

**CONFERENCE COMMITTEE REPORT  
DIGEST FOR EHB 1328**

**Citations Affected:** IC 12-7-2; IC 12-15; IC 16-28-15; IC 23-2-4; IC 27-1; IC 27-4-1-4; IC 27-8; IC 27-19.

**Synopsis:** Health matters. Conference committee report for EHB 1328. Defines populations that may be subject to Medicaid resource requirements. Eliminates certain Medicaid eligibility resource requirements. Specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost sharing amounts. Sets forth requirements for continuing care retirement communities that were registered before January 2, 2007. Provides for implementation of the federal Patient Protection and Affordable Care Act with respect to a health benefit exchange in Indiana. Specifies that Indiana insurance law applies to a health plan offered through a health benefit exchange to the same extent that the law would apply if the health plan were offered independent of the health benefit exchange. Specifies requirements for health plans issued through a health benefit exchange. Requires a navigator to be certified and an application organization to be registered before providing services with respect to a health benefit exchange. Provides for dissolution of the Indiana comprehensive health insurance association (ICHIA). Requires the office of Medicaid policy and planning to report to the health finance commission specified information regarding the participation of the aged, blind, and disabled Medicaid population in risk-based managed care, managed fee-for-service programs, and home and community based services management programs. Requires the office of the secretary of family and social services to report specified information to the legislative council and the health finance commission concerning school health care clinics in Indiana. **(This conference committee report: (1) adds language from SB 551 related to: (A) Medicaid eligibility resource requirements; (B) health benefit exchanges in Indiana; (C) the dissolution of ICHIA; and (D) a study concerning risk-based managed care; (2) amends the definition of "application organization" and "navigator"; (3) adds language concerning requirements for continuing care retirement communities that were registered before January 2, 2007; and (4) adds language requiring the office of the secretary of family and social services to provide a written report to the legislative council and the health finance commission setting forth specified information related to school health care clinics in Indiana.)**

**Effective:** Upon passage; July 1, 2013.



Adopted	Rejected
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## CONFERENCE COMMITTEE REPORT

**MR. SPEAKER:**

*Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed Senate Amendments to Engrossed House Bill No. 1328 respectfully reports that said two committees have conferred and agreed as follows to wit:*

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

- 1 Delete everything after the enacting clause and insert the following:  
2 SECTION 1. IC 12-7-2-155.3 IS ADDED TO THE INDIANA  
3 CODE AS A NEW SECTION TO READ AS FOLLOWS  
4 [EFFECTIVE JULY 1, 2013]: **Sec. 155.3. "Qualified Medicare**  
5 **beneficiary", for purposes of IC 12-15-2-26, has the meaning set**  
6 **forth in IC 12-15-2-26(b).**  
7 SECTION 2. IC 12-7-2-155.5 IS ADDED TO THE INDIANA  
8 CODE AS A NEW SECTION TO READ AS FOLLOWS  
9 [EFFECTIVE JULY 1, 2013]: **Sec. 155.5. "Qualifying individual",**  
10 **for purposes of IC 12-15-2-26, has the meaning set forth in**  
11 **IC 12-15-2-26(c).**  
12 SECTION 3. IC 12-7-2-180.4 IS ADDED TO THE INDIANA  
13 CODE AS A NEW SECTION TO READ AS FOLLOWS  
14 [EFFECTIVE JULY 1, 2013]: **Sec. 180.4. "Specified low-income**  
15 **Medicare beneficiary", for purposes of IC 12-15-2-26, has the**  
16 **meaning set forth in IC 12-15-2-26(d).**  
17 SECTION 4. IC 12-15-2-3.5 IS ADDED TO THE INDIANA CODE  
18 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
19 1, 2013]: **Sec. 3.5. An individual:**  
20 **(1) who is:**  
21 **(A) at least sixty-five (65) years of age; or**  
22 **(B) disabled, as determined by the Supplemental Security**

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

7                   SECTION 5. IC 12-15-2-13, AS AMENDED BY P.L.218-2007,  
 8                   SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 9                   JULY 1, 2013]: Sec. 13. (a) A pregnant woman:

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

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

13                   is eligible to receive Medicaid.

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

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

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

27                   (e) The office may apply a resource standard in determining the  
 28                   eligibility of a pregnant woman described in this section. **This**  
 29                   **subsection expires December 31, 2013.**

30                   SECTION 6. IC 12-15-2-14 IS AMENDED TO READ AS  
 31                   FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 14. (a) An individual:

32                   (1) who is less than nineteen (19) years of age;

33                   (2) who is not described in 42 U.S.C. 1396a(a)(10)(A)(I); and

34                   (3) whose family income does not exceed the income level  
 35                   established in subsection (b);

36                   is eligible to receive Medicaid.

37                   (b) An individual described in this section is eligible to receive  
 38                   Medicaid, subject to 42 U.S.C. 1396a et seq., if the individual's family  
 39                   income does not exceed one hundred fifty percent (150%) of the  
 40                   federal income poverty level for the same size family.

41                   (c) The office may apply a resource standard in determining the  
 42                   eligibility of an individual described in this section. **This subsection**  
 43                   **expires December 31, 2013.**

44                   SECTION 7. IC 12-15-2-17, AS AMENDED BY P.L.196-2011,  
 45                   SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 46                   JULY 1, 2013]: Sec. 17. (a) **This section applies beginning the later**  
 47                   **of the following:**

48                   **(1) The date that the office is informed that the United States**  
 49                   **Department of Health and Human Services has approved**  
 50                   **Indiana's conversion to 1634 status within the Medicaid**  
 51                   **program.**

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- (2) January 1, 2014.**
- (b) The office may apply this section only to the following Medicaid applicants or Medicaid recipients:**
  - (1) An individual whose eligibility for Medicaid does not require a determination of income by the office.**
  - (2) An individual who is at least sixty-five (65) years of age when age is a condition of eligibility.**
  - (3) An individual whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as blind or disabled.**
  - (4) An individual who requests coverage for long term care services and supports for the purpose of being evaluated for an eligibility group under which long term care services or supports are covered, including the following:**
    - (A) Nursing facility services.**
    - (B) Nursing facility level of care services provided in an institution.**
    - (C) Home and community based services.**
    - (D) Home health services.**
    - (E) Personal care services.**
  - (5) An individual applying for Medicare cost sharing assistance.**
- (a) (c) Except as provided in subsections ~~(b)~~ (d) and ~~(e)~~ (f), 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)~~ (d) Subject to subsection ~~(e)~~ (f), 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)~~ (e) Except as provided in IC 12-15-3-7, if an applicant for or a recipient of Medicaid owns resources described in subsection ~~(a)~~ (c) 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)~~ (f) 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,**

1 the applicant or recipient must designate the office or the applicant's or  
 2 recipient's estate to receive any remaining amounts after delivery of all  
 3 services and merchandise under the contract as reimbursement for  
 4 Medicaid assistance provided to the applicant or recipient after  
 5 fifty-five (55) years of age. The office may receive funds under this  
 6 subsection only to the extent permitted by 42 U.S.C. 1396p. The  
 7 computation of remaining amounts shall be made as of the date of  
 8 delivery of services and merchandise under the contract and must be  
 9 the excess, if any, derived from:

- 10 (1) growth in principal;
- 11 (2) accumulation and reinvestment of dividends;
- 12 (3) accumulation and reinvestment of interest; and
- 13 (4) accumulation and reinvestment of distributions;

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

18 SECTION 8. IC 12-15-2-26 IS ADDED TO THE INDIANA CODE  
 19 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
 20 1, 2013]: **Sec. 26. (a) This section applies beginning the later of the  
 21 following:**

22 **(1) The date that the office is informed that the United States  
 23 Department of Health and Human Services has approved  
 24 Indiana's conversion to 1634 status within the Medicaid  
 25 program.**

26 **(2) January 1, 2014.**

27 **(b) As used in this section, "qualified Medicare beneficiary"  
 28 means an individual defined in 42 U.S.C. 1396d(p)(1).**

29 **(c) As used in this section, "qualifying individual" refers to an  
 30 individual described in 42 U.S.C. 1396a(a)(10)(E)(iv).**

31 **(d) As used in this section, "specified low-income Medicare  
 32 beneficiary" refers to an individual described in 42 U.S.C.  
 33 1396a(a)(10)(E)(iii).**

34 **(e) The following individuals are eligible for the specified  
 35 coverage under this section:**

36 **(1) A qualified Medicare beneficiary whose:**

37 **(A) income does not exceed one hundred fifty percent  
 38 (150%) of the federal income poverty level; and**

39 **(B) resources do not exceed the resource limits established  
 40 by the office;**

41 **is eligible for Medicare Part A and Medicare Part B  
 42 premiums, coinsurance, and deductibles.**

43 **(2) A specified low-income Medicare beneficiary whose:**

44 **(A) income does not exceed one hundred seventy percent  
 45 (170%) of the federal income poverty level; and**

46 **(B) resources do not exceed the resource limits set by the  
 47 office;**

48 **is eligible for coverage of Medicare Part B premiums.**

49 **(3) A qualifying individual whose:**

50 **(A) income does not exceed one hundred eighty-five  
 51 percent (185%) of the federal income poverty level; and**

1                   **(B) resources do not exceed the resource limits set by the**  
 2                   **office;**  
 3                   **is eligible for coverage of Medicare Part B premiums.**  
 4                   **(f) The office may adopt rules under IC 4-22-2 to implement this**  
 5                   **section.**

6                   SECTION 9. IC 12-15-2.3-10 IS AMENDED TO READ AS  
 7                   FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 10. **(a)** If a woman  
 8                   described in section 1 of this chapter:

- 9                   (1) is determined to be presumptively eligible for Medicaid under  
 10                   this chapter; and
- 11                   (2) appoints, in writing, an agent of a qualified entity under  
 12                   section 4 of this chapter as the woman's authorized representative  
 13                   for purposes of completing all aspects of the Medicaid application  
 14                   process;

15                   the county office shall conduct any face-to-face interview that is  
 16                   necessary to determine the woman's eligibility for Medicaid with the  
 17                   woman's authorized representative.

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

19                   SECTION 10. IC 12-15-3-1, AS AMENDED BY P.L.196-2011,  
 20                   SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 21                   JULY 1, 2013]: Sec. 1. **(a)** Except as provided in subsections **(b)** and  
 22                   **(c)** and section 7 of this chapter, an applicant for or recipient of  
 23                   Medicaid is ineligible for assistance if the total cash value of money,  
 24                   stock, bonds, and life insurance owned by:

- 25                   (1) the applicant or recipient is more than one thousand five  
 26                   hundred dollars (\$1,500) for assistance to the aged, blind, or  
 27                   disabled; or
- 28                   (2) the applicant or recipient and the applicant's or recipient's  
 29                   spouse is more than two thousand two hundred fifty dollars  
 30                   (\$2,250) for medical assistance to the aged, blind, or disabled.

