



Reprinted
February 19, 2013

HOUSE BILL No. 1591

DIGEST OF HB 1591 (Updated February 18, 2013 5:28 pm - DI 97)

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

Synopsis: Medicaid matters. Establishes the Indiana affordable care committee. Amends application of certain Medicaid resource requirements. Specifies policies that must be included in a contract 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 to: (1) require risk based managed care for certain Medicaid recipients; (2) authorize implementation of a Medicaid program for individuals with an income less than 133% of the federal income poverty level; and (3) require certain Medicaid recipients to contribute to premiums and cost sharing. Requires the office to report to the health finance commission concerning Medicaid risk-based managed care. Establishes the Indiana health benefit exchange advisory committee.

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.
February 18, 2013, read second time, amended, ordered engrossed.

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HB 1591—LS 6665/DI 44+



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.

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**

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concerning the following:

(1) The implementation of an exchange established for Indiana.

(2) The definition of "essential health benefits" for use in Indiana under the Affordable Care Act, including ensuring that the definition results in adequate benefits.

(c) The committee shall receive and consider annual reports from the office of the secretary of family and social services concerning the status and operation of the exchange established for Indiana.

(d) The committee shall, not later than November 1 of each year, report the committee's findings and recommendations concerning the committee's study under subsection (b) to the legislative council in an electronic format under IC 5-14-6.

Sec. 5. The committee shall operate under the policies governing study committees adopted by the legislative council.

Sec. 6. (a) The committee consists of the following voting members:

(1) Four (4) members of the senate, not more than two (2) of whom may be members of the same political party, appointed by the president pro tempore.

(2) Four (4) members of the house of representatives, not more than two (2) of whom may be members of the same political party, appointed by the speaker.

(3) The secretary of family and social services or the secretary's designee.

(4) The commissioner of the state department of health or the commissioner's designee.

(5) The commissioner of insurance or the commissioner's designee.

(6) One (1) member representing the insurance industry.

(7) One (1) member representing hospitals.

(8) One (1) member representing physicians.

(9) One (1) member representing senior citizens.

(10) One (1) member representing children.

(11) One (1) member representing providers of mental health services.

The president pro tempore of the senate shall appoint the members described in subdivisions (6) through (8). The speaker of the house of representatives shall appoint the members described in subdivisions (9) through (11).

(b) The president pro tempore shall appoint a chairperson of the

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1 committee during each even-numbered year. The speaker shall
2 appoint a chairperson of the committee during each odd-numbered
3 year.

4 Sec. 7. The affirmative votes of a majority of the voting
5 members appointed to the committee are required for the
6 committee to take action on any measure, including final reports.

7 Sec. 8. This chapter expires July 1, 2016.

8 SECTION 2. IC 12-15-2-3.5 IS ADDED TO THE INDIANA CODE
9 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
10 1, 2013]: Sec. 3.5. An individual:

11 (1) who is:

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

13 (B) disabled, as determined by the Supplemental Security
14 Income program; and

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

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

25 (1) An individual whose eligibility for Medicaid does not
26 require a determination of income by the office, including an
27 individual receiving Supplemental Security Income.

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

30 (3) An individual whose eligibility is being determined on the
31 basis of being blind or disabled, or on the basis of being
32 treated as blind or disabled.

33 (4) An individual who requests coverage for long term care
34 services and supports for the purpose of being evaluated for
35 an eligibility group under which long term care services or
36 supports are covered, including the following:

37 (A) Nursing facility services.

38 (B) Nursing facility level of care services provided in an
39 institution.

40 (C) Intermediate care facility services for the mentally
41 retarded.

42 (D) Home and community based services.

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(E) Home health services.

(F) Personal care services.

