high risk of chronic disease;

to the Indiana comprehensive health insurance association for administration of the individual's plan benefits under IC 27-8-10.1.

(i) The following do not apply to the plan:

(1) IC 12-15-6.

(2) IC 12-15-12.

(3) IC 12-15-13.

(4) IC 12-15-14.

(5) IC 12-15-15.

(6) IC 12-15-21.

(7) IC 12-15-26.

(8) IC 12-15-31.1.

(9) IC 12-15-34.

(10) IC 12-15-35.

(11) IC 12-15-35.5.

(12) IC 16-42-22-10.

Sec. 4. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(b) The plan must do the following:

(1) Offer coverage for dental and vision services to an individual who participates in the plan.

(2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1).

(c) An individual who receives the dental or vision coverage offered under subsection (b) shall pay an amount determined by the office for the coverage. The office shall limit the payment to not more than five percent (5%) of the individual's annual household

income. The payment required under this subsection is in addition to the payment required under section 11(b)(2) of this chapter for coverage under the plan.

(d) Vision services offered by the plan must include services provided by an optometrist.

(e) The plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana.

(f) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

Sec. 5. (a) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(b) The plan shall, at no cost to the individual, provide payment for not more than five hundred dollars ($500) of qualifying preventative care services per year for an individual who participates in the plan. Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

Sec. 6. The plan has the following per participant coverage limitations:

(1) An annual individual maximum coverage limitation of three hundred thousand dollars ($300,000).

(2) A lifetime individual maximum coverage limitation of one million dollars ($1,000,000).

Sec. 7. The following requirements apply to funds appropriated by the general assembly to the plan:

(1) At least eighty-five percent (85%) of the funds must be used to fund payment for health care services.

(2) An amount determined by the office of the secretary to fund:

(A) administrative costs of; and

(B) any profit made by;

an insurer or a health maintenance organization under a contract with the office to provide health insurance coverage under the plan. The amount determined under this subdivision may not exceed fifteen percent (15%) of the funds.

Sec. 8. The plan is not an entitlement program. The maximum enrollment of individuals who may participate in the plan is dependent on funding appropriated for the plan.

Sec. 9. (a) An individual is eligible for participation in the plan if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(3) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(4) The individual is not eligible for health insurance coverage through the individual's employer.

(5) The individual has not had health insurance coverage for at least six (6) months.

(b) The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) A pregnant woman for purposes of pregnancy related services.

(3) An individual who is eligible for the Medicaid program as a disabled person.

(c) The eligibility requirements specified in subsection (a) are subject to approval for federal financial participation by the United States Department of Health and Human Services.

Sec. 10. (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan only by the following:

(1) The individual.

(2) An employer.

(3) The state.

(b) The minimum funding amount for a health care account is the amount required under section 11 of this chapter.

(c) An individual's health care account must be used to pay the individual's deductible for health care services under the plan.

(d) An individual may make payments to the individual's health care account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this chapter and distributed equally throughout the calendar year.

(2) Submission of the individual's contribution under this chapter to the office to deposit in the individual's health care account in a manner prescribed by the office.

(3) Another method determined by the office.

(e) An employer may make, from funds not payable by the employer to the employee, not more than fifty percent (50%) of an individual's required payment to the individual's health care account.

Sec. 11. (a) An individual's participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation may not exceed one-twelfth (1/12) of the annual payment required under subsection (b).

(b) To participate in the plan, an individual shall do the following:

(1) Apply for the plan on a form prescribed by the office. The

office may develop and allow a joint application for a household.

(2) If the individual is approved by the office to participate in the plan, contribute to the individual's health care account the lesser of the following:

(A) One thousand one hundred dollars ($1,100) per year, less any amounts paid by the individual under the:

(i) Medicaid program under IC 12-15;

(ii) children's health insurance program under IC 12-17.6; and

(iii) Medicare program (42 U.S.C. 1395 et seq.);

as determined by the office.

(B) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

(i) two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%);

(ii) three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%);

(iii) four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%); or

(iv) five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%);

of the federal income poverty level.

(c) The state shall contribute the difference to the individual's account if the individual's payment required under subsection (b)(2) is less than one thousand one hundred dollars ($1,100).

(d) If an individual's required payment to the plan is not made within sixty (60) days after the required payment date, the individual may be terminated from participation in the plan. The individual must receive written notice before the individual is terminated from the plan.

(e) After termination from the plan under subsection (d), the individual may not reapply to participate in the plan for twelve (12) months.

Sec. 12. (a) An individual who is approved to participate in the plan is eligible for a twelve (12) month plan period. An individual

who participates in the plan may not be refused renewal of participation in the plan for the sole reason that the plan has reached the plan's maximum enrollment.

(b) If the individual chooses to renew participation in the plan, the individual shall complete a renewal application and any necessary documentation, and submit to the office the documentation and application on a form prescribed by the office.

(c) If the individual chooses not to renew participation in the plan, the individual may not reapply to participate in the plan for at least twelve (12) months.

(d) Any funds remaining in the health care account of an individual who renews participation in the plan at the end of the individual's twelve (12) month plan period must be used to reduce the individual's payments for the subsequent plan period. However, if the individual did not, during the plan period, receive all qualified preventative services recommended as provided in section 5 of this chapter, the state's contribution to the health care account may not be used to reduce the individual's payments for the subsequent plan period.