31                   **(b)** In the case of an applicant who is an eligible individual, a  
 32                   Holocaust victim's settlement payment received by the applicant or the  
 33                   applicant's spouse may not be considered when calculating the total  
 34                   cash value of money, stock, bonds, and life insurance owned by the  
 35                   applicant or the applicant's spouse.

36                   **(c)** In the case of an individual who:

- 37                   (1) resides in a nursing facility or another medical institution; and
- 38                   (2) has a spouse who does not reside in a nursing facility or  
 39                   another medical institution;

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

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

44                   SECTION 11. IC 12-15-3-1.5 IS ADDED TO THE INDIANA  
 45                   CODE AS A **NEW** SECTION TO READ AS FOLLOWS  
 46                   [EFFECTIVE JULY 1, 2013]: **Sec. 1.5. (a) This section applies**  
 47                   **beginning the later of the following:**

- 48                   **(1) The date that the office is informed that the United States**  
 49                   **Department of Health and Human Services has approved**  
 50                   **Indiana's conversion to 1634 status within the Medicaid**  
 51                   **program.**

1           **(2) January 1, 2014.**

2           **(b) The office shall determine eligibility for a Medicaid**  
 3 **applicant or Medicaid recipient who is aged, blind, or disabled**  
 4 **under IC 12-15-2-3.5.**

5           **(c) If an individual:**

6           **(1) resides in a nursing facility or another medical institution;**  
 7 **and**

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

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

13           SECTION 12. IC 12-15-3-2, AS AMENDED BY P.L.196-2011,  
 14 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 15 JULY 1, 2013]: Sec. 2. (a) Except as provided in section 7 of this  
 16 chapter, if the parent of an applicant for or a recipient of assistance to  
 17 the blind or disabled who is less than eighteen (18) years of age owns  
 18 money, stock, bonds, and life insurance whose total cash value is more  
 19 than one thousand five hundred dollars (\$1,500), 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) However, a Holocaust victim's settlement payment received by  
 24 the parent of an applicant for or a recipient of assistance may not be  
 25 added to the total cash value of money, stock, bonds, and life insurance  
 26 owned by the applicant or recipient to determine the recipient's  
 27 eligibility for Medicaid under section 1 of this chapter.

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

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

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

40           SECTION 14. IC 12-15-44.2-9, AS AMENDED BY P.L.160-2011,  
 41 SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 42 JULY 1, 2013]: Sec. 9. (a) An individual is eligible for participation in  
 43 the plan if the individual meets the following requirements:

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

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

48           (3) The individual has an annual household income of not more  
 49 than the following:

50           (A) Effective through December 31, 2013, two hundred  
 51 percent (200%) of the federal income poverty level.

- 1 (B) Beginning January 1, 2014, one hundred thirty-three  
 2 percent (133%) of the federal income poverty level, based on  
 3 the adjusted gross income provisions set forth in Section  
 4 2001(a)(1) of the federal Patient Protection and Affordable  
 5 Care Act.
- 6 (4) Effective through December 31, 2013, the individual is not  
 7 eligible for health insurance coverage through the individual's  
 8 employer.
- 9 (5) Effective through December 31, 2013, the individual has:  
 10 (A) not had health insurance coverage for at least six (6)  
 11 months; **or**  
 12 **(B) had coverage under the Indiana comprehensive health**  
 13 **insurance association (IC 27-8-10) within the immediately**  
 14 **preceding six (6) months and the coverage no longer**  
 15 **applies under IC 27-8-10-0.5.**
- 16 (b) The following individuals are not eligible for the plan:  
 17 (1) An individual who participates in the federal Medicare  
 18 program (42 U.S.C. 1395 et seq.).  
 19 (2) A pregnant woman for purposes of pregnancy related services.  
 20 (3) An individual who is otherwise eligible for medical assistance.
- 21 (c) The eligibility requirements specified in subsection (a) are  
 22 subject to approval for federal financial participation by the United  
 23 States Department of Health and Human Services.
- 24 SECTION 15. IC 16-28-15-2, AS ADDED BY P.L.229-2011,  
 25 SECTION 162, IS AMENDED TO READ AS FOLLOWS  
 26 [EFFECTIVE JULY 1, 2013]: Sec. 2. As used in this chapter,  
 27 "continuing care retirement community" means a health care facility  
 28 that:  
 29 (1) provides independent living services and health facility  
 30 services in a campus setting with common areas;  
 31 (2) **either:**  
 32 **(A) holds continuing care agreements with at least twenty-five**  
 33 **percent (25%) of its residents (as defined in IC 23-2-4-1); or**  
 34 **(B) has continuously maintained, for a continuing care**  
 35 **retirement community that was registered under IC 23-2-4**  
 36 **before January 2, 2007, at least one (1) continuing care**  
 37 **agreement since on or before January 1, 2007, with an**  
 38 **individual residing in the continuing care retirement**  
 39 **community;**  
 40 (3) uses the money from the **agreement or** agreements described  
 41 in subdivision (2) to provide services to the resident before the  
 42 resident may be eligible for Medicaid under IC 12-15; and  
 43 (4) meets the requirements of IC 23-2-4.
- 44 SECTION 16. IC 16-28-15-7, AS ADDED BY P.L.229-2011,  
 45 SECTION 162, IS AMENDED TO READ AS FOLLOWS  
 46 [EFFECTIVE JULY 1, 2013]: Sec. 7. The office shall implement the  
 47 waiver approved by the United States Centers for Medicare and  
 48 Medicaid Services under 42 CFR 433.68(e)(2) that provides for the  
 49 following:  
 50 (1) Nonuniform quality assessment fee rates.  
 51 (2) An exemption from collection of a quality assessment fee

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from the following:

(A) A continuing care retirement community as follows:

(i) A continuing care retirement community that was registered with the securities commissioner as a continuing care retirement community on **or before** January 1, 2007, **is not required to meet the definition of a continuing care retirement community in section 2 of this chapter. and has continuously maintained at least one (1) continuing care agreement since on or before January 1, 2007, with an individual residing in the continuing care retirement community.**

(ii) A continuing care retirement community that, for the period January 1, 2007, through June 30, 2009, operated independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars (\$25,000).

(iii) An organization registered under IC 23-2-4 before July 1, 2009, that provides housing in an independent living unit for a religious order.

(iv) A continuing care retirement community that meets the definition set forth in section 2 of this chapter.

(B) A hospital based health facility.

(C) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this section is subject to and must comply with this chapter.

SECTION 17. IC 23-2-4-1, AS AMENDED BY P.L.153-2009, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 1. As used in this chapter, the term:

"Application fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in processing the individual's application to become a resident.

"Commissioner" means the securities commissioner as provided in IC 23-19-6-1(a).

"Continuing care agreement" means the following:

**(1) For continuing care retirement communities registered before January 2, 2007, an agreement by a provider to furnish to at least one (1) individual, for the payment of an entrance fee and periodic charges, accommodations in a living unit of a home, and at least two (2) of the following services for the life of the individual or for more than one (1) month unless the agreement is cancelled:**

**(A) Meals and related services.**

**(B) Nursing care services.**

**(C) Medical services.**

**(D) Other health related services.**

**(+) (2) For continuing care retirement communities registered after January 1, 2007, and before July 1, 2009, an agreement by a provider to furnish to an individual, for the payment of an entrance fee of at least twenty-five thousand dollars (\$25,000) and periodic charges:**

- 1 (A) accommodations in a living unit of a continuing care  
 2 retirement community;  
 3 (B) meals and related services;  
 4 (C) nursing care services;  
 5 (D) medical services;  
 6 (E) other health related services; or  
 7 (F) any combination of these services;  
 8 for the life of the individual or for more than one (1) month,  
 9 unless the agreement is canceled.
- 10 ~~(2)~~ **(3)** For continuing care retirement communities registered  
 11 after June 30, 2009, an agreement by a provider to furnish to an  
 12 individual, for the payment of an entrance fee of at least  
 13 twenty-five thousand dollars (\$25,000) and periodic charges:
- 14 (A) accommodations in a living unit of a continuing care  
 15 retirement community;  
 16 (B) meals and related services;  
 17 (C) nursing care services;  
 18 (D) medical services;  
 19 (E) other health related services; or  
 20 (F) any combination of these services;  
 21 for the life of the individual, unless the agreement is terminated  
 22 as specified under this chapter.
- 23 "Continuing care retirement community" includes both of the  
 24 following:
- 25 (1) An independent living facility.  
 26 (2) A health facility licensed under IC 16-28.
- 27 "Contracting party" means a person or persons who enter into a  
 28 continuing care agreement with a provider.
- 29 "Entrance fee" means the sum of money or other property paid or  
 30 transferred, or promised to be paid or transferred, to a provider in  
 31 consideration for one (1) or more individuals becoming a resident of a  
 32 continuing care retirement community under a continuing care  
 33 agreement.
- 34 "Living unit" means a room, apartment, cottage, or other area within  
 35 a continuing care retirement community set aside for the use of one (1)  
 36 or more identified residents.
- 37 "Long term financing" means financing for a period in excess of one  
 38 (1) year.
- 39 "Omission of a material fact" means the failure to state a material  
 40 fact required to be stated in any disclosure statement or registration in  
 41 order to make the disclosure statement or registration, in light of the  
 42 circumstances under which they were made, not misleading.
- 43 "Person" means an individual, a corporation, a partnership, an  
 44 association, a limited liability company, or other legal entity.
- 45 "Provider" means a person that agrees to provide care under a  
 46 continuing care agreement.
- 47 "Refurbishment fee" means the fee charged an individual, in  
 48 addition to the entrance fee or any other fee, to cover the provider's  
 49 reasonable costs in refurbishing a previously occupied living unit  
 50 specifically designated for occupancy by that individual.

1 "Resident" means an individual who is entitled to receive benefits  
2 under a continuing care agreement.

3 "Solicit" means any action of a provider in seeking to have an  
4 individual residing in Indiana pay an application fee and enter into a  
5 continuing care agreement, including:

6 (1) personal, telephone, or mail communication or any other  
7 communication directed to and received by any individual in  
8 Indiana; and

9 (2) advertising in any media distributed or communicated by any  
10 means to individuals residing in Indiana.

11 "Termination" refers to the cancellation of a continuing care  
12 agreement under this chapter.

13 SECTION 18. IC 23-2-4-3, AS AMENDED BY P.L.153-2009,  
14 SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
15 JULY 1, 2013]: Sec. 3. (a) A provider shall register each continuing  
16 care retirement community with the commissioner if:

17 (1) before opening the continuing care retirement community, the  
18 provider:

19 (A) enters into;

20 (B) extends; or

21 (C) solicits;

22 a continuing care agreement; or

23 (2) while operating the continuing care retirement community, the  
24 provider has **either:**

25 **(A) for a continuing care retirement community registered**  
26 **before January 2, 2007, continuously maintained since on**  
27 **or before January 1, 2007, at least one (1) continuing care**  
28 **agreement with an individual living in the continuing care**  
29 **community; or**

30 **(B) for a continuing care retirement community registered**  
31 **after January 1, 2007, entered into a continuing care**  
32 **agreement with at least twenty-five percent (25%) of the**  
33 **individuals living in the continuing care retirement**  
34 **community.**

35 (b) If a provider fails to register a continuing care retirement  
36 community, the provider may not:

37 (1) enter into, or extend the term of, a continuing care agreement  
38 to provide continuing care to any person at that continuing care  
39 retirement community;

40 (2) provide services at that continuing care retirement community  
41 under a continuing care agreement; or

42 (3) solicit the execution, by persons residing within Indiana, of a  
43 continuing care agreement to provide continuing care at that  
44 continuing care retirement community.

