



February 15, 2013

HOUSE BILL No. 1591

DIGEST OF HB 1591 (Updated February 13, 2013 7:29 pm - DI 104)

Citations Affected: IC 2-5; IC 12-15; noncode.

Synopsis: Medicaid matters. Establishes the Indiana affordable care committee and sets forth the committee's duties concerning the implementation of a health insurance exchange and the definition of "essential health benefits". Defines populations that may be subject to Medicaid resource requirements. Eliminates resource requirements in determining Medicaid eligibility for specified populations. Specifies policies that must be included in a contract entered into between the office of Medicaid policy and planning (office) and a managed care organization. Requires the office to apply to the United States Department of Health and Human Services for a state plan amendment or a Medicaid waiver to do the following: (1) Require a Medicaid recipient who is eligible for Medicaid based on the individual's aged, blind, or disabled status to enroll in risk-based managed care; (2) Authorize implementation of a Medicaid program to provide services to individuals with an income of less than 133% of the federal income poverty level and specifies components to be requested for the program; and (3) Require certain Medicaid recipients with an income of at least 150% of the federal income poverty level to make premium payments and require Medicaid recipients to participate in cost sharing. Requires the office to report to the health finance commission before October 1, 2013, concerning Indiana's use of risk-based managed care in Medicaid. Establishes the Indiana health benefit exchange advisory committee for the purpose of advising the office on policy and program administration concerning a health insurance exchange in Indiana and the expansion of Medicaid eligibility.

Effective: Upon passage; July 1, 2013.

Clere, Brown C, Brown T, Lehman

January 23, 2013, read first time and referred to Committee on Rules and Legislative Procedures.

January 31, 2013, reassigned to Committee on Public Health.

February 14, 2013, amended, reported — Do Pass.

HB 1591—LS 6665/DI 44+



C
O
P
Y

February 15, 2013

First Regular Session 118th General Assembly (2013)

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

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

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2012 Regular Session of the General Assembly.

C
O
P
Y

HOUSE BILL No. 1591

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

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

- 1 SECTION 1. IC 2-5-36 IS ADDED TO THE INDIANA CODE AS
2 A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON
3 PASSAGE]:
4 **Chapter 36. Indiana Affordable Care Study Committee**
5 **Sec. 1. As used in this chapter, "Affordable Care Act" refers to**
6 **the federal Patient Protection and Affordable Care Act (P.L.**
7 **111-148), as amended by the federal Health Care and Education**
8 **Reconciliation Act of 2010 (P.L. 111-152).**
9 **Sec. 2. As used in this chapter, "committee" refers to the**
10 **Indiana affordable care study committee established by section 4**
11 **of this chapter.**
12 **Sec. 3. As used in this chapter, "exchange" refers to an**
13 **American health benefit exchange established for Indiana under**
14 **the Affordable Care Act.**
15 **Sec. 4. (a) There is established the Indiana affordable care study**
16 **committee.**
17 **(b) The committee shall study and make recommendations**

