



February 15, 2013

# SENATE BILL No. 551

DIGEST OF SB 551 (Updated February 13, 2013 7:37 pm - DI 104)

**Citations Affected:** IC 12-15; IC 27-1; IC 27-4; IC 27-8; IC 27-19; noncode.

**Synopsis:** Federal health care reform. Defines populations that may be subject to Medicaid resource requirements. Eliminates resource requirements in determining Medicaid eligibility for specified populations. Authorizes the office of Medicaid policy and planning (office) to negotiate with the United States Department of Health and Human Services (HHS) to establish a block grant system for providing services under the Medicaid program, including expanding coverage to specified individuals. Specifies conditions that must be included in the negotiations. Requires the office to apply to HHS for an amendment to the state Medicaid plan to require Medicaid recipients to participate in cost sharing. Provides for implementation of the federal Patient Protection and Affordable Care Act with respect to a health benefit exchange in Indiana. Specifies requirements for health plans issued through a health benefit exchange. Requires a navigator or an assister to be certified or registered before providing services with respect to a health benefit exchange. Provides for dissolution of the Indiana comprehensive health insurance association. Requires the office to present specified information to the health finance commission (commission) before August 1, 2013. Requires the department of insurance, the office of the secretary of family and social services, and the state department of health to prepare a report for the commission concerning the establishment and implementation of an exchange in Indiana and concerning the definition of "essential health benefits".

C  
O  
P  
Y

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

**Miller Patricia, Kenley, Tallian,  
Charbonneau**

January 14, 2013, read first time and referred to Committee on Health and Provider Services.  
February 14, 2013, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

SB 551—LS 7434/DI 104+



February 15, 2013

First Regular Session 118th General Assembly (2013)

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

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

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

C  
O  
P  
Y

## SENATE BILL No. 551

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

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

1 SECTION 1. IC 12-15-2-3.5 IS ADDED TO THE INDIANA CODE  
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
3 1, 2013]: **Sec. 3.5. An individual:**

4 (1) **who is:**  
5 (A) **at least sixty-five (65) years of age; or**  
6 (B) **disabled, as determined by the Supplemental Security**  
7 **Income program; and**  
8 (2) **whose income and resources do not exceed those levels**  
9 **established by the Supplemental Security Income program;**  
10 **is eligible to receive Medicaid assistance if the individual's family**  
11 **income does not exceed one hundred percent (100%) of the federal**  
12 **income poverty level for the same family.**

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

16 (1) **who is not described in 42 U.S.C. 1396a(a)(10)(A)(i); and**  
17 (2) **whose family income does not exceed the income level**

SB 551—LS 7434/DI 104+



1 established in subsection (b);  
2 is eligible to receive Medicaid.

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

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

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

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

19 SECTION 3. IC 12-15-2-14 IS AMENDED TO READ AS  
20 FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 14. (a) An individual:

- 21 (1) who is less than nineteen (19) years of age;  
22 (2) who is not described in 42 U.S.C. 1396a(a)(10)(A)(I); and  
23 (3) whose family income does not exceed the income level  
24 established in subsection (b);

25 is eligible to receive Medicaid.

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

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

33 SECTION 4. IC 12-15-2-17, AS AMENDED BY P.L.196-2011,  
34 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
35 JULY 1, 2013]: Sec. 17. (a) **Beginning January 1, 2014, the office**  
36 **may apply this section only to the following Medicaid applicants or**  
37 **Medicaid recipients:**

- 38 (1) **An individual whose eligibility for Medicaid does not**  
39 **require a determination of income by the office.**  
40 (2) **An individual who is at least sixty-five (65) years of age**  
41 **when age is a condition of eligibility.**  
42 (3) **An individual whose eligibility is being determined on the**

C  
o  
p  
y



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

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

- (1) establishes one (1) irrevocable trust that has a value of not more than ten thousand dollars (\$10,000), exclusive of interest, and is established for the sole purpose of providing money for the burial of the applicant or recipient;
- (2) enters into an irrevocable prepaid funeral agreement having a value of not more than ten thousand dollars (\$10,000); or
- (3) owns a life insurance policy with a face value of not more than ten thousand dollars (\$10,000) and with respect to which provision is made to pay not more than ten thousand dollars (\$10,000) toward the applicant's or recipient's funeral expenses;

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

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

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

~~(d)~~ **(e)** In order for a trust, an escrow, a life insurance policy, or a prepaid funeral agreement to be exempt as a resource in determining