45 (c) The provider's application for registration must be filed with the  
46 commissioner by the provider on forms prescribed by the  
47 commissioner, and must be accompanied by an application fee of two  
48 hundred fifty dollars (\$250). The application must contain the  
49 following information:

50 (1) an initial disclosure statement, as described in section 4 of this  
51 chapter; and

1 (2) any other information required by the commissioner under  
2 rules adopted under this chapter.

3 (d) The commissioner may accept, in lieu of the information  
4 required by subsection (c), any other registration, disclosure statement,  
5 or other document filed by the provider in Indiana, in any other state,  
6 or with the federal government if the commissioner determines that  
7 such document substantially complies with the requirements of this  
8 chapter.

9 (e) Upon receipt of the application for registration, the  
10 commissioner shall mark the application filed. Within sixty (60) days  
11 of the filing of the application, the commissioner shall enter an order  
12 registering the provider or rejecting the registration. If no order of  
13 rejection is entered within that sixty (60) day period, the provider shall  
14 be considered registered unless the provider has consented in writing  
15 to an extension of time; if no order of rejection is entered within the  
16 time period as extended by consent, the provider shall be considered  
17 registered.

18 (f) If the commissioner determines that the application for  
19 registration complies with all of the requirements of this chapter, the  
20 commissioner shall enter an order registering the provider. If the  
21 commissioner determines that such requirements have not been met,  
22 the commissioner shall notify the provider of the deficiencies and shall  
23 inform the provider that it has sixty (60) days to correct them. If the  
24 deficiencies are not corrected within sixty (60) days, the commissioner  
25 shall enter an order rejecting the registration. The order rejecting the  
26 registration shall include the findings of fact upon which the order is  
27 based. The provider may petition for reconsideration, and is entitled to  
28 a hearing upon that petition.

29 SECTION 19. IC 27-1-3-7 IS AMENDED TO READ AS  
30 FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 7. (a) The department  
31 may promulgate rules and regulations for any of the following  
32 enumerated purposes:

- 33 (1) For the conduct of the work of the department.  
34 (2) Prescribing the methods and standards to be used in making  
35 the examinations and prescribing the forms of reports of the  
36 several insurance companies to which IC 27-1 is applicable.  
37 (3) Defining what is a safe or an unsafe manner and a safe or an  
38 unsafe condition for conducting business by any insurance  
39 company to which IC 27-1 is applicable.  
40 (4) For the establishment of safe and sound methods for the  
41 transaction of business by such insurance companies and for the  
42 purpose of safeguarding the interests of policyholders, creditors,  
43 and shareholders respecting the withdrawal or payment of funds  
44 by any life insurance company in times of emergency. Any rule or  
45 regulation promulgated under this subdivision may apply to one  
46 (1) or more insurance companies as the department may  
47 determine.  
48 (5) For the administration and termination of the affairs of any  
49 such insurance company which is in involuntary liquidation or  
50 whose business and property have been taken possession of by the

1 department for the purpose of rehabilitation, liquidation,  
2 conservation, or dissolution under IC 27-1.

3 (6) For the regulation of the solicitation or use of proxies, in  
4 general and as they concern consents or authorizations, in respect  
5 of securities issued by any domestic stock company for the  
6 purpose of protecting investors by prescribing the form of proxies,  
7 including such consents or authorizations, and by requiring  
8 adequate disclosure of information relevant to such proxies,  
9 including such consents or authorizations, and relevant to the  
10 business to be transacted at any meeting of shareholders with  
11 respect to which such proxies, including such consents or  
12 authorizations, may be used, which regulations may, in general,  
13 conform to those prescribed by the National Association of  
14 Insurance Commissioners.

15 **(7) For regulation related to a health benefit exchange**  
16 **established under the federal Patient Protection and**  
17 **Affordable Care Act (P.L. 111-148), as amended by the**  
18 **federal Health Care and Education Reconciliation Act of 2010**  
19 **(P.L. 111-152), and operating in Indiana.**

20 (b) The department may adopt a rule under IC 4-22-2 to provide  
21 reasonable simplification of the terms and coverage of individual and  
22 group Medicare supplement accident and sickness insurance policies  
23 and individual and group Medicare supplement subscriber contracts in  
24 order to facilitate public understanding and comparison and to  
25 eliminate provisions contained in those policies or contracts which may  
26 be misleading or confusing in connection either with the purchase of  
27 those coverages or with the settlement of claims and to provide for full  
28 disclosure in the sale of those coverages.

29 SECTION 20. IC 27-1-3-10.5 IS AMENDED TO READ AS  
30 FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 10.5. (a) As used in this  
31 section, "confidential information" means information that has been  
32 designated as confidential by statute, rule, or regulation issued under  
33 a statute.

34 (b) The commissioner may not:

- 35 (1) disclose; or
- 36 (2) subject to subpoena;

37 financial information regarding material transactions disclosed by an  
38 insurer under IC 27-2-18.

39 (c) The commissioner may not disclose any information, including  
40 any document or report received from:

- 41 (1) the National Association of Insurance Commissioners; or
- 42 (2) an insurance department of another state;

43 if the information is designated as confidential information in the other  
44 jurisdiction.

45 (d) The commissioner may share confidential information with:

- 46 (1) the National Association of Insurance Commissioners; or
- 47 (2) an insurance department of another state;

48 on the condition that the National Association of Insurance  
49 Commissioners and the other state agree to maintain the same level of  
50 confidentiality that is provided to the information under Indiana law.

51 **(e) The commissioner may share confidential information**

1 **related to a health benefit exchange established under the federal**  
 2 **Patient Protection and Affordable Care Act (P.L. 111-148), as**  
 3 **amended by the federal Health Care and Education Reconciliation**  
 4 **Act of 2010 (P.L. 111-152), with the health benefit exchange if the**  
 5 **health benefit exchange:**

- 6 **(1) agrees to maintain the same level of confidentiality that is**  
 7 **provided to the confidential information under Indiana law;**  
 8 **and**  
 9 **(2) complies with all applicable confidentiality requirements**  
 10 **under federal law.**

11 SECTION 21. IC 27-1-15.7-2, AS AMENDED BY HEA  
 12 1321-2013, SECTION 15, IS AMENDED TO READ AS FOLLOWS  
 13 [EFFECTIVE JULY 1, 2013]: Sec. 2. (a) Except as provided in  
 14 subsection (b), to renew a license issued under IC 27-1-15.6, a resident  
 15 insurance producer must complete at least twenty-four (24) hours of  
 16 credit in continuing education courses. If the insurance producer has a  
 17 qualification described in IC 27-1-15.6-7(a)(1), IC 27-1-15.6-7(a)(2),  
 18 or IC 27-1-15.6-7(a)(5), for a license renewal that occurs after June 30,  
 19 2014, at least three (3) of the hours of credit required by this subsection  
 20 must be related to ethical practices in the marketing and sale of life,  
 21 health, or annuity insurance products. An attorney in good standing  
 22 who is admitted to the practice of law in Indiana and holds a license  
 23 issued under IC 27-1-15.6 may complete all or any number of hours of  
 24 continuing education required by this subsection by completing an  
 25 equivalent number of hours in continuing legal education courses that  
 26 are related to the business of insurance.

27 (b) Except as provided in subsection (c), to renew a license issued  
 28 under IC 27-1-15.6, a limited lines producer with a title qualification  
 29 under IC 27-1-15.6-7(a)(8) must complete at least seven (7) hours of  
 30 credit in continuing education courses related to the business of title  
 31 insurance with at least one (1) hour of instruction in a structured setting  
 32 or comparable self-study in each of the following:

- 33 (1) Ethical practices in the marketing and selling of title  
 34 insurance.  
 35 (2) Title insurance underwriting.  
 36 (3) Escrow issues.  
 37 (4) Principles of the federal Real Estate Settlement Procedures  
 38 Act (12 U.S.C. 2608).

39 An attorney in good standing who is admitted to the practice of law in  
 40 Indiana and holds a license issued under IC 27-1-15.6 with a title  
 41 qualification under IC 27-1-15.6-7(a)(8) may complete all or any  
 42 number of hours of continuing education required by this subsection by  
 43 completing an equivalent number of hours in continuing legal  
 44 education courses related to the business of title insurance or any  
 45 aspect of real property law.

46 (c) The following insurance producers are not required to complete  
 47 continuing education courses to renew a license under this chapter:

- 48 (1) A limited lines producer who is licensed without examination  
 49 under IC 27-1-15.6-18(1).  
 50 (2) A limited line credit insurance producer.  
 51 (3) A nonresident limited lines producer with a title qualification:

- 1 (A) whose home state requires continuing education for a title  
 2 qualification; and  
 3 (B) who has met the continuing education requirements  
 4 described in clause (A).
- 5 (d) To satisfy the requirements of subsection (a) or (b), a licensee  
 6 may use only those credit hours earned in continuing education courses  
 7 completed by the licensee:
- 8 (1) after the effective date of the licensee's last renewal of a  
 9 license under this chapter; or  
 10 (2) if the licensee is renewing a license for the first time, after the  
 11 date on which the licensee was issued the license under this  
 12 chapter.
- 13 (e) If an insurance producer receives qualification for a license in  
 14 more than one (1) line of authority under IC 27-1-15.6, the insurance  
 15 producer may not be required to complete a total of more than  
 16 twenty-four (24) hours of credit in continuing education courses to  
 17 renew the license.
- 18 (f) Except as provided in subsection (g), a licensee may receive  
 19 credit only for completing **the following** continuing education courses:
- 20 **(1) Continuing education courses** that have been approved by  
 21 the commissioner under section 4 of this chapter.  
 22 **(2) Continuing education courses that are required for the**  
 23 **licensee under IC 27-19-4-14.**
- 24 (g) A licensee who teaches a course approved by the commissioner  
 25 under section 4 of this chapter shall receive continuing education credit  
 26 for teaching the course.
- 27 (h) When a licensee renews a license issued under this chapter, the  
 28 licensee must submit:
- 29 (1) a continuing education statement that:
- 30 (A) is in a format authorized by the commissioner;  
 31 (B) is signed by the licensee under oath; and  
 32 (C) lists the continuing education courses completed by the  
 33 licensee to satisfy the continuing education requirements of  
 34 this section; and  
 35 (2) any other information required by the commissioner.
- 36 (i) A continuing education statement submitted under subsection (h)  
 37 may be reviewed and audited by the department.
- 38 (j) A licensee shall retain a copy of the original certificate of  
 39 completion received by the licensee for completion of a continuing  
 40 education course.
- 41 (k) A licensee who completes a continuing education course that:
- 42 (1) is approved by the commissioner under section 4 of this  
 43 chapter;  
 44 (2) is held in a classroom setting; and  
 45 (3) concerns ethics;
- 46 shall receive continuing education credit not to exceed four (4) hours  
 47 in a renewal period.
- 48 SECTION 22. IC 27-4-1-4, AS AMENDED BY P.L.67-2011,  
 49 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 50 JULY 1, 2013]: Sec. 4. (a) The following are hereby defined as unfair

1 methods of competition and unfair and deceptive acts and practices in  
2 the business of insurance:

3 (1) Making, issuing, circulating, or causing to be made, issued, or  
4 circulated, any estimate, illustration, circular, or statement:

5 (A) misrepresenting the terms of any policy issued or to be  
6 issued or the benefits or advantages promised thereby or the  
7 dividends or share of the surplus to be received thereon;

8 (B) making any false or misleading statement as to the  
9 dividends or share of surplus previously paid on similar  
10 policies;

11 (C) making any misleading representation or any  
12 misrepresentation as to the financial condition of any insurer,  
13 or as to the legal reserve system upon which any life insurer  
14 operates;

15 (D) using any name or title of any policy or class of policies  
16 misrepresenting the true nature thereof; or

17 (E) making any misrepresentation to any policyholder insured  
18 in any company for the purpose of inducing or tending to  
19 induce such policyholder to lapse, forfeit, or surrender the  
20 policyholder's insurance.