HB 1591—LS 6665/DI 44+



- 1 concerning the following:
- 2 (1) The implementation of an exchange established for
- 3 Indiana.
- 4 (2) The definition of "essential health benefits" for use in
- 5 Indiana under the Affordable Care Act, including ensuring
- 6 that the definition results in adequate benefits.
- 7 (c) The committee shall receive and consider annual reports
- 8 from the office of the secretary of family and social services
- 9 concerning the status and operation of the exchange established for
- 10 Indiana.
- 11 (d) The committee shall, not later than November 1 of each
- 12 year, report the committee's findings and recommendations
- 13 concerning the committee's study under subsection (b) to the
- 14 legislative council in an electronic format under IC 5-14-6.
- 15 Sec. 5. The committee shall operate under the policies governing
- 16 study committees adopted by the legislative council.
- 17 Sec. 6. (a) The committee consists of the following voting
- 18 members:
- 19 (1) Four (4) members of the senate, not more than two (2) of
- 20 whom may be members of the same political party, appointed
- 21 by the president pro tempore.
- 22 (2) Four (4) members of the house of representatives, not
- 23 more than two (2) of whom may be members of the same
- 24 political party, appointed by the speaker.
- 25 (3) The secretary of family and social services or the
- 26 secretary's designee.
- 27 (4) The commissioner of the state department of health or the
- 28 commissioner's designee.
- 29 (5) The commissioner of insurance or the commissioner's
- 30 designee.
- 31 (6) One (1) member representing the insurance industry.
- 32 (7) One (1) member representing hospitals.
- 33 (8) One (1) member representing physicians.
- 34 (b) The president pro tempore shall appoint a chairperson of the
- 35 committee during each even-numbered year. The speaker shall
- 36 appoint a chairperson of the committee during each odd-numbered
- 37 year.
- 38 Sec. 7. The affirmative votes of a majority of the voting
- 39 members appointed to the committee are required for the
- 40 committee to take action on any measure, including final reports.
- 41 Sec. 8. This chapter expires July 1, 2016.
- 42 SECTION 2. IC 12-15-2-3.5 IS ADDED TO THE INDIANA CODE

C
O
P
Y



1 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
2 1, 2013]: **Sec. 3.5. An individual:**

3 **(1) who is:**

4 **(A) at least sixty-five (65) years of age; or**

5 **(B) disabled, as determined by the Supplemental Security
6 Income program; and**

7 **(2) whose income and resources do not exceed those levels
8 established by the Supplemental Security Income program;
9 is eligible to receive Medicaid assistance if the individual's family
10 income does not exceed one hundred percent (100%) of the federal
11 income poverty level for the same size family.**

12 SECTION 3. IC 12-15-2-17, AS AMENDED BY P.L.196-2011,
13 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
14 JULY 1, 2013]: **Sec. 17. (a) Beginning January 1, 2014, the office
15 may apply this section only to the following Medicaid applicants or
16 Medicaid recipients:**

17 **(1) An individual whose eligibility for Medicaid does not
18 require a determination of income by the office, including an
19 individual receiving Supplemental Security Income.**

20 **(2) An individual who is at least sixty-five (65) years of age if
21 age is a condition of eligibility.**

22 **(3) An individual whose eligibility is being determined on the
23 basis of being blind or disabled, or on the basis of being
24 treated as blind or disabled.**

25 **(4) An individual who requests coverage for long term care
26 services and supports for the purpose of being evaluated for
27 an eligibility group under which long term care services or
28 supports are covered, including the following:**

29 **(A) Nursing facility services.**

30 **(B) Nursing facility level of care services provided in an
31 institution.**

32 **(C) Intermediate care facility services for the mentally
33 retarded.**

34 **(D) Home and community based services.**

35 **(E) Home health services.**

36 **(F) Personal care services.**

37 **(5) An individual applying for Medicare cost sharing
38 assistance.**

39 **(a) (b) Except as provided in subsections (b) (c) and (d); (e), if an
40 applicant for or a recipient of Medicaid:**

41 **(1) establishes one (1) irrevocable trust that has a value of not
42 more than ten thousand dollars (\$10,000), exclusive of interest,**

C
o
p
y



1 and is established for the sole purpose of providing money for the
2 burial of the applicant or recipient;

3 (2) enters into an irrevocable prepaid funeral agreement having a
4 value of not more than ten thousand dollars (\$10,000); or

5 (3) owns a life insurance policy with a face value of not more than
6 ten thousand dollars (\$10,000) and with respect to which
7 provision is made to pay not more than ten thousand dollars
8 (\$10,000) toward the applicant's or recipient's funeral expenses;

9 the value of the trust, prepaid funeral agreement, or life insurance
10 policy may not be considered as a resource in determining the
11 applicant's or recipient's eligibility for Medicaid.

12 ~~(b)~~ (c) Subject to subsection ~~(d)~~, (e), if an applicant for or a
13 recipient of Medicaid establishes an irrevocable trust or escrow under
14 IC 30-2-13, the entire value of the trust or escrow may not be
15 considered as a resource in determining the applicant's or recipient's
16 eligibility for Medicaid.