(e) If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the office shall, not more than sixty (60) days after the last date of participation in the plan, refund to the individual the amount determined under subsection (f) of any funds remaining in the individual's health care account as follows:

(1) An individual who is no longer eligible for the plan or does not renew participation in the plan at the end of the plan period shall receive the amount determined under STEP FOUR of subsection (f).

(2) An individual who is terminated from the plan due to nonpayment of a required payment shall receive the amount determined under STEP FIVE of subsection (f).

(f) The office shall determine the amount payable to an individual described in subsection (e) as follows:

STEP ONE: Determine the total amount paid into the individual's health care account under section 10(d) of this chapter.

STEP TWO: Determine the total amount paid into the individual's health care account from all sources.

STEP THREE: Divide STEP ONE by STEP TWO.

STEP FOUR: Multiply the ratio determined in STEP THREE by the total amount remaining in the individual's health care account.

STEP FIVE: Multiply the amount determined under STEP FOUR by seventy-five hundredths (0.75).

Sec. 13. Subject to appeal to the office, an individual may be held responsible under the plan for receiving nonemergency services in an emergency room setting, including prohibiting the individual from using funds in the individual's health care account to pay for the nonemergency services. However, an individual may

not be prohibited from using funds in the individual's health care account to pay for nonemergency services provided in an emergency room setting for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

Sec. 14. (a) An insurer or health maintenance organization that contracts with the office to provide health insurance coverage, dental coverage, or vision coverage to an individual that participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a reimbursement rate of:

(A) not less than the federal Medicare reimbursement rate for the service provided; or

(B) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan, unless the individual has met the coverage limitations described in section 6 of this chapter.

(b) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

Sec. 15. (a) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) has not had health insurance coverage during the previous six (6) months; and

(2) meets the eligibility requirements specified in section 9 of this chapter for participation in the plan but is not enrolled because the plan has reached maximum enrollment.

(b) The insurance underwriting and rating practices applied to health insurance coverage offered under subsection (a) must not be different from underwriting and rating practices used for the health insurance coverage provided under the plan.

(c) The state does not provide funding for health insurance coverage received under this section.

Sec. 16. (a) An insurer or a health maintenance organization

that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) has not had health insurance coverage during the previous six (6) months; and

(2) does not meet the eligibility requirements specified in section 9 of this chapter for participation in the plan.

(b) An insurer, a health maintenance organization, or an affiliate described in subsection (a) may apply to health insurance coverage offered under subsection (a) the insurer's, health maintenance organization's, or affiliate's standard individual or small group insurance underwriting and rating practices.

(c) The state does not provide funding for health insurance coverage received under this section.

Sec. 17. (a) The Indiana check-up plan trust fund is established for the following purposes:

(1) Administering a plan created by the general assembly to provide health insurance coverage for low income residents of the state under this chapter.

(2) Providing copayments, preventative care services, and premiums for individuals enrolled in the plan.

(3) Funding tobacco use prevention and cessation programs, childhood immunization programs, and other health care initiatives designed to promote the general health and well being of Indiana residents.

The fund is separate from the state general fund.

(b) The fund shall be administered by the office of the secretary of family and social services.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The fund shall consist of the following:

(1) Cigarette tax revenues designated by the general assembly to be part of the fund.

(2) Other funds designated by the general assembly to be part of the fund.

(3) Federal funds available for the purposes of the fund.

(4) Gifts or donations to the fund.

(e) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested.

(f) Money must be appropriated before funds are available for use.

(g) Money in the fund does not revert to the state general fund at the end of any fiscal year.

(h) The fund is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the fund by the state board of finance, the budget agency, or any other state agency.

Sec. 18. (a) The office may not:

(1) enroll applicants;
(2) approve any contracts with vendors to provide services or administer the plan;
(3) incur costs other than costs necessary to study and plan for the implementation of the plan; or
(4) create financial obligations for the state;

unless both of the conditions of subsection (b) are satisfied.

(b) The office may not take any action described in subsection (a) unless:

(1) there is a specific appropriation from the general assembly to implement the plan; and
(2) after review by the budget committee, the budget agency approves an actuarial analysis that reflects a determination that sufficient funding is reasonably estimated to be available to operate the plan for at least the following five (5) years.

The actuarial analysis approved under subdivision (2) must clearly indicate the cost and revenue assumptions used in reaching the determination.

(c) The office may not operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations authorized for the plan.

Sec. 19. (a) The office may adopt rules under IC 4-22-2 necessary to implement this chapter.

(b) The office may adopt emergency rules under IC 4-22-2-37.1 to implement the plan on an emergency basis.

(c) Notwithstanding IC 12-8-1-9 and IC 12-8-3, rules adopted under this section before January 1, 2009, are not subject to review or approval by the family and social services committee established by IC 12-8-3-2. This subsection expires December 31, 2009.

Sec. 20. (a) The office may establish a health insurance coverage premium assistance program for individuals who:

(1) have an annual household income of not more than two hundred percent (200%) of the federal income poverty level; and
(2) are eligible for health insurance coverage through an employer but can not afford the health insurance coverage premiums.

(b) A program established under this section must:

(1) contain eligibility requirements that are similar to the eligibility requirements of the plan;
(2) include a health care account as a component; and
(3) provide that an individual's payment:
(A) to a health care account; or
(B) for a health insurance coverage premium;
may not exceed five percent (5%) of the individual's annual income.