21 (2) Making, publishing, disseminating, circulating, or placing  
22 before the public, or causing, directly or indirectly, to be made,  
23 published, disseminated, circulated, or placed before the public,  
24 in a newspaper, magazine, or other publication, or in the form of  
25 a notice, circular, pamphlet, letter, or poster, or over any radio or  
26 television station, or in any other way, an advertisement,  
27 announcement, or statement containing any assertion,  
28 representation, or statement with respect to any person in the  
29 conduct of the person's insurance business, which is untrue,  
30 deceptive, or misleading.

31 (3) Making, publishing, disseminating, or circulating, directly or  
32 indirectly, or aiding, abetting, or encouraging the making,  
33 publishing, disseminating, or circulating of any oral or written  
34 statement or any pamphlet, circular, article, or literature which is  
35 false, or maliciously critical of or derogatory to the financial  
36 condition of an insurer, and which is calculated to injure any  
37 person engaged in the business of insurance.

38 (4) Entering into any agreement to commit, or individually or by  
39 a concerted action committing any act of boycott, coercion, or  
40 intimidation resulting or tending to result in unreasonable  
41 restraint of, or a monopoly in, the business of insurance.

42 (5) Filing with any supervisory or other public official, or making,  
43 publishing, disseminating, circulating, or delivering to any person,  
44 or placing before the public, or causing directly or indirectly, to  
45 be made, published, disseminated, circulated, delivered to any  
46 person, or placed before the public, any false statement of  
47 financial condition of an insurer with intent to deceive. Making  
48 any false entry in any book, report, or statement of any insurer  
49 with intent to deceive any agent or examiner lawfully appointed  
50 to examine into its condition or into any of its affairs, or any

1 public official to which such insurer is required by law to report,  
2 or which has authority by law to examine into its condition or into  
3 any of its affairs, or, with like intent, willfully omitting to make a  
4 true entry of any material fact pertaining to the business of such  
5 insurer in any book, report, or statement of such insurer.

6 (6) Issuing or delivering or permitting agents, officers, or  
7 employees to issue or deliver, agency company stock or other  
8 capital stock, or benefit certificates or shares in any common law  
9 corporation, or securities or any special or advisory board  
10 contracts or other contracts of any kind promising returns and  
11 profits as an inducement to insurance.

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

13 (A) Unfair discrimination between individuals of the same  
14 class and equal expectation of life in the rates or assessments  
15 charged for any contract of life insurance or of life annuity or  
16 in the dividends or other benefits payable thereon, or in any  
17 other of the terms and conditions of such contract. However,  
18 in determining the class, consideration may be given to the  
19 nature of the risk, plan of insurance, the actual or expected  
20 expense of conducting the business, or any other relevant  
21 factor.

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

32 (C) Excessive or inadequate charges for premiums, policy  
33 fees, assessments, or rates, or making or permitting any unfair  
34 discrimination between persons of the same class involving  
35 essentially the same hazards, in the amount of premiums,  
36 policy fees, assessments, or rates charged or made for:

37 (i) policies or contracts of reinsurance or joint reinsurance,  
38 or abstract and title insurance;

39 (ii) policies or contracts of insurance against loss or damage  
40 to aircraft, or against liability arising out of the ownership,  
41 maintenance, or use of any aircraft, or of vessels or craft,  
42 their cargoes, marine builders' risks, marine protection and  
43 indemnity, or other risks commonly insured under marine,  
44 as distinguished from inland marine, insurance; or

45 (iii) policies or contracts of any other kind or kinds of  
46 insurance whatsoever.

47 However, nothing contained in clause (C) shall be construed to  
48 apply to any of the kinds of insurance referred to in clauses (A)  
49 and (B) nor to reinsurance in relation to such kinds of insurance.

50 Nothing in clause (A), (B), or (C) shall be construed as making or

1 permitting any excessive, inadequate, or unfairly discriminatory  
2 charge or rate or any charge or rate determined by the department  
3 or commissioner to meet the requirements of any other insurance  
4 rate regulatory law of this state.

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

26 (A) Paying bonuses to policyholders or otherwise abating their  
27 premiums in whole or in part out of surplus accumulated from  
28 nonparticipating insurance, so long as any such bonuses or  
29 abatement of premiums are fair and equitable to policyholders  
30 and for the best interests of the company and its policyholders.

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

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

41 (D) Paying by an insurer or insurance producer thereof duly  
42 licensed as such under the laws of this state of money,  
43 commission, or brokerage, or giving or allowing by an insurer  
44 or such licensed insurance producer thereof anything of value,  
45 for or on account of the solicitation or negotiation of policies  
46 or other contracts of any kind or kinds, to a broker, an  
47 insurance producer, or a solicitor duly licensed under the laws  
48 of this state, but such broker, insurance producer, or solicitor  
49 receiving such consideration shall not pay, give, or allow  
50 credit for such consideration as received in whole or in part,

- 1 directly or indirectly, to the insured by way of rebate.
- 2 (9) Requiring, as a condition precedent to loaning money upon the  
3 security of a mortgage upon real property, that the owner of the  
4 property to whom the money is to be loaned negotiate any policy  
5 of insurance covering such real property through a particular  
6 insurance producer or broker or brokers. However, this  
7 subdivision shall not prevent the exercise by any lender of the  
8 lender's right to approve or disapprove of the insurance company  
9 selected by the borrower to underwrite the insurance.
- 10 (10) Entering into any contract, combination in the form of a trust  
11 or otherwise, or conspiracy in restraint of commerce in the  
12 business of insurance.
- 13 (11) Monopolizing or attempting to monopolize or combining or  
14 conspiring with any other person or persons to monopolize any  
15 part of commerce in the business of insurance. However,  
16 participation as a member, director, or officer in the activities of  
17 any nonprofit organization of insurance producers or other  
18 workers in the insurance business shall not be interpreted, in  
19 itself, to constitute a combination in restraint of trade or as  
20 combining to create a monopoly as provided in this subdivision  
21 and subdivision (10). The enumeration in this chapter of specific  
22 unfair methods of competition and unfair or deceptive acts and  
23 practices in the business of insurance is not exclusive or  
24 restrictive or intended to limit the powers of the commissioner or  
25 department or of any court of review under section 8 of this  
26 chapter.
- 27 (12) Requiring as a condition precedent to the sale of real or  
28 personal property under any contract of sale, conditional sales  
29 contract, or other similar instrument or upon the security of a  
30 chattel mortgage, that the buyer of such property negotiate any  
31 policy of insurance covering such property through a particular  
32 insurance company, insurance producer, or broker or brokers.  
33 However, this subdivision shall not prevent the exercise by any  
34 seller of such property or the one making a loan thereon of the  
35 right to approve or disapprove of the insurance company selected  
36 by the buyer to underwrite the insurance.
- 37 (13) Issuing, offering, or participating in a plan to issue or offer,  
38 any policy or certificate of insurance of any kind or character as  
39 an inducement to the purchase of any property, real, personal, or  
40 mixed, or services of any kind, where a charge to the insured is  
41 not made for and on account of such policy or certificate of  
42 insurance. However, this subdivision shall not apply to any of the  
43 following:
- 44 (A) Insurance issued to credit unions or members of credit  
45 unions in connection with the purchase of shares in such credit  
46 unions.
- 47 (B) Insurance employed as a means of guaranteeing the  
48 performance of goods and designed to benefit the purchasers  
49 or users of such goods.
- 50 (C) Title insurance.

- 1 (D) Insurance written in connection with an indebtedness and  
 2 intended as a means of repaying such indebtedness in the  
 3 event of the death or disability of the insured.
- 4 (E) Insurance provided by or through motorists service clubs  
 5 or associations.
- 6 (F) Insurance that is provided to the purchaser or holder of an  
 7 air transportation ticket and that:
- 8 (i) insures against death or nonfatal injury that occurs during  
 9 the flight to which the ticket relates;
- 10 (ii) insures against personal injury or property damage that  
 11 occurs during travel to or from the airport in a common  
 12 carrier immediately before or after the flight;
- 13 (iii) insures against baggage loss during the flight to which  
 14 the ticket relates; or
- 15 (iv) insures against a flight cancellation to which the ticket  
 16 relates.
- 17 (14) Refusing, because of the for-profit status of a hospital or  
 18 medical facility, to make payments otherwise required to be made  
 19 under a contract or policy of insurance for charges incurred by an  
 20 insured in such a for-profit hospital or other for-profit medical  
 21 facility licensed by the state department of health.
- 22 (15) Refusing to insure an individual, refusing to continue to issue  
 23 insurance to an individual, limiting the amount, extent, or kind of  
 24 coverage available to an individual, or charging an individual a  
 25 different rate for the same coverage, solely because of that  
 26 individual's blindness or partial blindness, except where the  
 27 refusal, limitation, or rate differential is based on sound actuarial  
 28 principles or is related to actual or reasonably anticipated  
 29 experience.
- 30 (16) Committing or performing, with such frequency as to  
 31 indicate a general practice, unfair claim settlement practices (as  
 32 defined in section 4.5 of this chapter).
- 33 (17) Between policy renewal dates, unilaterally canceling an  
 34 individual's coverage under an individual or group health  
 35 insurance policy solely because of the individual's medical or  
 36 physical condition.
- 37 (18) Using a policy form or rider that would permit a cancellation  
 38 of coverage as described in subdivision (17).
- 39 (19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1  
 40 concerning motor vehicle insurance rates.
- 41 (20) Violating IC 27-8-21-2 concerning advertisements referring  
 42 to interest rate guarantees.
- 43 (21) Violating IC 27-8-24.3 concerning insurance and health plan  
 44 coverage for victims of abuse.
- 45 (22) Violating IC 27-8-26 concerning genetic screening or testing.
- 46 (23) Violating IC 27-1-15.6-3(b) concerning licensure of  
 47 insurance producers.
- 48 (24) Violating IC 27-1-38 concerning depository institutions.
- 49 (25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning  
 50 the resolution of an appealed grievance decision.