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

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

(1) establishes one (1) irrevocable trust that has a value of not more than ten thousand dollars (\$10,000), exclusive of interest, and is established for the sole purpose of providing money for the burial of the applicant or recipient;

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

(3) owns a life insurance policy with a face value of not more than ten thousand dollars (\$10,000) and with respect to which provision is made to pay not more than ten thousand dollars (\$10,000) toward the applicant's or recipient's funeral expenses; the value of the trust, prepaid funeral agreement, or life insurance policy may not be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

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

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

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

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- 1 (1) growth in principal;
 2 (2) accumulation and reinvestment of dividends;
 3 (3) accumulation and reinvestment of interest; and
 4 (4) accumulation and reinvestment of distributions;
 5 on the applicant's or recipient's trust, escrow, life insurance policy, or
 6 prepaid funeral agreement over and above the seller's current retail
 7 price of all services, merchandise, and cash advance items set forth in
 8 the applicant's or recipient's contract.
- 9 SECTION 4. IC 12-15-3-1, AS AMENDED BY P.L.196-2011,
 10 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 11 JULY 1, 2013]: Sec. 1. (a) Except as provided in subsections (b) and
 12 (c) and section 7 of this chapter, an applicant for or recipient of
 13 Medicaid is ineligible for assistance if the total cash value of money,
 14 stock, bonds, and life insurance owned by:
 15 (1) the applicant or recipient is more than one thousand five
 16 hundred dollars (\$1,500) for assistance to the aged, blind, or
 17 disabled; or
 18 (2) the applicant or recipient and the applicant's or recipient's
 19 spouse is more than two thousand two hundred fifty dollars
 20 (\$2,250) for medical assistance to the aged, blind, or disabled.
 21 (b) In the case of an applicant who is an eligible individual, a
 22 Holocaust victim's settlement payment received by the applicant or the
 23 applicant's spouse may not be considered when calculating the total
 24 cash value of money, stock, bonds, and life insurance owned by the
 25 applicant or the applicant's spouse.
 26 (c) In the case of an individual who:
 27 (1) resides in a nursing facility or another medical institution; and
 28 (2) has a spouse who does not reside in a nursing facility or
 29 another medical institution;
 30 the total cash value of money, stock, bonds, and life insurance that may
 31 be owned by the couple to be eligible for the program is determined
 32 under IC 12-15-2-24.
 33 **(d) This section expires December 31, 2013.**
 34 SECTION 5. IC 12-15-3-1.5 IS ADDED TO THE INDIANA CODE
 35 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 36 1, 2013]: **Sec. 1.5. (a) Beginning January 1, 2014, the office shall
 37 determine eligibility for a Medicaid applicant or Medicaid
 38 recipient who is aged, blind, or disabled under IC 12-15-2-3.5.**
 39 **(b) If an individual:**
 40 **(1) resides in a nursing facility or another medical institution;**
 41 **and**
 42 **(2) has a spouse who does not reside in a nursing facility or**

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1 **another medical institution;**
 2 **the total cash value of money, stock, bonds, and life insurance that**
 3 **may be owned by the couple to be eligible for Medicaid is**
 4 **determined under IC 12-15-2-24.**

5 SECTION 6. IC 12-15-3-2, AS AMENDED BY P.L.196-2011,
 6 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 7 JULY 1, 2013]: Sec. 2. (a) Except as provided in section 7 of this
 8 chapter, if the parent of an applicant for or a recipient of assistance to
 9 the blind or disabled who is less than eighteen (18) years of age owns
 10 money, stock, bonds, and life insurance whose total cash value is more
 11 than one thousand five hundred dollars (\$1,500), the amount of the
 12 excess shall be added to the total cash value of money, stock, bonds,
 13 and life insurance owned by the applicant or recipient to determine the
 14 recipient's eligibility for Medicaid under section 1 of this chapter.

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

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

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

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

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

- 38 (1) **Increase positive health outcomes.**
 39 (2) **Promote personal responsibility and informed decision**
 40 **making by a Medicaid recipient concerning the Medicaid**
 41 **recipient's health.**
 42 (3) **Promote the greatest degree of independence and use of**



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1 community based supports, including home and community
2 based services, for long term care.

3 (4) Prevent fraud, waste, and abuse by both Medicaid
4 providers and Medicaid recipients participating in the
5 program.