Sec. 21. A denial of federal approval and federal financial participation that applies to any part of this chapter does not prohibit the office from implementing any other part of this chapter that:

(1) is federally approved for federal financial participation; or

(2) does not require federal approval or federal financial participation.

SECTION 23. IC 12-16-3.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. A ~~hospital shall~~ **provider may** provide a patient, and if the patient is not able to understand the statement, the patient's representative, with a statement of the eligibility and benefit standards adopted by the division if at least one (1) of the following occurs:

(1) The ~~hospital~~ **provider** has reason to believe that the patient may be indigent.

(2) The patient requests a statement of the standards.

SECTION 24. IC 12-16-4.5-1, AS AMENDED BY P.L.145-2005, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) To receive assistance under the hospital care for the indigent program under this article, a ~~hospital, a physician, a transportation~~ provider, the person, or the person's representative must file an application regarding the person with the division.

(b) Upon receipt of an application under subsection (a), the division shall determine whether the person is a resident of Indiana and, if so, the person's county of residence. If the person is a resident of Indiana, the division shall provide a copy of the application to the county office of the person's county of residence. If the person is not a resident of Indiana, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred. If the division cannot determine whether the person is a resident of Indiana or, if the person is a resident of Indiana, the person's county of residence, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred.

(c) A county office that receives a request from the division shall cooperate with the division in determining whether a person is a resident of Indiana and, if the person is a resident of Indiana, the person's county of residence.

SECTION 25. IC 12-16-4.5-2, AS AMENDED BY P.L.145-2005, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. A ~~hospital, physician, or transportation~~ provider must file the application with the division not more than forty-five (45) days after the person has been released or discharged from the hospital, unless the person is medically unable and the next of kin or legal representative is unavailable.

SECTION 26. IC 12-16-4.5-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 7. (a) A patient must sign an application if the patient is medically able to sign.

(b) If a patient is medically unable to sign an application, the patient's next of kin or a legal representative, if available, may sign the application.

(c) If no person under subsections (a) and (b) is able to sign the application to file a timely application, a ~~hospital~~ **provider's** representative may sign the application instead of the patient.

SECTION 27. IC 12-16-4.5-8.5, AS ADDED BY P.L.145-2005, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2007]: Sec. 8.5. A claim for ~~hospital items or services, physician services, or transportation~~ services must be filed with the division not more than one hundred eighty (180) days after the person who received the care has been released or discharged from the hospital. For good cause as determined by the division, this one hundred eighty (180) day limit may be extended or waived for a claim.

SECTION 28. IC 12-16-5.5-1, AS AMENDED BY P.L.145-2005, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) The division shall, upon receipt of an application of or for a person who was admitted to, or who was otherwise provided care by a ~~hospital,~~ **provider,** promptly investigate to determine the person's eligibility under the hospital care for the indigent program. The division shall consider the following information obtained by the ~~hospital~~ **provider** regarding the person:

(1) Income.

(2) Resources.

(3) Place of residence.

(4) Medical condition.

~~(5) Hospital care.~~

~~(6)~~ **(5)** Physician care.

~~(7)~~ **(6)** Transportation to and from the hospital.

The division may rely on the ~~hospital's~~ **provider's** information in determining the person's eligibility under the program.

(b) The division may choose not to interview the person if, based on the information provided to the division, the division determines that it appears that the person is eligible for the program. If the division determines that an interview of the person is necessary, the division shall allow the interview to occur by telephone with the person or with the person's representative if the person is not able to participate in the interview.

(c) The county office located in:

(1) the county where the person is a resident; or

(2) the county where the onset of the medical condition that necessitated the care occurred if the person's Indiana residency or Indiana county of residence cannot be determined;

shall cooperate with the division in determining the person's eligibility under the program.

SECTION 29. IC 12-16-5.5-1.2, AS ADDED BY P.L.145-2005, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.2. (a) The division shall, upon receipt of a claim pertaining to a person:

(1) who was ~~admitted to, or who was otherwise~~ provided care by ~~a hospital,~~ **an eligible provider;** and

(2) whose medical condition satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3);

promptly review the claim to determine if the health care items or services identified in the claim were necessitated by the person's medical condition or, if applicable, if the items or services were a direct consequence of the person's medical condition.

(b) In conducting the review of a claim referenced in subsection (a), the division shall calculate the amount of the claim. For purposes of this section, IC 12-15-15-9, IC 12-15-15-9.5, IC 12-16-6.5, and IC 12-16-7.5, the amount of a claim shall be calculated in a manner described in IC 12-16-7.5-2.5(c).

SECTION 30. IC 12-16-5.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) The ~~hospital providing~~ **provider of** medical care to a patient shall provide information the ~~hospital~~ **provider** has that would assist in the verification of indigency of a patient.

(b) A ~~hospital~~ **provider** that provides information under subsection (a) is immune from civil and criminal liability for divulging the information.

SECTION 31. IC 12-16-5.5-3, AS AMENDED BY P.L.145-2005, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) Subject to subsection (b) and IC 12-16-6.5-1.5, if the division is unable after prompt and diligent efforts to verify information contained in the application that is reasonably necessary to determine eligibility, the division may deny assistance under the hospital care for the indigent program. The pending expiration of the period specified in IC 12-16-6.5-1.5 is not a valid reason for denying a person's eligibility for the hospital care for the indigent program.