- 1 (26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired  
 2 July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1,  
 3 2007, and repealed).
- 4 (27) Violating IC 27-2-21 concerning use of credit information.
- 5 (28) Violating IC 27-4-9-3 concerning recommendations to  
 6 consumers.
- 7 (29) Engaging in dishonest or predatory insurance practices in  
 8 marketing or sales of insurance to members of the United States  
 9 Armed Forces as:
- 10 (A) described in the federal Military Personnel Financial  
 11 Services Protection Act, P.L.109-290; or
- 12 (B) defined in rules adopted under subsection (b).
- 13 (30) Violating IC 27-8-19.8-20.1 concerning stranger originated  
 14 life insurance.
- 15 (31) Violating IC 27-2-22 concerning retained asset accounts.
- 16 **(32) Violating IC 27-8-5-29 concerning health plans offered**  
 17 **through a health benefit exchange (as defined in**  
 18 **IC 27-19-2-8).**
- 19 **(33) Violating a requirement of the federal Patient Protection**  
 20 **and Affordable Care Act (P.L. 111-148), as amended by the**  
 21 **federal Health Care and Education Reconciliation Act of 2010**  
 22 **(P.L. 111-152), that is enforceable by the state.**
- 23 (b) Except with respect to federal insurance programs under  
 24 Subchapter III of Chapter 19 of Title 38 of the United States Code, the  
 25 commissioner may, consistent with the federal Military Personnel  
 26 Financial Services Protection Act (P.L.109-290), adopt rules under  
 27 IC 4-22-2 to:
- 28 (1) define; and
- 29 (2) while the members are on a United States military installation  
 30 or elsewhere in Indiana, protect members of the United States  
 31 Armed Forces from;  
 32 dishonest or predatory insurance practices.
- 33 SECTION 23. IC 27-8-5-1, AS AMENDED BY P.L.160-2011,  
 34 SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 35 JULY 1, 2013]: Sec. 1. (a) The term "policy of accident and sickness  
 36 insurance", as used in this chapter, includes any policy or contract  
 37 covering one (1) or more of the kinds of insurance described in Class  
 38 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual  
 39 basis under this section and sections 2 through 9 of this chapter, on the  
 40 group basis under this section and sections 16 through 19 of this  
 41 chapter, on the franchise basis under this section and section 11 of this  
 42 chapter, or on a blanket basis under section 15 of this chapter and  
 43 (except as otherwise expressly provided in this chapter) shall be  
 44 exclusively governed by this chapter.
- 45 (b) No policy of accident and sickness insurance may be issued or  
 46 delivered to any person in this state, nor may any application, rider, or  
 47 endorsement be used in connection with an accident and sickness  
 48 insurance policy, until a copy of the form of the policy and of the  
 49 classification of risks and the premium rates, or, in the case of  
 50 assessment companies, the estimated cost pertaining thereto, have been  
 51 filed with and reviewed by the commissioner under section 1.5 of this

1 chapter. This section is applicable also to assessment companies and  
2 fraternal benefit associations or societies.

3 (c) This chapter shall be applied in conformity with the  
4 requirements of the federal Patient Protection and Affordable Care Act  
5 (P.L. 111-148), as amended by the federal Health Care and Education  
6 Reconciliation Act of 2010 (P.L. 111-152), as in effect on September  
7 23, 2010.

8 **(d) A policy of accident and sickness insurance that is issued or**  
9 **delivered through a health benefit exchange established under the**  
10 **federal Patient Protection and Affordable Care Act (P.L. 111-148),**  
11 **as amended by the federal Health Care and Education**  
12 **Reconciliation Act of 2010 (P.L. 111-152), is subject to the**  
13 **requirements of this chapter. The commissioner may adopt rules**  
14 **under IC 4-22-2 to implement this subsection, including rules**  
15 **concerning:**

16 **(1) certification or decertification of a qualified health plan**  
17 **(as defined in IC 27-19-2-16); and**

18 **(2) open enrollment.**

19 SECTION 24. IC 27-8-5-1.5, AS AMENDED BY P.L.111-2008,  
20 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
21 JULY 1, 2013]: Sec. 1.5. (a) This section applies to a policy of accident  
22 and sickness insurance issued on an individual, a group, a franchise, or  
23 a blanket basis, including a policy issued by an assessment company or  
24 a fraternal benefit society.

25 (b) As used in this section, "commissioner" refers to the insurance  
26 commissioner appointed under IC 27-1-1-2.

27 (c) As used in this section, "grossly inadequate filing" means a  
28 policy form filing:

29 (1) that fails to provide key information, including state specific  
30 information, regarding a product, policy, or rate; or

31 (2) that demonstrates an insufficient understanding of applicable  
32 legal requirements.

33 (d) As used in this section, "policy form" means a policy, a contract,  
34 a certificate, a rider, an endorsement, an evidence of coverage, or any  
35 amendment that is required by law to be filed with the commissioner  
36 for approval before use in Indiana.

37 (e) As used in this section, "type of insurance" refers to a type of  
38 coverage listed on the National Association of Insurance  
39 Commissioners Uniform Life, Accident and Health, Annuity and Credit  
40 Product Coding Matrix, or a successor document, under the heading  
41 "Continuing Care Retirement Communities", "Health", "Long Term  
42 Care", or "Medicare Supplement".

43 (f) Each person having a role in the filing process described in  
44 subsection (i) shall act in good faith and with due diligence in the  
45 performance of the person's duties.

46 (g) A policy form, **including a policy form of a policy, contract,**  
47 **certificate, rider, endorsement, evidence of coverage, or**  
48 **amendment that is issued through a health benefit exchange (as**  
49 **defined in IC 27-19-2-8), may not be issued or delivered in Indiana**  
50 **unless the policy form has been filed with and approved by the**  
51 **commissioner.**

- 1 (h) The commissioner shall do the following:
- 2 (1) Create a document containing a list of all product filing
- 3 requirements for each type of insurance, with appropriate
- 4 citations to the law, administrative rule, or bulletin that specifies
- 5 the requirement, including the citation for the type of insurance
- 6 to which the requirement applies.
- 7 (2) Make the document described in subdivision (1) available on
- 8 the department of insurance Internet site.
- 9 (3) Update the document described in subdivision (1) at least
- 10 annually and not more than thirty (30) days following any change
- 11 in a filing requirement.
- 12 (i) The filing process is as follows:
- 13 (1) A filer shall submit a policy form filing that:
- 14 (A) includes a copy of the document described in subsection
- 15 (h);
- 16 (B) indicates the location within the policy form or supplement
- 17 that relates to each requirement contained in the document
- 18 described in subsection (h); and
- 19 (C) certifies that the policy form meets all requirements of
- 20 state law.
- 21 (2) The commissioner shall review a policy form filing and, not
- 22 more than thirty (30) days after the commissioner receives the
- 23 filing under subdivision (1):
- 24 (A) approve the filing; or
- 25 (B) provide written notice of a determination:
- 26 (i) that deficiencies exist in the filing; or
- 27 (ii) that the commissioner disapproves the filing.
- 28 A written notice provided by the commissioner under clause (B)
- 29 must be based only on the requirements set forth in the document
- 30 described in subsection (h) and must cite the specific
- 31 requirements not met by the filing. A written notice provided by
- 32 the commissioner under clause (B)(i) must state the reasons for
- 33 the commissioner's determination in sufficient detail to enable the
- 34 filer to bring the policy form into compliance with the
- 35 requirements not met by the filing.
- 36 (3) A filer may resubmit a policy form that:
- 37 (A) was determined deficient under subdivision (2) and has
- 38 been amended to correct the deficiencies; or
- 39 (B) was disapproved under subdivision (2) and has been
- 40 revised.
- 41 A policy form resubmitted under this subdivision must meet the
- 42 requirements set forth as described in subdivision (1) and must be
- 43 resubmitted not more than thirty (30) days after the filer receives
- 44 the commissioner's written notice of deficiency or disapproval. If
- 45 a policy form is not resubmitted within thirty (30) days after
- 46 receipt of the written notice, the commissioner's determination
- 47 regarding the policy form is final.
- 48 (4) The commissioner shall review a policy form filing
- 49 resubmitted under subdivision (3) and, not more than thirty (30)
- 50 days after the commissioner receives the resubmission:

- 1 (A) approve the resubmitted policy form; or  
 2 (B) provide written notice that the commissioner disapproves  
 3 the resubmitted policy form.
- 4 A written notice of disapproval provided by the commissioner  
 5 under clause (B) must be based only on the requirements set forth  
 6 in the document described in subsection (h), must cite the specific  
 7 requirements not met by the filing, and must state the reasons for  
 8 the commissioner's determination in detail. The commissioner's  
 9 approval or disapproval of a resubmitted policy form under this  
 10 subdivision is final, except that the commissioner may allow the  
 11 filer to resubmit a further revised policy form if the filer, in the  
 12 filer's resubmission under subdivision (3), introduced new  
 13 provisions or materially modified a substantive provision of the  
 14 policy form. If the commissioner allows a filer to resubmit a  
 15 further revised policy form under this subdivision, the filer must  
 16 resubmit the further revised policy form not more than thirty (30)  
 17 days after the filer receives notice under clause (B), and the  
 18 commissioner shall issue a final determination on the further  
 19 revised policy form not more than thirty (30) days after the  
 20 commissioner receives the further revised policy form.
- 21 (5) If the commissioner disapproves a policy form filing under  
 22 this subsection, the commissioner shall notify the filer, in writing,  
 23 of the filer's right to a hearing as described in subsection (m). A  
 24 disapproved policy form filing may not be used for a policy of  
 25 accident and sickness insurance unless the disapproval is  
 26 overturned in a hearing conducted under this subsection.
- 27 (6) If the commissioner does not take any action on a policy form  
 28 that is filed or resubmitted under this subsection in accordance  
 29 with any applicable period specified in subdivision (2), (3), or (4),  
 30 the policy form filing is considered to be approved.
- 31 (j) Except as provided in this subsection, the commissioner may not  
 32 disapprove a policy form resubmitted under subsection (i)(3) or (i)(4)  
 33 for a reason other than a reason specified in the original notice of  
 34 determination under subsection (i)(2)(B). The commissioner may  
 35 disapprove a resubmitted policy form for a reason other than a reason  
 36 specified in the original notice of determination under subsection (i)(2)  
 37 if:
- 38 (1) the filer has introduced a new provision in the resubmission;  
 39 (2) the filer has materially modified a substantive provision of the  
 40 policy form in the resubmission;  
 41 (3) there has been a change in requirements applying to the policy  
 42 form; or  
 43 (4) there has been reviewer error and the written disapproval fails  
 44 to state a specific requirement with which the policy form does  
 45 not comply.
- 46 (k) The commissioner may return a grossly inadequate filing to the  
 47 filer without triggering a deadline set forth in this section.
- 48 (l) The commissioner may disapprove a policy form if:  
 49 (1) the benefits provided under the policy form are not reasonable  
 50 in relation to the premium charged; or