17 ~~(c)~~ (d) Except as provided in IC 12-15-3-7, if an applicant for or a
18 recipient of Medicaid owns resources described in subsection ~~(a)~~ (b)
19 and the total value of those resources is more than ten thousand dollars
20 (\$10,000), the value of those resources that is more than ten thousand
21 dollars (\$10,000) may be considered as a resource in determining the
22 applicant's or recipient's eligibility for Medicaid.

23 ~~(d)~~ (e) In order for a trust, an escrow, a life insurance policy, or a
24 prepaid funeral agreement to be exempt as a resource in determining
25 an applicant's or a recipient's eligibility for Medicaid under this section,
26 the applicant or recipient must designate the office or the applicant's or
27 recipient's estate to receive any remaining amounts after delivery of all
28 services and merchandise under the contract as reimbursement for
29 Medicaid assistance provided to the applicant or recipient after
30 fifty-five (55) years of age. The office may receive funds under this
31 subsection only to the extent permitted by 42 U.S.C. 1396p. The
32 computation of remaining amounts shall be made as of the date of
33 delivery of services and merchandise under the contract and must be
34 the excess, if any, derived from:

- 35 (1) growth in principal;
- 36 (2) accumulation and reinvestment of dividends;
- 37 (3) accumulation and reinvestment of interest; and
- 38 (4) accumulation and reinvestment of distributions;

39 on the applicant's or recipient's trust, escrow, life insurance policy, or
40 prepaid funeral agreement over and above the seller's current retail
41 price of all services, merchandise, and cash advance items set forth in
42 the applicant's or recipient's contract.



C
o
p
y

1 SECTION 4. IC 12-15-3-1, AS AMENDED BY P.L.196-2011,
 2 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 3 JULY 1, 2013]: Sec. 1. (a) Except as provided in subsections (b) and
 4 (c) and section 7 of this chapter, an applicant for or recipient of
 5 Medicaid is ineligible for assistance if the total cash value of money,
 6 stock, bonds, and life insurance owned by:

7 (1) the applicant or recipient is more than one thousand five
 8 hundred dollars (\$1,500) for assistance to the aged, blind, or
 9 disabled; or

10 (2) the applicant or recipient and the applicant's or recipient's
 11 spouse is more than two thousand two hundred fifty dollars
 12 (\$2,250) for medical assistance to the aged, blind, or disabled.

13 (b) In the case of an applicant who is an eligible individual, a
 14 Holocaust victim's settlement payment received by the applicant or the
 15 applicant's spouse may not be considered when calculating the total
 16 cash value of money, stock, bonds, and life insurance owned by the
 17 applicant or the applicant's spouse.

18 (c) In the case of an individual who:

19 (1) resides in a nursing facility or another medical institution; and

20 (2) has a spouse who does not reside in a nursing facility or
 21 another medical institution;

22 the total cash value of money, stock, bonds, and life insurance that may
 23 be owned by the couple to be eligible for the program is determined
 24 under IC 12-15-2-24.

25 **(d) This section expires December 31, 2013.**

26 SECTION 5. IC 12-15-3-1.5 IS ADDED TO THE INDIANA CODE
 27 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 28 1, 2013]: **Sec. 1.5. (a) Beginning January 1, 2014, the office shall
 29 determine eligibility for a Medicaid applicant or Medicaid
 30 recipient who is aged, blind, or disabled under IC 12-15-2-3.5.**

31 **(b) If an individual:**

32 **(1) resides in a nursing facility or another medical institution;
 33 and**

34 **(2) has a spouse who does not reside in a nursing facility or
 35 another medical institution;**

36 **the total cash value of money, stock, bonds, and life insurance that
 37 may be owned by the couple to be eligible for Medicaid is
 38 determined under IC 12-15-2-24.**

39 SECTION 6. IC 12-15-3-2, AS AMENDED BY P.L.196-2011,
 40 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 41 JULY 1, 2013]: Sec. 2. (a) Except as provided in section 7 of this
 42 chapter, if the parent of an applicant for or a recipient of assistance to

C
o
p
y



1 the blind or disabled who is less than eighteen (18) years of age owns
 2 money, stock, bonds, and life insurance whose total cash value is more
 3 than one thousand five hundred dollars (\$1,500), the amount of the
 4 excess shall be added to the total cash value of money, stock, bonds,
 5 and life insurance owned by the applicant or recipient to determine the
 6 recipient's eligibility for Medicaid under section 1 of this chapter.