(b) Before denying assistance under the hospital care for the indigent program, the division must provide the person **and** the ~~hospital, and any other~~ provider who submitted a claim under IC 12-16-4.5-8.5 written notice of:

(1) the specific information or verification needed to determine eligibility;

(2) the specific efforts undertaken to obtain the information or verification; and

(3) the statute or rule requiring the information or verification identified under subdivision (1).

(c) The division must provide the ~~hospital and any other~~ provider who submitted a claim under IC 12-16-4.5-8.5 a period of time, not less than ten (10) days beyond the deadline established under IC 12-16-6.5-1.5, to submit to the division information concerning the person's eligibility. If the division does not make a determination of the person's eligibility within ten (10) days after receiving the information under this subsection, the person is eligible without the division's determination of the person's eligibility for the hospital care for the indigent care program under this article.

SECTION 32. IC 12-16-5.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. The division shall notify in writing the person and the ~~hospital~~ **provider** of the following:

(1) A decision concerning eligibility.

(2) The reasons for a denial of eligibility.

(3) That either party has the right to appeal the decision.

SECTION 33. IC 12-16-6.5-1, AS AMENDED BY P.L.145-2005, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. If the division determines that a person is not

eligible for assistance for ~~medical care, hospital care, or transportation~~ services, an affected person ~~physician, hospital~~, or ~~transportation~~ provider may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person ~~physician, hospital,~~ or ~~transportation~~ provider to the last known address of the person ~~physician, hospital,~~ or ~~transportation~~ provider.

SECTION 34. IC 12-16-6.5-1.2, AS ADDED BY P.L.145-2005, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.2. (a) If the division determines that an item or service identified in a claim:

(1) was not necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was not a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the affected person ~~physician, hospital, and transportation~~ **or** provider may appeal to the division not later than ninety (90) days after the mailing of the notice of that determination to the affected person ~~physician, hospital,~~ or ~~transportation~~ provider to the last known address of the person ~~physician, hospital,~~ or ~~transportation~~ provider.

(b) If the division determines that an item or service identified in a claim:

(1) was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

but the affected ~~physician, hospital, or transportation~~ provider disagrees with the amount of the claim calculated by the division under IC 12-16-5.5-1.2(b), the affected ~~physician, hospital, or transportation~~ provider may appeal the calculation to the division not later than ninety (90) days after the mailing of the notice of that calculation to the affected ~~physician, hospital, or transportation~~ provider to the last known address of the ~~physician, hospital, or transportation~~ provider.

SECTION 35. IC 12-16-6.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. A notice of the hearing shall be served upon all persons interested in the matter, including any affected ~~physician, hospital, or transportation~~ provider, at least twenty (20) days before the time fixed for the hearing.

SECTION 36. IC 12-16-7.5-1.2, AS ADDED BY P.L.145-2005, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.2. (a) A person determined to be eligible under the hospital care for the indigent program is not financially obligated for ~~hospital items or services, physician services, or transportation~~ services provided to the person during the person's eligibility under the program, if the items or services were:

(1) identified in a claim filed with the division under IC 12-16-4.5; and

(2) determined:

(A) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) ~~Based on a hospital's items or services identified in a claim under subsection (a), the hospital~~ **Hospitals** may receive a payment from the office calculated and made under IC 12-15-15-9 and, if applicable, IC 12-15-15-9.5. **Hospitals shall not file claims for payments under IC 12-15-15-9 and IC 12-15-15-9.5 for payments attributable to state fiscal years beginning after June 30, 2007.**

(c) Based on a physician's services identified in a claim under subsection (a), the physician may receive a payment from the division calculated and made under section 5 of this chapter.

(d) Based on the transportation services identified in a claim under subsection (a), the transportation provider may receive a payment from the division calculated and made under section 5 of this chapter.

SECTION 37. IC 12-16-7.5-2.5, AS AMENDED BY P.L.1-2006, SECTION 189, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.5. (a) Payable claims shall be segregated by state fiscal year.

(b) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14, "payable claim" refers to the following:

(1) Subject to subdivision (2), a claim for payment for physician care, hospital care, or transportation services under this chapter:

(A) that includes, on forms prescribed by the division, all the information required for timely payment;

(B) that is for a period during which the person is determined to be financially and medically eligible for the hospital care for the indigent program; and

(C) for which the payment amounts for the care and services are determined by the division.

This subdivision applies for the state fiscal year ending June 30, 2004.

(2) For state fiscal years ending after June 30, 2004, **and before July 1, 2007,** a claim for payment for physician care, hospital care, or transportation services under this chapter:

(A) provided to a person under the hospital care for the indigent program under this article during the person's eligibility under the program;

(B) identified in a claim filed with the division; and

(C) determined to:

(i) have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(ii) be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through

IC 12-16-3.5-1(a)(3).

(3) For state fiscal years beginning after June 30, 2007, a claim for payment for physician care or transportation services under this chapter:

(A) provided to a person under the hospital care for the indigent program under this article during the person's eligibility under the program;

(B) identified in a claim filed with the division; and

(C) determined to:

(i) be necessary after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the outcomes described in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(ii) be a direct consequence of the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the outcomes listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(c) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14, "amount" when used in regard to a claim or payable claim means an amount calculated under STEP THREE of the following formula:

STEP ONE: Identify the items and services identified in a claim or payable claim.

STEP TWO: Using the applicable Medicaid fee for service reimbursement rates, calculate the reimbursement amounts for each of the items and services identified in STEP ONE.

STEP THREE: Calculate the sum of the amounts identified in STEP TWO.