6 SECTION 9. IC 12-15-46-3 IS ADDED TO THE INDIANA CODE
7 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
8 UPON PASSAGE]: Sec. 3. (a) Before July 1, 2013, the office shall
9 apply to the United States Department of Health and Human
10 Services to amend the state Medicaid plan or for a Medicaid
11 waiver to require a Medicaid recipient who is eligible for Medicaid
12 based on the individual's aged, blind, or disabled status to enroll in
13 the risk-based managed care program.

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

17 (c) The office may not implement the state plan amendment or
18 Medicaid waiver described in this section until the office files an
19 affidavit with the governor attesting that the state plan amendment
20 or Medicaid waiver applied for under this section has been
21 approved by the United States Department of Health and Human
22 Services. The office shall file the affidavit under this subsection not
23 later than five (5) days after the office is notified that the state plan
24 amendment or Medicaid waiver described in this section has been
25 approved.

26 (d) The office shall, not later than October 1, 2013, implement
27 the state plan amendment or Medicaid waiver described in
28 subsection (a) if the state plan amendment or Medicaid waiver is
29 approved by the United States Department of Health and Human
30 Services and the governor has received the affidavit required
31 under subsection (c).

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

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



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1 (b) The request for a program in the state plan amendment or
2 waiver described in subsection (a) must include the following
3 components:

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

7 (2) Require a health care account to be used to pay the
8 recipient's out-of-pocket health care expenses associated with
9 health care coverage provided as part of the recipient's
10 participation in the program described in this section.

11 (3) Include health care initiatives designed to promote the
12 general health and well being of recipients and encourage an
13 understanding of the cost and quality of care.

14 (4) Include coverage for preventative care services provided
15 at no cost to the recipient.

16 (5) Use of a managed care organization model for providing
17 services to program recipients.

18 (6) Provision of the following services:

19 (A) Outpatient services.

20 (B) Inpatient services.

21 (C) Pharmaceutical services.

22 (D) Behavioral health.

23 (E) Other services determined by the office.

24 (7) Provide incentives for health behavior and encourage an
25 understanding of the cost and quality of health care.

26 (8) Require to the fullest extent possible the use of home and
27 community based services for long term care.

28 (9) Opportunities for cost containment.

29 (c) The office may not implement the state plan amendment or
30 waiver described in this section until the office files an affidavit
31 with the governor attesting that the state plan amendment or
32 Medicaid waiver applied for under this section is in effect. The
33 office shall file the affidavit under this subsection not later than
34 five (5) days after the office is notified by the United States
35 Department of Health and Human Services that the state plan
36 amendment or Medicaid waiver described in this section is
37 approved.

38 (d) If the office receives approval for a state plan amendment or
39 a Medicaid waiver under this section and the governor receives the
40 affidavit described in subsection (c), the office shall implement the
41 state plan amendment or Medicaid waiver.

42 (e) The office may adopt rules under IC 4-22-2 necessary to

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1 **implement this section.**

2 SECTION 11. IC 12-15-46-4.5 IS ADDED TO THE INDIANA
3 CODE AS A NEW SECTION TO READ AS FOLLOWS
4 [EFFECTIVE UPON PASSAGE]: **Sec. 4.5. (a) As used in this section,**
5 **"Affordable Care Act" refers to the federal Patient Protection and**
6 **Affordable Care Act (P.L. 111-148), as amended by the federal**
7 **Health Care and Education Reconciliation Act of 2010 (P.L.**
8 **111-152).**

9 (b) As used in this section, "exchange" refers to an American
10 health benefit exchange established for Indiana under the
11 Affordable Care Act.

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

- 15 (1) an exchange established for Indiana under the Affordable
16 Care Act consistent with the requirements of federal law; and
17 (2) implementation of a program under section 4 of this
18 chapter.