- 1 (2) the policy form contains provisions that are unjust, unfair,  
 2 inequitable, misleading, or deceptive, or that encourage  
 3 misrepresentation of the policy.
- 4 (m) Upon disapproval of a filing under this section, the  
 5 commissioner shall provide written notice to the filer or insurer of the  
 6 right to a hearing within twenty (20) days of a request for a hearing.
- 7 (n) Unless a policy form approved under this chapter contains a  
 8 material error or omission, the commissioner may not:
- 9 (1) retroactively disapprove the policy form; or  
 10 (2) examine the filer of the policy form during a routine or  
 11 targeted market conduct examination for compliance with a policy  
 12 form filing requirement that was not in existence at the time the  
 13 policy form was filed.
- 14 SECTION 25. IC 27-8-5-29 IS ADDED TO THE INDIANA CODE  
 15 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
 16 1, 2013]: **Sec. 29. (a) The definitions in IC 27-19-2 apply throughout  
 17 this section.**
- 18 (b) **A health plan may not be offered to any person in Indiana  
 19 through a health benefit exchange unless:**
- 20 (1) **the form of the policy, classification of risks, and premium  
 21 rates that apply to the health plan have been filed with and  
 22 reviewed and approved by the commissioner under this  
 23 chapter; and**
- 24 (2) **the insurer is authorized under this title to engage in the  
 25 business of insurance in Indiana.**
- 26 (c) **An insurer that offers a multistate health plan under Section  
 27 1334 of PPACA through a health benefit exchange shall file, for  
 28 review and approval, the form of the policy, classification of risks,  
 29 and premium rates that apply to the multistate health plan with the  
 30 commissioner within five (5) business days of the date on which the  
 31 same filing is made with the federal government.**
- 32 (d) **This title, in conformity with PPACA, applies to a health  
 33 plan offered through a health benefit exchange to the same extent  
 34 that this title would apply if the health plan were offered  
 35 independently of a health benefit exchange.**
- 36 SECTION 26. IC 27-8-10-0.5 IS ADDED TO THE INDIANA  
 37 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 38 [EFFECTIVE UPON PASSAGE]: **Sec. 0.5. (a) Except as provided in  
 39 this section, the insurance operations of the association cease on the  
 40 later of:**
- 41 (1) **the date on which a health benefit exchange (as defined in  
 42 IC 27-19-2-8) begins operating in Indiana; or**
- 43 (2) **December 31, 2013.**
- 44 (b) **A claim for payment under an association policy must be  
 45 made to the association not later than the later of:**
- 46 (1) **sixty (60) days after the date on which the insurance  
 47 operations cease under subsection (a); or**
- 48 (2) **March 1, 2014.**
- 49 (c) **An appeal or grievance under this chapter must be resolved  
 50 not later than ninety (90) days after the date on which the  
 51 insurance operations cease under subsection (a).**

1 (d) Balance billing under this chapter by a health care provider  
 2 that is not a member of a health care provider network  
 3 arrangement used by the association is prohibited after the later  
 4 of:

- 5 (1) ninety (90) days after the date on which the insurance  
 6 operations cease under subsection (a); or  
 7 (2) March 30, 2014.

8 (e) The association shall, not later than June 30, 2013, submit to  
 9 the commissioner a plan of dissolution for the association. The  
 10 following apply to a plan of dissolution submitted under this  
 11 subsection:

- 12 (1) The plan of dissolution must provide for the following:  
 13 (A) Continuity of care for an individual who is covered  
 14 under an association policy and is an inpatient on the date  
 15 on which the insurance operations cease under subsection  
 16 (a).  
 17 (B) A final accounting described in section 2.1(g) of this  
 18 chapter of the:  
 19 (i) assessments; and  
 20 (ii) cessation of the liability;  
 21 of members of the association.  
 22 (C) Resolution of any net asset deficiency.  
 23 (D) Cessation of all liability of the association.  
 24 (E) Final dissolution of the association.

- 25 (2) The plan of dissolution may provide that, with the  
 26 approval of the board and the commissioner, a power or duty  
 27 of the association may be delegated to a person that is to  
 28 perform functions similar to the functions of the association.

29 (f) The commissioner shall, after notice and hearing, approve a  
 30 plan of dissolution submitted under subsection (e) if the  
 31 commissioner determines that the plan:

- 32 (1) is suitable to ensure the fair, reasonable, and equitable  
 33 dissolution of the association; and  
 34 (2) complies with subsection (e).

35 (g) A plan of dissolution submitted under subsection (e) is  
 36 effective upon the written approval of the commissioner.

37 (h) An action by or against the association must be filed not  
 38 more than one (1) year after the date on which the insurance  
 39 operations cease under subsection (a).

40 (i) This chapter expires on the date on which final dissolution of  
 41 the association occurs under the plan of dissolution approved by  
 42 the commissioner under subsection (f).

43 (j) Funds remaining in the association on the date on which final  
 44 dissolution of the association occurs must be transferred into the  
 45 state general fund.

46 (k) The association, or the person to which the association  
 47 delegates powers or duties under subsection (e), may implement  
 48 this section in accordance with the plan of dissolution approved by  
 49 the commissioner under subsection (f).

50 SECTION 27. IC 27-19 IS ADDED TO THE INDIANA CODE AS  
 51 A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1,

1 2013]:

2 **ARTICLE 19. HEALTH BENEFIT EXCHANGE**

3 **Chapter 1. General Provisions**

4 **Sec. 1. Except as otherwise provided in this title, a reference to**  
 5 **a federal law in this article is a reference to the federal law as in**  
 6 **effect on January 1, 2012.**

7 **Sec. 2. This article applies to a state agency with respect to the**  
 8 **state agency's interactions with a health benefit exchange operated**  
 9 **in Indiana.**

10 **Sec. 3. This article expires immediately upon the occurrence of**  
 11 **any of the following events:**

12 (1) **The complete repeal of PPACA.**

13 (2) **The repeal of the PPACA requirement that one (1) or**  
 14 **more health benefit exchanges be established in each state.**

15 (3) **Any other congressional action, or federal court decision,**  
 16 **rendering the establishment of a health benefit exchange**  
 17 **unnecessary.**

18 (4) **The issuance of an executive order by the governor**  
 19 **specifying that the establishment of a health benefit exchange**  
 20 **in Indiana is unnecessary or inappropriate.**

21 **Sec. 4. The commissioner may do the following to implement**  
 22 **this article:**

23 (1) **Adopt rules under IC 4-22-2.**

24 (2) **Enter into a contract, agreement, or memorandum of**  
 25 **understanding with the following:**

26 (A) **A health benefit exchange.**

27 (B) **An entity that contracts with, or is a subcontractor of,**  
 28 **a health benefit exchange.**

29 (C) **A federal or state agency.**

30 (D) **A health benefit exchange operating in another state.**

31 (E) **An agency of another state.**

32 (F) **A health plan.**

33 (G) **Another person, for purposes of the performance of**  
 34 **necessary functions, as determined by the commissioner.**

35 (3) **Enter with a person described in subdivision (2) into an**  
 36 **information sharing agreement:**

37 (A) **that concerns the disclosure and receiving of data**  
 38 **necessary to implement this article or PPACA; and**

39 (B) **that:**

40 (i) **includes adequate protections with respect to**  
 41 **confidentiality of the shared information; and**

42 (ii) **complies with applicable state and federal law.**

43 **Chapter 2. Definitions**

44 **Sec. 1. The definitions in this chapter apply throughout this**  
 45 **article.**

46 **Sec. 2. "Administrator" refers to the administrator of the office**  
 47 **of Medicaid policy and planning appointed under IC 12-8-6.5-2.**

48 **Sec. 3. (a) Subject to subsections (b) and (c), "application**  
 49 **organization" means an entity that:**

50 (1) **is a navigator described in Section 1311(i) of PPACA (42**  
 51 **U.S.C. 18031(i));**

- 1 (2) assists individuals with application for and enrollment in  
 2 a health benefit exchange or public health insurance program;  
 3 or  
 4 (3) performs the functions of a navigator with respect to a  
 5 health benefit exchange as established by the commissioner.  
 6 (b) In the commissioner's discretion, the term does not include  
 7 an entity that does one (1) or more of the following:  
 8 (1) Provides assistance with application for and enrollment in  
 9 Medicaid to individuals who, based on preliminary  
 10 information obtained by the entity, may be eligible for  
 11 Medicaid without respect to the individuals' income or assets.  
 12 (2) Provides individuals with general information concerning  
 13 the application process for enrollment in a public health  
 14 insurance program, but does not participate with the  
 15 individuals in making application for the individuals'  
 16 enrollment in a public health insurance program.  
 17 (c) The term does not include an entity that makes presumptive  
 18 eligibility determinations concerning individuals' eligibility for  
 19 enrollment in a public health insurance program.  
 20 Sec. 4. "CHIP office" refers to the office of the children's health  
 21 insurance program established by IC 12-17.6-2-1.  
 22 Sec. 5. "Commissioner" refers to the insurance commissioner  
 23 appointed under IC 27-1-1-2.  
 24 Sec. 6. "Department" refers to the department of insurance  
 25 created by IC 27-1-1-1.  
 26 Sec. 7. "Group health plan" means a group health plan (as  
 27 defined in Section 2791 of the federal Public Health Service Act (42  
 28 U.S.C. 300gg-91)) that provides health insurance coverage.  
 29 Sec. 8. "Health benefit exchange" means an American health  
 30 benefit exchange operating in Indiana under PPACA.  
 31 Sec. 9. "Health insurance coverage" has the meaning set forth  
 32 in Section 2791 of the federal Public Health Service Act (42 U.S.C.  
 33 300gg-91).  
 34 Sec. 10. (a) "Health plan" means a policy or contract that  
 35 provides health insurance coverage.  
 36 (b) The term includes a group health plan.  
 37 Sec. 11. "Medicaid" refers to the federal Medicaid program (42  
 38 U.S.C. 1396 et seq.).  
 39 Sec. 12. (a) Subject to subsections (b), (c), and (d), "navigator"  
 40 means an individual who:  
 41 (1) is described in Section 1311(i) of PPACA (42 U.S.C.  
 42 18031(i));  
 43 (2) assists other individuals with application for and  
 44 enrollment in a health benefit exchange or public health  
 45 insurance program; or  
 46 (3) performs the functions of a navigator with respect to a  
 47 health benefit exchange as established by the commissioner.  
 48 (b) In the commissioner's discretion, the term does not include  
 49 an individual who does one (1) or more of the following:  
 50 (1) Provides assistance with application for and enrollment in  
 51 Medicaid to other individuals who, based on preliminary

1 information obtained by the individual, may be eligible for  
 2 Medicaid without respect to the other individuals' income or  
 3 assets.