(d) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14, a ~~physician, hospital, or transportation~~ provider that submits a claim to the division is considered to have submitted the claim during the state fiscal year during which the amount of the claim was determined under IC 12-16-5.5-1.2(b) or, if successfully appealed by a ~~physician, hospital, or transportation~~ provider, the state fiscal year in which the appeal was decided.

(e) The division shall determine the amount of a claim under IC 12-16-5.5-1.2(b).

SECTION 38. IC 12-16-7.5-4.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4.5. (a) Not later than October 31 following the end of each state fiscal year, the division shall:

(1) calculate for each county the total amount of payable claims submitted to the division during the state fiscal year attributed to:

(A) patients who were residents of the county; and

(B) patients:

(i) who were not residents of Indiana;

(ii) whose state of residence could not be determined by the division; and

(iii) who were residents of Indiana but whose county of residence in Indiana could not be determined by the division;

and whose medical condition that necessitated the care or service occurred in the county;

(2) notify each county of the amount of payable claims attributed to the county under the calculation made under subdivision (1); and

(3) with respect to payable claims attributed to a county under subdivision (1):

(A) calculate the total amount of payable claims submitted during the state fiscal year for:

(i) each hospital;

(ii) each physician; and

(iii) each transportation provider; and

(B) determine the amount of each payable claim for each hospital, physician, and transportation provider listed in clause (A).

(b) **For the state fiscal years beginning after June 30, 2005, but before July 1, 2007, and** before November 1 following the end of a state fiscal year, the division shall allocate the funds transferred from a county's hospital care for the indigent fund to the state hospital care for the indigent fund under IC 12-16-14 during or for the **following** state fiscal ~~year.~~ **years:**

(1) For the state fiscal year ending June 30, 2006, as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred from all counties' hospital care for the indigent funds by the counties to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year from all counties under subsection (a), determine the amount that is the lesser of:

(A) the amount of total physician payable claims and total transportation provider payable claims; or

(B) three million dollars ($3,000,000).

The amount determined under this STEP shall be used by the division to make payments under section 5 of this chapter.

STEP THREE: Transfer an amount equal to the sum of:

(A) the non-federal share of the payments made under clause (A) of STEP FIVE of IC 12-15-15-1.5(b);

(B) the amount transferred under IC 12-15-20-2(8)(F); and

(C) the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5;

to the Medicaid indigent care trust fund for funding the transfer to the office and the non-federal share of the payments identified in this STEP.

STEP FOUR: Transfer an amount equal to sixty-one million dollars ($61,000,000) less the sum of:

(A) the amount determined in STEP TWO; and

(B) the amount transferred under STEP THREE;

to the Medicaid indigent care trust fund for funding the non-federal share of payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(b).

STEP FIVE: Transfer to the Medicaid indigent care trust fund for the programs referenced at IC 12-15-20-2(8)(D)(vi) and funded in accordance with IC 12-15-20-2(8)(H) the amount determined under STEP ONE, less the sum of the amount:

(A) determined in STEP TWO;

(B) transferred in STEP THREE; and

(C) transferred in STEP FOUR.

(2) For the state fiscal year ending June 30, 2007, as required under the following steps:

STEP ONE: Determine the total amount of funds transferred from all counties' hospital care for the indigent funds by the counties to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year from all counties under subsection (a), determine the amount that is the lesser of:

(A) the amount of total physician payable claims and total transportation provider payable claims; or

(B) three million dollars ($3,000,000).

The amount determined under this STEP shall be used by the division for making payments under section 5 of this chapter or for the non-federal share of Medicaid payments for physicians and transportation providers, as determined by the office.

STEP THREE: Transfer an amount equal to the sum of:

(A) the non-federal share of five million dollars ($5,000,000) for the payment made under clause (A) of STEP FIVE of IC 12-15-15-1.5(b);

(B) the amount transferred under IC 12-15-20-2(8)(F); and

(C) the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5;

to the Medicaid indigent care trust fund for funding the transfer to the office and the non-federal share of the payments identified in this STEP.

STEP FOUR: Transfer an amount equal to the amount determined under STEP ONE less the sum of:

(A) the amount determined in STEP TWO; and

(B) the amount transferred under STEP THREE;

to the Medicaid indigent care trust fund for funding the non-federal share of payments under clause (B) of STEP

FIVE of IC 12-15-15-1.5(b).

(c) For the state fiscal years beginning after June 30, 2007, before November 1 following the end of the state fiscal year, the division shall allocate the funds transferred from a county's hospital care for the indigent fund to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred from a county's hospital care for the indigent fund by the county to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year attributed to the county under subsection (a), determine the amount of total ~~hospital payable claims, total~~ physician payable claims, and total transportation provider payable claims. Of the amounts determined for physicians and transportation providers, calculate the sum of those amounts as a percentage of an amount equal to the sum of the total payable physician claims and total payable transportation provider claims attributed to all the counties submitted to the division during the state fiscal year.

STEP THREE: Multiply three million dollars ($3,000,000) by the percentage calculated under STEP TWO.

STEP FOUR: Transfer to the Medicaid indigent care trust fund for purposes of ~~IC 12-15-20-2(8)(D)~~ **IC 12-15-20-2(8)(G)** an amount equal to the amount calculated under STEP ONE, minus an amount equal to the amount calculated under STEP THREE.