7 (b) However, a Holocaust victim's settlement payment received by
 8 the parent of an applicant for or a recipient of assistance may not be
 9 added to the total cash value of money, stock, bonds, and life insurance
 10 owned by the applicant or recipient to determine the recipient's
 11 eligibility for Medicaid under section 1 of this chapter.

12 **(c) This section expires December 31, 2013.**

13 SECTION 7. IC 12-15-3-3, AS AMENDED BY P.L.196-2011,
 14 SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 15 JULY 1, 2013]: Sec. 3. (a) Except as provided in section 7 of this
 16 chapter, if the parents of an applicant for or a recipient of assistance to
 17 the blind or disabled who is less than eighteen (18) years of age own
 18 money, stock, bonds, and life insurance whose total cash value is more
 19 than two thousand two hundred fifty dollars (\$2,250), the amount of the
 20 excess shall be added to the total cash value of money, stock, bonds,
 21 and life insurance owned by the applicant or recipient to determine the
 22 recipient's eligibility for Medicaid under section 1 of this chapter.

23 **(b) This section expires December 31, 2013.**

24 SECTION 8. IC 12-15-12-22.2 IS ADDED TO THE INDIANA
 25 CODE AS A NEW SECTION TO READ AS FOLLOWS
 26 [EFFECTIVE JULY 1, 2013]: **Sec. 22.2. The office shall include in a
 27 contract entered into between the office and a managed care
 28 organization requirements for managed care organizations to
 29 actively implement policies that do the following:**

- 30 **(1) Increase positive health outcomes.**
 31 **(2) Promote personal responsibility and informed decision
 32 making by a Medicaid recipient concerning the Medicaid
 33 recipient's health.**
 34 **(3) Promote the greatest degree of independence and use of
 35 community based supports, including home and community
 36 based services, for long term care.**
 37 **(4) Prevent fraud, waste, and abuse by both Medicaid
 38 providers and Medicaid recipients participating in the
 39 program.**

40 SECTION 9. IC 12-15-46-3 IS ADDED TO THE INDIANA CODE
 41 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
 42 UPON PASSAGE]: **Sec. 3. (a) Before July 1, 2013, the office shall**

C
o
p
y



1 apply to the United States Department of Health and Human
 2 Services to amend the state Medicaid plan or for a Medicaid
 3 waiver to require a Medicaid recipient who is eligible for Medicaid
 4 based on the individual's aged, blind, or disabled status to enroll in
 5 the risk-based managed care program.

6 (b) The office may apply to the United States Department of
 7 Health and Human Services for authorization to require other
 8 Medicaid population groups to enroll in risk-based managed care.

9 (c) The office may not implement the state plan amendment or
 10 Medicaid waiver described in this section until the office files an
 11 affidavit with the governor attesting that the state plan amendment
 12 or Medicaid waiver applied for under this section has been
 13 approved by the United States Department of Health and Human
 14 Services. The office shall file the affidavit under this subsection not
 15 later than five (5) days after the office is notified that the state plan
 16 amendment or Medicaid waiver described in this section has been
 17 approved.

18 (d) The office shall, not later than October 1, 2013, implement
 19 the state plan amendment or Medicaid waiver described in
 20 subsection (a) if the state plan amendment or Medicaid waiver is
 21 approved by the United States Department of Health and Human
 22 Services and the governor has received the affidavit required
 23 under subsection (c).

24 (e) The office may adopt rules under IC 4-22-2 necessary to
 25 implement this section.