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

- 21 (1) One (1) member who is a representative of health
22 consumer advocates.
23 (2) One (1) member who is a representative of small business.
24 (3) One (1) member who is a self-employed individual.
25 (4) One (1) member who has expertise in small employer
26 health insurance coverage.
27 (5) One (1) member who has expertise in individual health
28 insurance coverage.
29 (6) One (1) member who has expertise in administration of a
30 health benefit plan.
31 (7) One (1) member who has expertise in administration of a
32 public or private health care delivery system.
33 (8) Two (2) members who are eligible for or enrolled in
34 Medicaid risk-based managed care implemented under
35 sections 4 and 5 of this chapter.

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

- 38 (1) The commissioner or the commissioner's designee, who
39 shall serve as chairperson.
40 (2) The secretary of family and social services or the
41 secretary's designee.
42 (3) The commissioner of the state department of health, or the

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commissioner's designee.

(f) Members of the advisory committee:

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

(g) Members of the advisory committee shall serve without compensation. However, if sufficient money is available from federal grant funds or revenues generated by the exchange, each member may receive the per diem allowance and travel expenses provided for in rules that apply to executive committees adopted by the Indiana department of administration.

(h) The advisory committee shall do the following:

- (1) Review and comment on policy initiatives related to quality improvement, health care benefits, and eligibility of individuals for coverage through the exchange and implementation of sections 4 and 5 of this chapter.
- (2) Advise the department in setting budget priorities, including consideration of scope of benefits, beneficiary eligibility, health care professional reimbursement rates, funding outlook, financing options, and possible budget recommendations.
- (3) Assess the effectiveness of implementation of sections 4 and 5 of this chapter.
- (4) Not later than June 30 of each year, submit recommendations to the governor and, in an electronic format under IC 5-14-6, to the legislative council concerning the implementation of the exchange and of sections 4 and 5 of this chapter.
- (5) Provide other advisory assistance as requested by the department or other agencies of the state.

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

- (1) Require a recipient who has an annual household income of at least one hundred fifty percent (150%) of the federal income poverty level to make premium payments in order to participate in the program.
- (2) Require Medicaid recipients to participate in cost sharing, as allowable under federal law.

(b) The office may not implement the state plan amendment

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1 described in this section until the office files an affidavit with the
2 governor attesting that the state plan amendment applied for
3 under this section has been approved by the United States
4 Department of Health and Human Services. The office shall file the
5 affidavit under this subsection not later than five (5) days after the
6 office is notified that the state plan amendment described in this
7 section has been approved.

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

10 SECTION 13. [EFFECTIVE UPON PASSAGE] (a) As used in this
11 SECTION, "commission" refers to the health finance commission
12 established by IC 2-5-23-3.

13 (b) Before October 1, 2013, the office of Medicaid policy and
14 planning shall present a plan to the commission concerning
15 whether to increase Indiana's use of a risk-based managed care
16 model to provide care to Medicaid populations currently being
17 served under fee-for-service Medicaid. The plan must do the
18 following:

19 (1) Provide an overview of the Medicaid populations in
20 Indiana that are currently being served under fee-for-service
21 Medicaid.

22 (2) Review the use of risk-based managed care for Medicaid
23 populations in other states, including Texas and Florida.

24 (3) Explain any determination that a current fee-for-service
25 Medicaid population should continue to be served under the
26 fee-for-service model.

27 (4) Make recommendations concerning the use of risk-based
28 managed care for Medicaid recipients receiving long term
29 care services.

30 (c) This SECTION expires December 31, 2013.

31 SECTION 14. An emergency is declared for this act.

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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.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1591 be amended to read as follows:

Page 2, between lines 33 and 34, begin a new line block indented and insert:

"(9) One (1) member representing senior citizens.

(10) One (1) member representing children.

(11) One (1) member representing providers of mental health services.

The president pro tempore of the senate shall appoint the members described in subdivisions (6) through (8). The speaker of the house of representatives shall appoint the members described in subdivisions (9) through (11)."

(Reference is to HB 1591 as printed February 15, 2013.)

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1591 be amended to read as follows:

Page 8, between lines 19 and 20, begin a new line block indented and insert:

"(9) Opportunities for cost containment."

(Reference is to HB 1591 as printed February 15, 2013.)

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