STEP FIVE: The division shall retain an amount equal to the amount remaining in the state hospital care for the indigent fund after the transfer in STEP FOUR for purposes of making payments under section 5 of this chapter **or for the non-federal share of Medicaid payments for physicians and transportation providers, as determined by the office.**

~~(c)~~ **(d)** The costs of administering the hospital care for the indigent program, including the processing of claims, shall be paid from the funds transferred to the state hospital care for the indigent fund.

SECTION 39. IC 12-16-7.5-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 5. Before December 15 following the end of each state fiscal year, the division shall, from the amounts combined from the counties' hospital care for the indigent funds and retained under section 4.5(b) ~~STEP FIVE~~ **or 4.5(c)** of this chapter, pay each physician and transportation provider a pro rata part of that amount. The total payments available under this section may not exceed three million dollars ($3,000,000).

SECTION 40. IC 12-16-14-3, AS AMENDED BY P.L.246-2005, SECTION 111, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) ~~For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).~~

~~(b)~~ For taxes first due and payable in 2003, each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2002; multiplied by

(2) the county's assessed value growth quotient determined under IC 6-1.1-18.5-2 for taxes first due and payable in 2003.

~~(c)~~ **(b)** For taxes first due and payable in 2004, ~~2005, 2006, 2007, and 2008,~~ **and each year after 2004,** each county shall impose a hospital care for the indigent property tax levy equal to the ~~product of:~~ **hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year, multiplied by the statewide average assessed value growth quotients determined under IC 6-1.1-18.5-2, for the year in which the tax levy under this subsection is first due and payable.**

~~(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in the preceding year; multiplied by~~

~~(2) the assessed value growth quotient determined in the last STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.~~

~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

~~(d) Except as provided in subsection (e):~~

~~(1) for taxes first due and payable in 2009, each county shall impose a hospital care for the indigent property tax levy equal to the average of the annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the state fiscal years beginning:~~

~~(A) July 1, 2005;~~

~~(B) July 1, 2006; and~~

~~(C) July 1, 2007; and~~

~~(2) for all subsequent annual levies under this section, the average annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the three (3) most recently completed state fiscal years.~~

~~(e) A county may not impose an annual levy under subsection (d) in an amount greater than the product of:~~

~~(1) The greater of:~~

~~(A) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2008; or~~

~~(B) the amount of the county's maximum hospital care for the indigent property tax levy determined under this subsection for taxes first due and payable in the immediately preceding year; multiplied by~~

~~(2) the assessed value growth quotient determined in the last~~

~~STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.~~

~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

SECTION 41. IC 12-17.6-3-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) To be eligible to enroll in the program, a child must meet the following requirements:

(1) The child is less than nineteen (19) years of age.

(2) The child is a member of a family with an annual income of:

(A) more than one hundred fifty percent (150%); and

(B) not more than ~~two~~ **three** hundred percent ~~(200%),~~ **(300%);**

of the federal income poverty level.

(3) The child is a resident of Indiana.

(4) The child meets all eligibility requirements under Title XXI of the federal Social Security Act.

(5) The child's family agrees to pay any cost sharing amounts required by the office.

(b) The office may adjust eligibility requirements based on available program resources under rules adopted under IC 4-22-2.

SECTION 42. IC 12-17.6-3-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) Subject to ~~subsection~~ **subsections** (b) **and (c),** a child who is eligible for the program shall receive services from the program until the earlier of the following:

(1) The child becomes financially ineligible.

(2) The child becomes nineteen (19) years of age.

(b) Subsection (a) applies only if the child and the child's family comply with enrollment requirements.

(c) After a child who is less than three (3) years of age is determined to be eligible for the program, the child is not required to submit eligibility information more frequently than once in a twelve (12) month period until the child becomes three (3) years of age.

SECTION 43. IC 16-18-2-331.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 331.8. "Small employer", for purposes of IC 16-46-13 has the meaning set forth in IC 16-3.1-31.2-3.**

SECTION 44. IC 16-46-13 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 13. Small Employer Wellness Programs

Sec. 1. (a) The state department shall adopt rules under IC 4-22-2 to establish:

(1) minimum standards for use by a small employer in establishing a wellness program to improve the health of employees of the small employer; and

(2) criteria and a process for certification of a small employer's wellness program that meets the minimum standards established under subdivision (1) as a qualified wellness program for purposes of IC 6-3.1-31.2.

(b) The minimum standards established under subsection (a) must include a requirement that a wellness program provide rewards for employee:

(1) appropriate weight loss;

(2) smoking cessation; and

(3) pursuit of preventative health care services.

Sec. 2. (a) A small employer may submit to the state department for certification a wellness program developed by the small employer.

(b) The state department shall review and, based on the criteria established under section 1 of this chapter, make a determination of whether to certify a wellness program submitted under subsection (a) as a qualified wellness program.

(c) If a wellness program is certified by the state department, the state department shall provide to the small employer a certificate reflecting that the wellness program is a qualified wellness program for purposes of IC 6-3.1-31.2.

SECTION 45. IC 27-8-5-2, AS AMENDED BY SEA 94-2007, SECTION 194, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy ~~may~~ **must** insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children ~~under a specified age, which shall not exceed nineteen (19)~~ **who are less than twenty-four (24)** years **of age,** and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform

and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

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

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

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

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

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

(B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a child who has mental retardation or a mental or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than

one hundred twenty (120) days after August 18, 1969.