26 SECTION 10. IC 12-15-46-4 IS ADDED TO THE INDIANA
 27 CODE AS A NEW SECTION TO READ AS FOLLOWS
 28 [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) Before July 1, 2013, the
 29 office shall apply to the United States Department of Health and
 30 Human Services for a state plan amendment or a Medicaid waiver
 31 requesting to implement a program for individuals who have an
 32 annual household income of not more than one hundred
 33 thirty-three percent (133%) of the federal income poverty level, as
 34 described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

35 (b) The request for a program in the state plan amendment or
 36 waiver described in subsection (a) must include the following
 37 components:

38 (1) Require a recipient to make out-of-pocket payments
 39 related to coverage for health care expenses provided under
 40 the program.

41 (2) Require a health care account to be used to pay the
 42 recipient's out-of-pocket health care expenses associated with

C
o
p
y



- 1 health care coverage provided as part of the recipient's
- 2 participation in the program described in this section.
- 3 (3) Include health care initiatives designed to promote the
- 4 general health and well being of recipients and encourage an
- 5 understanding of the cost and quality of care.
- 6 (4) Include coverage for preventative care services provided
- 7 at no cost to the recipient.
- 8 (5) Use of a managed care organization model for providing
- 9 services to program recipients.
- 10 (6) Provision of the following services:
- 11 (A) Outpatient services.
- 12 (B) Inpatient services.
- 13 (C) Pharmaceutical services.
- 14 (D) Behavioral health.
- 15 (E) Other services determined by the office.
- 16 (7) Provide incentives for health behavior and encourage an
- 17 understanding of the cost and quality of health care.
- 18 (8) Require to the fullest extent possible the use of home and
- 19 community based services for long term care.
- 20 (c) The office may not implement the state plan amendment or
- 21 waiver described in this section until the office files an affidavit
- 22 with the governor attesting that the state plan amendment or
- 23 Medicaid waiver applied for under this section is in effect. The
- 24 office shall file the affidavit under this subsection not later than
- 25 five (5) days after the office is notified by the United States
- 26 Department of Health and Human Services that the state plan
- 27 amendment or Medicaid waiver described in this section is
- 28 approved.
- 29 (d) If the office receives approval for a state plan amendment or
- 30 a Medicaid waiver under this section and the governor receives the
- 31 affidavit described in subsection (c), the office shall implement the
- 32 state plan amendment or Medicaid waiver.
- 33 (e) The office may adopt rules under IC 4-22-2 necessary to
- 34 implement this section.
- 35 SECTION 11. IC 12-15-46-4.5 IS ADDED TO THE INDIANA
- 36 CODE AS A NEW SECTION TO READ AS FOLLOWS
- 37 [EFFECTIVE UPON PASSAGE]: Sec. 4.5. (a) As used in this section,
- 38 "Affordable Care Act" refers to the federal Patient Protection and
- 39 Affordable Care Act (P.L. 111-148), as amended by the federal
- 40 Health Care and Education Reconciliation Act of 2010 (P.L.
- 41 111-152).
- 42 (b) As used in this section, "exchange" refers to an American

COPY



1 health benefit exchange established for Indiana under the
2 Affordable Care Act.

3 (c) The Indiana health benefit exchange advisory committee is
4 created for the purpose of advising the office with respect to policy
5 and program administration related to:

- 6 (1) an exchange established for Indiana under the Affordable
7 Care Act consistent with the requirements of federal law; and
8 (2) implementation of a program under section 4 of this
9 chapter.

10 (d) The governor shall appoint nine (9) members of the advisory
11 committee as follows:

- 12 (1) One (1) member who is a representative of health
13 consumer advocates.
14 (2) One (1) member who is a representative of small business.
15 (3) One (1) member who is a self-employed individual.
16 (4) One (1) member who has expertise in small employer
17 health insurance coverage.
18 (5) One (1) member who has expertise in individual health
19 insurance coverage.
20 (6) One (1) member who has expertise in administration of a
21 health benefit plan.
22 (7) One (1) member who has expertise in administration of a
23 public or private health care delivery system.
24 (8) Two (2) members who are eligible for or enrolled in
25 Medicaid risk-based managed care implemented under
26 sections 4 and 5 of this chapter.