4 (2) Provides other individuals with general information  
 5 concerning the application process for enrollment in a public  
 6 health insurance program, but does not participate with the  
 7 other individuals in making application for the other  
 8 individuals' enrollment in a public health insurance program.

9 (c) The term does not include an individual who makes  
 10 presumptive eligibility determinations concerning other  
 11 individuals' eligibility for enrollment in a public health insurance  
 12 program.

13 (d) The term does not include a representative authorized by an  
 14 individual to perform functions on behalf of the individual in  
 15 connection with Medicaid.

16 Sec. 13. "Person" means an individual or an entity.

17 Sec. 14. "PPACA" refers to the federal Patient Protection and  
 18 Affordable Care Act (P.L. 111-148), as amended by the federal  
 19 Health Care and Education Reconciliation Act of 2010 (P.L.  
 20 111-152).

21 Sec. 15. (a) "Public health insurance program" refers to health  
 22 coverage provided under a state or federal government program.

23 (b) The term includes the following:

24 (1) Medicaid (42 U.S.C. 1396 et seq.).

25 (2) The Indiana check-up plan established by IC 12-15-44.2-3.

26 (3) The children's health insurance program established  
 27 under IC 12-17.6.

28 Sec. 16. "Qualified health plan" means a health plan that has  
 29 been certified under Section 1301 of PPACA (42 U.S.C. 18021(a))  
 30 to meet the criteria for availability through a health benefit  
 31 exchange operated in Indiana.

32 Sec. 17. "Secretary" refers to the secretary of family and social  
 33 services appointed under IC 12-8-1.5-2.

### 34 Chapter 3. Health Benefit Exchange Authority

35 Sec. 1. This chapter applies to a health benefit exchange  
 36 operating in Indiana.

37 Sec. 2. (a) The commissioner and the department may  
 38 implement and enforce the insurance law of this state in connection  
 39 with a health benefit exchange.

40 (b) A law of this state concerning a health benefit exchange does  
 41 not preempt or supersede the authority of the commissioner or  
 42 department to regulate the business of insurance in Indiana.

43 (c) This section does not require the department to perform any  
 44 function related to a health benefit exchange without being  
 45 appropriately compensated for the performance of the function.

46 Sec. 3. (a) The secretary, the administrator, and the CHIP office  
 47 may implement and enforce the social services law of this state in  
 48 connection with a health benefit exchange.

49 (b) A law of this state concerning a health benefit exchange does  
 50 not preempt or supersede the authority of the secretary, the  
 51 administrator, or the CHIP office to administer and regulate social

1 services in Indiana.

2 (c) This section does not require the secretary, the  
3 administrator, or the CHIP office to perform any function related  
4 to a health benefit exchange without being appropriately  
5 compensated for the performance of the function.

6 (d) The secretary may adopt rules under IC 4-22-2 to implement  
7 this section.

8 (e) The administrator and the CHIP office may do the following  
9 to implement this section:

10 (1) Enter into a contract, agreement, or memorandum of  
11 understanding with the following:

12 (A) A health benefit exchange.

13 (B) An entity that contracts with, or is a subcontractor of,  
14 a health benefit exchange.

15 (C) A federal or state agency.

16 (D) A health benefit exchange operating in another state.

17 (E) An agency of another state.

18 (F) A health plan.

19 (2) Enter with a person described in subdivision (1) into an  
20 information sharing agreement:

21 (A) that concerns the disclosure and receiving of data  
22 necessary to implement this section or PPACA; and

23 (B) that:

24 (i) includes adequate protections with respect to  
25 confidentiality of the shared information; and

26 (ii) complies with applicable state and federal law.

27 **Chapter 4. Health Benefit Exchange Navigators and Application**  
28 **Organizations**

29 **Sec. 1. (a) This chapter applies to a person that acts as a**  
30 **navigator or an application organization for a health benefit**  
31 **exchange in Indiana. This chapter must be applied in conformity**  
32 **with PPACA.**

33 **(b) An individual who intends to act as a navigator shall obtain**  
34 **certification under this chapter before acting as a navigator.**

35 **(c) An entity that intends to act as an application organization**  
36 **shall obtain registration under this chapter before acting as an**  
37 **application organization.**

38 **(d) The following are subject to regulation by the commissioner**  
39 **and the secretary:**

40 **(1) A navigator.**

41 **(2) An application organization.**

42 **Sec. 2. Neither a navigator nor an application organization is**  
43 **subject to the licensing requirements of IC 27-1-15.6.**

44 **Sec. 3. (a) A person that is a navigator or an application**  
45 **organization must meet all the following:**

46 **(1) Shall not provide incorrect, misleading, incomplete, or**  
47 **materially untrue information in an application for**  
48 **certification or registration.**

49 **(2) Shall not violate any of the following:**

50 **(A) An insurance law.**

51 **(B) A regulation.**

- 1 (C) A subpoena of the commissioner.  
 2 (D) An order of the commissioner.  
 3 (E) A rule of a health benefit exchange operating in  
 4 Indiana.  
 5 (F) A rule adopted under IC 27-19-3-3(d).  
 6 (G) PPACA or a federal regulation adopted under PPACA.  
 7 (3) Shall not intentionally misrepresent the terms of an actual  
 8 or proposed insurance contract or application for insurance.  
 9 (4) Must not have had:  
 10 (A) an insurance producer or consultant license;  
 11 (B) a navigator certification or an application organization  
 12 registration; or  
 13 (C) an equivalent to a license, certification, or registration  
 14 described in clause (A) or (B);  
 15 denied, suspended, or revoked in any state, province, district,  
 16 or territory.  
 17 (5) If the person is a navigator, shall not fail to satisfy the  
 18 continuing education requirements established under section  
 19 12 of this chapter.  
 20 (6) Shall not obtain or attempt to obtain a license,  
 21 certification, or registration through misrepresentation or  
 22 fraud.  
 23 (7) Shall not fail to disclose a conflict of interest to the  
 24 commissioner:  
 25 (A) in an application under this chapter; or  
 26 (B) arising after application is made under this chapter.  
 27 (8) If the person is a navigator, must not have been convicted  
 28 of a felony or other crimes determined by the commissioner  
 29 or secretary.  
 30 (9) Must not have admitted to committing or have been found  
 31 to have committed an unfair trade practice or fraud in the  
 32 business of insurance.  
 33 (10) Shall not use fraudulent, coercive, or dishonest practices,  
 34 or demonstrate incompetence or untrustworthiness, in acting  
 35 as a navigator or an application organization.  
 36 (11) Shall not improperly use notes or other reference  
 37 material to complete an examination for certification under  
 38 this chapter.  
 39 (12) If the person is a navigator, must not have failed, and  
 40 shall not fail, to comply with an administrative or court order  
 41 imposing a child support obligation.  
 42 (13) Must not have failed, and shall not fail, to pay state  
 43 income tax or comply with any administrative or court order  
 44 directing payment of state income tax.  
 45 (14) Shall not fail to timely inform the commissioner of a  
 46 change in legal name or address.  
 47 (15) If the person is an application organization, shall not fail  
 48 to verify that each navigator working for the application  
 49 organization meets the following requirements:  
 50 (A) The navigator is certified under this chapter.  
 51 (B) The navigator has not committed an act that would be

1 grounds for denial, suspension, or revocation of  
2 certification under this chapter.

3 (16) Shall not receive consideration from a health insurance  
4 issuer (as defined in Section 2791 of the federal Public Health  
5 Service Act (42 U.S.C. 300gg-91)) in connection with the  
6 enrollment of an individual in a health plan.

7 (b) The commissioner may:

- 8 (1) reprimand a navigator or an application organization;  
9 (2) levy a civil penalty against a navigator or an application  
10 organization;  
11 (3) place a navigator or an application organization on  
12 probation;  
13 (4) suspend a navigator's certification or an application  
14 organization's registration;  
15 (5) revoke a navigator's certification or an application  
16 organization's registration for a period of years;  
17 (6) permanently revoke a navigator's certification or an  
18 application organization's registration;  
19 (7) issue a cease and desist order to a navigator or an  
20 application organization; or  
21 (8) take any combination of the actions described in  
22 subdivisions (1) through (7);

23 for a violation described in subsection (a).

24 Sec. 4. The commissioner shall, in consultation with the  
25 secretary, do the following to implement this chapter:

- 26 (1) Develop a policy concerning conflicts of interest affecting  
27 navigators and application organizations, including conflicts  
28 of interest involving financial and nonfinancial considerations.  
29 (2) Develop a consumer complaint procedure and applicable  
30 forms for filing a complaint.  
31 (3) Define a reasonable period for the duration of navigator  
32 certification, after which the navigator must pay a renewal  
33 fee, complete continuing education, and reapply for  
34 certification.  
35 (4) Define a reasonable period for the duration of application  
36 organization registration, after which the application  
37 organization must pay a renewal fee and reapply for  
38 registration.  
39 (5) Develop a policy, procedure, and form for use by an  
40 application organization to attest to the commissioner that a  
41 navigator who provides the navigator's services on behalf of  
42 the application organization meets the requirements of section  
43 3 of this chapter.

44 Sec. 5. (a) Before acting as a navigator in Indiana, an individual  
45 must:

- 46 (1) apply for certification as a navigator on a form prescribed  
47 by the commissioner; and  
48 (2) declare, under penalty of denial, suspension, or revocation  
49 of the certification, that the statements made in the  
50 application are true, correct, and complete to the best of the  
51 individual's knowledge and belief.

1 (b) Before approving an application submitted under subsection  
 2 (a), the commissioner shall determine whether the individual meets  
 3 the following requirements:

4 (1) The individual is at least eighteen (18) years of age.

5 (2) The individual has not committed any act described in  
 6 section 3 of this chapter that would be grounds for denial,  
 7 suspension, or revocation of certification.

8 (3) The individual has completed a precertification course of  
 9 study prescribed by the commissioner.

10 (4) The individual has paid the nonrefundable fee established  
 11 under section 7 of this chapter.

12 (5) The individual has successfully passed the examination  
 13 required by section 11 of this chapter.

14 Sec. 6. (a) Before acting as an application organization in  
 15 Indiana, an entity must be registered as an application  
 16 organization as follows:

17 (1) The entity must apply for registration as an application  
 18 organization on a form prescribed by the commissioner.

19 (2) The entity's application for registration:

20 (A) must be signed by an individual who is an owner,  
 21 partner, officer, director, member, or manager of the  
 22 entity, under penalty of denial, suspension, or revocation  
 23 of registration; and

24 (B) must declare that the statements made in the  
 25 application are true, correct, and complete to the best of  
 26 the signing individual's knowledge and belief.

27 (b) Before approving an application submitted under subsection  
 28 (a), the commissioner shall:

29 (1) verify that the entity is in good standing with the Indiana  
 30 secretary of state; and

31 (2) determine whether the entity meets the following  
 32 requirements:

33 (A) The entity has paid the nonrefundable fee established  
 34 under section 7 of this chapter.

35 (B) The entity has designated a certified navigator to be  
 36 responsible for the entity's compliance with this chapter.