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

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

SECTION 46. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more

creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of

any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be

covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 47. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), ~~or~~ 16(7), **or 16(8)** of this chapter unless the commissioner finds that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

SECTION 48. IC 27-8-5-28 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-four (24) years of age.**

SECTION 49. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 10.1. High Risk Indiana Check-Up Plan Participants

Sec. 1. As used in this chapter, "association" means the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.

Sec. 2. As used in this chapter, "participant" means an individual entitled to coverage under the plan.

Sec. 3. As used in this chapter, "plan" refers to the Indiana check-up plan established by IC 12-15-44-3.

Sec. 4. (a) The association shall administer the plan for participants who are referred to the association by the office of the secretary of family and social services.

(b) Coverage under the plan is separate from the coverage provided under IC 27-8-10.

(c) The following apply to the administration of the plan under this chapter:

(1) Only participants referred by the office of the secretary of family and social services are eligible for plan coverage administered under this chapter.

(2) Plan coverage administered under this chapter must provide medical management services.

(d) A participant who is referred to the association under subsection (a) shall participate in medical management services provided under this chapter.

SECTION 50. IC 27-13-7-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

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

(2) Eligibility requirements.

(3) Benefits and services within the service area.

(4) Emergency care benefits and services.

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

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

(7) Limitations and exclusions.

(8) Enrollee termination provisions.

(9) Any enrollee reinstatement provisions.

(10) Claims procedures.

(11) Enrollee grievance procedures.

(12) Continuation of coverage provisions.

(13) Conversion provisions.

(14) Extension of benefit provisions.

(15) Coordination of benefit provisions.

(16) Any subrogation provisions.

(17) A description of the service area.

(18) The entire contract provisions.

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

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

(21) Right of renewal provisions.

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

(23) Grace period provisions.

(24) A provision on conformity with state law.

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

(A) guaranteed renewability; and

(B) group portability;

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

(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the date the child becomes twenty-four (24) years of age.

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

SECTION 51. IC 34-30-2-45.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 45.7. IC 12-16-5.5-2 (Concerning ~~hospitals~~ **providers** for providing information verifying indigency of patient).

SECTION 52. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2007]: IC 12-15-15-9.8; IC 12-15-20.7-3; IC 12-16-2.5-6.5; IC 12-16-8.5; IC 12-16-12.5.

SECTION 53. [EFFECTIVE JANUARY 1, 2007 (RETROACTIVE)] **IC 6-3.1-31 and IC 6-3.1-31.2, both as added by this act, apply only to taxable years beginning after December 31, 2006.**

SECTION 54. [EFFECTIVE JULY 1, 2007] **Notwithstanding IC 6-7-1-14, revenue stamps paid for before July 1, 2007, and in the possession of a distributor may be used after June 30, 2007, only if the full amount of the tax imposed by IC 6-7-1-12, as effective after June 30, 2007, and as amended by this act, is remitted to the department of state revenue under the procedures prescribed by the department.**

SECTION 55. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for any amendment to the state Medicaid plan or demonstration waiver that is needed to provide for presumptive eligibility for a pregnant woman described in IC 12-15-2-13, as amended by this act.

(c) The office may not implement the amendment or waiver until the office files an affidavit with the governor attesting that the amendment or waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that the amendment or waiver is approved.

(d) If the office receives approval for the amendment or waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (c), the office shall implement the amendment or waiver not more than sixty (60) days after the governor receives the affidavit.

(e) The office may adopt rules under IC 4-22-2 to implement this SECTION.

SECTION 56. [EFFECTIVE JULY 1, 2007] **(a) IC 27-8-5-2, as amended by this act, and IC 27-8-5-28, as added by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.**

(b) IC 27-13-7-3, as amended by this act, applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

SECTION 57. [EFFECTIVE JULY 1, 2007] **(a) The definitions in IC 12-15-44, as added by this act, apply to this SECTION.**

(b) As used in this SECTION, "task force" refers to the Indiana check-up plan task force established by subsection (c).

(c) The Indiana check-up plan task force is established to:

(1) study, monitor, provide guidance, and make recommendations to the state concerning the Indiana check-up plan;

(2) develop methods to increase availability of affordable coverage for health care services for all Indiana residents;

(3) develop an education and orientation program for

individuals participating in the plan; and

(4) make recommendations to the legislative council.

(d) The affirmative votes of a majority of the voting members appointed to the task force are required for the task force to take action on any measure, including final reports.

(e) The office of Medicaid policy and planning established by IC 12-8-6-1 shall staff the task force.

(f) The task force consists of the following voting members:

(1) Four (4) members described in subsection (g)(1) through (g)(4) appointed by the speaker of the house of representatives, two (2) of whom are appointed based on the recommendation of the minority leader of the house of representatives and none of whom are legislators.

(2) Four (4) members described in subsection (g)(5) through (g)(8) appointed by the president pro tempore of the senate, two (2) of whom are appointed based on the recommendation of the minority leader of the senate and none of whom are legislators.

(3) Four (4) members described in subsection (g)(9) through (g)(12) appointed by the governor, not more than two (2) of whom are members of the same political party.

(g) The members appointed under subsection (f) must represent the following interests:

(1) Hospitals.

(2) Insurance companies.

(3) Primary care providers.

(4) Health professionals who are not primary care providers.

(5) Minority health concern experts.

(6) Business.

(7) Organized labor.

(8) Consumers.

(9) Children's health issues.

(10) Adult health issues.

(11) Mental health issues.

(12) Pharmaceutical industry.