27 (e) Three (3) individuals shall serve as ex officio members of the
28 advisory committee, as follows:

- 29 (1) The commissioner or the commissioner's designee, who
30 shall serve as chairperson.
31 (2) The secretary of family and social services or the
32 secretary's designee.
33 (3) The commissioner of the state department of health, or the
34 commissioner's designee.

35 (f) Members of the advisory committee:

- 36 (1) shall serve a three (3) year term;
37 (2) may be reappointed to successive terms; and
38 (3) serve at the pleasure of the governor.

39 (g) Members of the advisory committee shall serve without
40 compensation. However, if sufficient money is available from
41 federal grant funds or revenues generated by the exchange, each
42 member may receive the per diem allowance and travel expenses



C
o
p
y

1 provided for in rules that apply to executive committees adopted
2 by the Indiana department of administration.

3 (h) The advisory committee shall do the following:

4 (1) Review and comment on policy initiatives related to
5 quality improvement, health care benefits, and eligibility of
6 individuals for coverage through the exchange and
7 implementation of sections 4 and 5 of this chapter.

8 (2) Advise the department in setting budget priorities,
9 including consideration of scope of benefits, beneficiary
10 eligibility, health care professional reimbursement rates,
11 funding outlook, financing options, and possible budget
12 recommendations.

13 (3) Assess the effectiveness of implementation of sections 4
14 and 5 of this chapter.

15 (4) Not later than June 30 of each year, submit
16 recommendations to the governor and, in an electronic format
17 under IC 5-14-6, to the legislative council concerning the
18 implementation of the exchange and of sections 4 and 5 of this
19 chapter.

20 (5) Provide other advisory assistance as requested by the
21 department or other agencies of the state.

22 SECTION 12. IC 12-15-46-5 IS ADDED TO THE INDIANA
23 CODE AS A NEW SECTION TO READ AS FOLLOWS
24 [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) The office shall apply
25 to the United States Department of Health and Human Services for
26 an amendment to the state Medicaid plan to do the following:

27 (1) Require a recipient who has an annual household income
28 of at least one hundred fifty percent (150%) of the federal
29 income poverty level to make premium payments in order to
30 participate in the program.

31 (2) Require Medicaid recipients to participate in cost sharing,
32 as allowable under federal law.

33 (b) The office may not implement the state plan amendment
34 described in this section until the office files an affidavit with the
35 governor attesting that the state plan amendment applied for
36 under this section has been approved by the United States
37 Department of Health and Human Services. The office shall file the
38 affidavit under this subsection not later than five (5) days after the
39 office is notified that the state plan amendment described in this
40 section has been approved.

41 (c) The office may adopt rules under IC 4-22-2 necessary to
42 implement this section.

C
o
p
y



1 SECTION 13. [EFFECTIVE UPON PASSAGE] (a) As used in this
2 SECTION, "commission" refers to the health finance commission
3 established by IC 2-5-23-3.
4 (b) Before October 1, 2013, the office of Medicaid policy and
5 planning shall present a plan to the commission concerning
6 whether to increase Indiana's use of a risk-based managed care
7 model to provide care to Medicaid populations currently being
8 served under fee-for-service Medicaid. The plan must do the
9 following:
10 (1) Provide an overview of the Medicaid populations in
11 Indiana that are currently being served under fee-for-service
12 Medicaid.
13 (2) Review the use of risk-based managed care for Medicaid
14 populations in other states, including Texas and Florida.
15 (3) Explain any determination that a current fee-for-service
16 Medicaid population should continue to be served under the
17 fee-for-service model.
18 (4) Make recommendations concerning the use of risk-based
19 managed care for Medicaid recipients receiving long term
20 care services.
21 (c) This SECTION expires December 31, 2013.
22 SECTION 14. An emergency is declared for this act.

C
o
p
y



COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1591, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

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

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1591 as introduced.)

CLERE, Chair

Committee Vote: yeas 11, nays 0.

C
O
P
Y