37 (C) The entity has not committed any act described in  
 38 section 3 of this chapter that would be grounds for denial,  
 39 suspension, or revocation of registration.

40 (D) No owner, partner, officer, director, member, or  
 41 manager of the entity has committed an act described in  
 42 clause (C) or in section 3 of this chapter that would be  
 43 grounds for denial, suspension, or revocation of  
 44 certification as a navigator under this chapter.

45 Sec. 7. (a) The commissioner may require the production of any  
 46 document that is reasonably necessary to verify the information  
 47 contained in an application submitted under section 5 or 6 of this  
 48 chapter.

49 (b) The commissioner shall collect from each applicant for  
 50 certification or registration under this chapter a nonrefundable  
 51 application fee established by the commissioner in an amount

1 expected to generate revenue sufficient to cover the costs incurred  
2 by the commissioner in implementing this chapter.

3 **Sec. 8. (a) A navigator who works for an application  
4 organization must be appointed by the application organization in  
5 writing.**

6 **(b) If an application organization, because of a violation  
7 described in section 3 of this chapter, revokes the appointment of  
8 a navigator described in subsection (a) who works for the  
9 application organization, the application organization shall, not  
10 more than thirty (30) days after the revocation occurs:**

11 **(1) submit a written report to the commissioner concerning  
12 the revocation; and**

13 **(2) provide a copy of the report to the navigator at the  
14 navigator's last known address by:**

15 **(A) certified mail, return receipt requested, postage  
16 prepaid; or**

17 **(B) overnight delivery using a nationally recognized  
18 carrier.**

19 **Sec. 9. A certified navigator who is unable to comply with the  
20 certification renewal procedures under this chapter due to military  
21 service or another extenuating circumstance may request from the  
22 commissioner:**

23 **(1) a temporary waiver of:**

24 **(A) the renewal procedure; or**

25 **(B) an examination requirement; or**

26 **(2) a waiver of a penalty or sanction that might otherwise be  
27 imposed for failure to comply with the renewal procedures.**

28 **Sec. 10. (a) A certification or registration under this chapter  
29 must contain the navigator's or application organization's name  
30 and address, the date of issuance, the expiration date, and any  
31 other information the commissioner considers necessary.**

32 **(b) A navigator or an application organization shall inform the  
33 commissioner of a change of address or legal name:**

34 **(1) not more than thirty (30) days after the change occurs;  
35 and**

36 **(2) by any means acceptable to the commissioner.**

37 **Sec. 11. (a) An individual who applies for certification as a  
38 navigator in Indiana must complete a course of study and pass a  
39 written examination as prescribed by the commissioner in  
40 consultation with the secretary.**

41 **(b) The course of study required under subsection (a) must  
42 provide instruction in:**

43 **(1) the functions of a health benefit exchange;**

44 **(2) the duties and responsibilities of a navigator;**

45 **(3) the insurance laws of Indiana that apply to the functions  
46 of a navigator with respect to a health benefit exchange,  
47 including rules related to public health insurance programs;  
48 and**

49 **(4) the obligations of a navigator related to confidentiality of  
50 information and conflicts of interest.**

51 **(c) The examination required by subsection (a) must test the**

1 knowledge of the individual concerning the applicable:

- 2 (1) functions of a health benefit exchange;  
 3 (2) duties and responsibilities of a navigator;  
 4 (3) insurance laws of Indiana that apply to the functions of a  
 5 navigator with respect to a health benefit exchange, including  
 6 rules related to public health insurance programs; and  
 7 (4) the obligations of a navigator related to confidentiality of  
 8 information and conflicts of interest.

9 (d) The commissioner:

10 (1) in consultation with the secretary, shall develop:

- 11 (A) a curriculum for a course of study for navigators; and  
 12 (B) policies and procedures to allow a registered  
 13 application organization to develop a training program  
 14 and a course curriculum that meets the requirements of  
 15 subsection (b) for use in training navigators who perform  
 16 the navigators' services on behalf of the registered  
 17 application organization; and

18 (2) may contract with one (1) or more third party  
 19 organizations to do any of the following with respect to the  
 20 course of study described in subdivision (1)(A):

- 21 (A) Develop examinations and course materials.  
 22 (B) Administer examinations and courses of study.  
 23 (C) Collect nonrefundable course and examination fees.

24 (e) All training programs, course curriculums, examinations,  
 25 course materials, and examination fees referred to in subsection (d)  
 26 must be approved in advance by the commissioner in consultation  
 27 with the secretary.

28 Sec. 12. (a) The commissioner:

29 (1) in consultation with the secretary, shall develop continuing  
 30 education requirements for navigators; and

31 (2) may contract with one (1) or more third party  
 32 organizations to:

- 33 (A) develop continuing education materials to meet the  
 34 requirements developed under subdivision (1);  
 35 (B) administer continuing education programs; and  
 36 (C) collect nonrefundable continuing education program  
 37 fees.

38 (b) All continuing education materials, programs, and fees  
 39 referred to in subsection (a)(2) must be approved in advance by the  
 40 commissioner in consultation with the secretary.

41 (c) The commissioner may require a navigator to complete  
 42 specific continuing education requirements, as prescribed by the  
 43 commissioner in consultation with the secretary, as a prerequisite  
 44 to the authority to perform specific functions with respect to a  
 45 health benefit exchange.

46 Sec. 13. An individual who fails to:

- 47 (1) appear for a scheduled examination required under  
 48 section 11(a) of this chapter; or  
 49 (2) pass the examination;

50 may not be rescheduled for the examination unless the individual  
 51 reapplies for the examination and remits all required fees and

1 forms.

2 **Sec. 14. (a) An insurance producer or insurance consultant:**  
 3 **(1) may not act as a navigator unless the insurance producer**  
 4 **or insurance consultant has completed the continuing**  
 5 **education requirements that apply to a navigator; and**  
 6 **(2) shall receive a designation from the commissioner as a**  
 7 **navigator upon completion of the continuing education**  
 8 **requirements;**  
 9 **under this chapter.**

10 **(b) The commissioner may require an insurance producer or**  
 11 **insurance consultant to complete specific continuing education**  
 12 **requirements, as prescribed by the commissioner in consultation**  
 13 **with the secretary, as a prerequisite to the authority to perform**  
 14 **specific functions with respect to a health benefit exchange.**

15 **(c) An insurance producer or insurance consultant is not**  
 16 **required to complete continuing education hours of credit in excess**  
 17 **of the required number of hours of credit in continuing education**  
 18 **that apply to the insurance producer or insurance consultant under**  
 19 **IC 27-1-15.7.**

20 **SECTION 28. [EFFECTIVE JULY 1, 2013] (a) As used in this**  
 21 **SECTION, "risk based managed care program" means a program**  
 22 **where a managed care entity or an accountable care organization**  
 23 **receives capitated payments from the office of Medicaid policy and**  
 24 **planning to cover designated health and social support services**  
 25 **provided to Medicaid recipients.**

26 **(b) As used in this SECTION, "managed fee-for-service**  
 27 **program" means a program in which the office of Medicaid policy**  
 28 **and planning contracts with health care providers, managed care**  
 29 **entities, or accountable care organizations in order to integrate**  
 30 **delivery of health and social support services by primarily using**  
 31 **fee-for-service payment arrangements and include incentives for**  
 32 **high quality and efficient performance. The term may include:**

- 33 **(1) primary care case management;**  
 34 **(2) care coordination; and**  
 35 **(3) chronic care management models;**

36 **and may be coupled with capitated payments for certain health**  
 37 **care services or beneficiary populations.**

38 **(c) As used in this SECTION, "home and community based**  
 39 **services management program" means a program in which the**  
 40 **office of Medicaid policy and planning contracts with an area**  
 41 **agency on aging or other community based care coordination**  
 42 **provider to provide services to maintain a Medicaid recipient in a**  
 43 **home and community based setting, or to return a Medicaid**  
 44 **recipient to a home and community based setting. The term may**  
 45 **include:**

- 46 **(1) primary care management;**  
 47 **(2) care coordination; and**  
 48 **(3) integrated delivery of health and social support services.**

49 **(d) Before December 15, 2013, the office of Medicaid policy and**  
 50 **planning shall prepare and submit a written report to the health**  
 51 **finance commission established by IC 2-5-23-3 in an electronic**

1 format under IC 5-14-6 concerning the following:

2 (1) An estimate of the cost savings to Indiana if Medicaid  
3 recipients who are eligible for Medicaid based on the  
4 individual's aged, blind, or disabled status are enrolled in a  
5 risk-based managed care program, a managed fee-for-service  
6 program, or a home and community based services  
7 management program.

8 (2) A description of provisions of a risk-based managed care  
9 program, a managed fee-for-service program, and a home  
10 and community based services management program that are  
11 likely to ensure that enrollees who are aged, blind, or disabled  
12 have timely access to efficient and high quality care,  
13 including:

14 (A) beneficiary choice of network and nonnetwork  
15 providers;

16 (B) impact to enrollees during transition to the program;

17 (C) provider network and rate setting processes; and

18 (D) coordination of care for dually eligible enrollees.

19 (3) Whether all Medicaid recipients within the aged, blind,  
20 and disabled category should be enrolled in a risk-based  
21 managed care program, managed fee-for-service program, or  
22 a home and community based services management program  
23 and a description of any group that should be excluded.

24 (4) Whether participation of the aged, blind, or disabled  
25 Medicaid recipients in a risk-based managed care program,  
26 a managed fee-for-service program, or a home and  
27 community based services management program would do  
28 the following:

29 (A) Reduce or eliminate supplemental payments under the  
30 Medicaid program that are received by nonstate  
31 governmental entities.

32 (B) Affect the collection and use of the health facility  
33 quality assessment fee, the hospital assessment fee, or any  
34 other provider assessment fee.

35 (d) This SECTION expires December 31, 2013.

36 SECTION 29. [EFFECTIVE UPON PASSAGE] (a) Before  
37 October 1, 2013, the office of the secretary of family and social  
38 services shall provide to the legislative council and the health  
39 finance commission in an electronic format under IC 5-14-6  
40 written report setting forth the following concerning health care  
41 clinics in school settings:

42 (1) The number of schools and school corporations that have  
43 a health care clinic on the school premises.

44 (2) Of the health care clinics identified under subdivision (1),  
45 the following information:

46 (A) The hours of operation for the clinic.

47 (B) Whether the health care clinic only sees students or is  
48 open to family members or community members as well.

49 (C) How the health care clinic is funded.

50 (3) Whether Medicaid statutes or rules would need to be  
51 amended in order for a school health care clinic to provide

- 1           **services to a Medicaid recipient.**
- 2           **(b) This SECTION expires December 31, 2014.**
- 3           **SECTION 30. An emergency is declared for this act.**  
              (Reference is to EHB 1328 as printed March 29, 2013.)

**Conference Committee Report**  
**on**  
**Engrossed House Bill 1328**

**S**igned by:

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Representative Brown T  
Chairperson

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Senator Miller Patricia

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Representative Goodin

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Senator Miller Pete

**House Conferees**

**Senate Conferees**