(h) The secretary of the office of the secretary of family and social services shall call the first meeting of the task force, at which the members shall elect the chairperson of the task force.

(i) The task force shall report findings and make recommendations to the governor and to the legislative council in an electronic format under IC 5-14-6 as follows:

(1) A report not later than November 1, 2008.

(2) A final report not later than November 1, 2009.

(j) The task force members are not eligible for per diem reimbursement or reimbursement for expenses incurred for travel to and from task force meetings.

(k) This SECTION expires December 31, 2009.

SECTION 58. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of

Health and Human Services for approval of a Section 1115 demonstration waiver or a Medicaid state plan amendment to develop and implement the following:

(1) Health insurance coverage program to cover individuals who meet the following requirements:

(A) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(B) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(C) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(D) The individual is not eligible for health insurance coverage through the individual's employer.

(E) The individual has been without health insurance coverage for at least six (6) months or is without health insurance coverage because of a change in employment.

(2) A premium assistance program described in IC 12-15-44-20, as added by this act.

(c) The office shall include in the waiver application or state plan amendment a request to fund the program in part by using:

(1) enhanced federal financial participation; and

(2) hospital care for the indigent dollars, upper payment limit dollars, or disproportionate share hospital dollars.

(d) The office may not implement the waiver or state plan amendment until the office:

(1) files an affidavit with the governor attesting that the federal waiver or amendment applied for under this SECTION is in effect; and

(2) has sufficient funding for the program.

The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver or amendment is approved.

(e) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(f) This SECTION expires December 31, 2013.

SECTION 59. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for approval of an amendment to the state's Medicaid plan that is necessary to do the following:

(1) Amend the state's upper payment limit program.

(2) Make changes to the state's disproportionate share hospital program.

(c) The office may not implement an approved amendment to the state plan until the office files an affidavit with the governor attesting that the state plan amendment applied for under subsection (b)(1) or (b)(2) of this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment is

approved.

(d) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(e) This SECTION expires December 31, 2013.

SECTION 60. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.**

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(c) The office shall report to the commission during the 2007 interim, updating the commission on the status of the development and implementation of the Indiana check-up plan established by IC 12-15-44-3, as added by this act.

(d) The commission shall, during the 2007 interim of the general assembly, study the following:

(1) Whether the acute care hospital in Gary, Indiana, should be converted from a private corporation to a county hospital, a municipal hospital, or other governmental hospital. In considering whether a conversion should occur, the commission shall consider the following:

(A) Whether the conversion would result in better quality care that would be sufficient to meet the needs of the community.

(B) Whether the hospital's finances would be improved.

(C) The legal requirements to convert the hospital.

(2) Ways in which the state and other entities can encourage physicians to practice in rural and county hospitals.

(3) The manner in which a not-for-profit hospital can be converted into a county or municipal hospital.

(4) Federal guidelines concerning county hospitals and intergovernmental transfers.

(5) A prohibition against smoking in public places in Indiana.

(6) Mechanisms for providing programs to provide health care coverage for uninsured individuals in Indiana.

(7) Review of the use of sources of funding for Medicaid reimbursement and implications for the uses of the funding sources.

(e) This SECTION expires December 31, 2008.

SECTION 61. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.**

(b) The commissioner of the department of insurance and the office of the secretary of family and social services may implement a program to allow two (2) or more small employers to join

together to purchase health insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION.

SECTION 62. [EFFECTIVE JULY 1, 2007] **(a) There is annually transferred from the state general fund to the Indiana tobacco use prevention and cessation trust fund established by IC 4-12-4-10 one million two hundred thousand dollars ($1,200,000) on a schedule determined by the office of management and budget. The transfer shall be treated as part of the amount described in IC 6-7-1-28.1(7), as added by this act. There is annually appropriated to the Indiana tobacco use prevention and cessation executive board one million two hundred thousand dollars ($1,200,000) from the state general fund for the purpose of tobacco education, prevention, and use control. The appropriation under this subsection is in addition to any other appropriation made by the general assembly to the Indiana tobacco use prevention and cessation executive board.**

(b) There is appropriated from the Indiana check-up plan trust fund established by IC 12-15-44-17, as added by this act, for the period beginning July 1, 2007, and ending June 30, 2008, eleven million dollars ($11,000,000) to the state department of health for use in childhood immunization programs. On June 30, 2008, the state department shall transfer to the Indiana check-up plan trust fund any unexpended funds appropriated to the state department under this subsection.

(c) There is appropriated from the Indiana check-up plan trust fund established by IC 12-15-44-17, as added by this act, for the period beginning July 1, 2008, and ending June 30, 2009, eleven million dollars ($11,000,000) to the state department of health for use in childhood immunization programs. On June 30, 2009, the state department shall transfer to the Indiana check-up plan trust fund any unexpended funds appropriated to the state department under this subsection.

(d) The money in the Indiana check-up plan trust fund established by IC 12-15-44-17, as added by this act, is appropriated to the office of the secretary of family and social services for the period beginning July 1, 2007, and ending June 30, 2009, for the purposes of the fund.

Section 63. **An emergency is declared for this act.**

(Reference is to EHB 1678 as printed March 23, 2007.)

Conference Committee Report
on
Engrossed House Bill 1678

Signed by:

_____	_____
Representative Brown C Chairperson	Senator Miller
_____	_____
Representative Brown T	Senator Simpson
House Conferees	**Senate Conferees**