C  
o  
p  
y



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

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

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

19 SECTION 5. IC 12-15-2.3-10 IS AMENDED TO READ AS  
 20 FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 10. **(a)** If a woman  
 21 described in section 1 of this chapter:

- 22 (1) is determined to be presumptively eligible for Medicaid under  
 23 this chapter; and
- 24 (2) appoints, in writing, an agent of a qualified entity under  
 25 section 4 of this chapter as the woman's authorized representative  
 26 for purposes of completing all aspects of the Medicaid application  
 27 process;

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

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

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

- 38 (1) the applicant or recipient is more than one thousand five  
 39 hundred dollars (\$1,500) for assistance to the aged, blind, or  
 40 disabled; or
- 41 (2) the applicant or recipient and the applicant's or recipient's  
 42 spouse is more than two thousand two hundred fifty dollars

SB 551—LS 7434/DI 104+



C  
o  
p  
y

- 1 (\$2,250) for medical assistance to the aged, blind, or disabled.
- 2 (b) In the case of an applicant who is an eligible individual, a  
3 Holocaust victim's settlement payment received by the applicant or the  
4 applicant's spouse may not be considered when calculating the total  
5 cash value of money, stock, bonds, and life insurance owned by the  
6 applicant or the applicant's spouse.
- 7 (c) In the case of an individual who:  
8 (1) resides in a nursing facility or another medical institution; and  
9 (2) has a spouse who does not reside in a nursing facility or  
10 another medical institution;  
11 the total cash value of money, stock, bonds, and life insurance that may  
12 be owned by the couple to be eligible for the program is determined  
13 under IC 12-15-2-24.
- 14 **(d) This section expires December 31, 2013.**
- 15 SECTION 7. IC 12-15-3-1.5 IS ADDED TO THE INDIANA CODE  
16 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
17 1, 2013]: **Sec. 1.5. (a) Beginning January 1, 2014, the office shall  
18 determine eligibility for a Medicaid applicant or Medicaid  
19 recipient who is aged, blind, or disabled under IC 12-15-2-3.5.**
- 20 **(b) If an individual:**  
21 **(1) resides in a nursing facility or another medical institution;**  
22 **and**  
23 **(2) has a spouse who does not reside in a nursing facility or**  
24 **another medical institution;**  
25 **the total cash value of money, stock, bonds, and life insurance that**  
26 **may be owned by the couple to be eligible for Medicaid is**  
27 **determined under IC 12-15-2-24.**
- 28 SECTION 8. IC 12-15-3-2, AS AMENDED BY P.L.196-2011,  
29 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
30 JULY 1, 2013]: Sec. 2. (a) Except as provided in section 7 of this  
31 chapter, if the parent of an applicant for or a recipient of assistance to  
32 the blind or disabled who is less than eighteen (18) years of age owns  
33 money, stock, bonds, and life insurance whose total cash value is more  
34 than one thousand five hundred dollars (\$1,500), the amount of the  
35 excess shall be added to the total cash value of money, stock, bonds,  
36 and life insurance owned by the applicant or recipient to determine the  
37 recipient's eligibility for Medicaid under section 1 of this chapter.
- 38 (b) However, a Holocaust victim's settlement payment received by  
39 the parent of an applicant for or a recipient of assistance may not be  
40 added to the total cash value of money, stock, bonds, and life insurance  
41 owned by the applicant or recipient to determine the recipient's  
42 eligibility for Medicaid under section 1 of this chapter.

C  
O  
P  
Y

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

2           SECTION 9. IC 12-15-3-3, AS AMENDED BY P.L.196-2011,  
3           SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
4           JULY 1, 2013]: Sec. 3. **(a)** Except as provided in section 7 of this  
5           chapter, if the parents of an applicant for or a recipient of assistance to  
6           the blind or disabled who is less than eighteen (18) years of age own  
7           money, stock, bonds, and life insurance whose total cash value is more  
8           than two thousand two hundred fifty dollars (\$2,250), the amount of the  
9           excess shall be added to the total cash value of money, stock, bonds,  
10          and life insurance owned by the applicant or recipient to determine the  
11          recipient's eligibility for Medicaid under section 1 of this chapter.

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

13          SECTION 10. IC 12-15-44.2-9, AS AMENDED BY P.L.160-2011,  
14          SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
15          JULY 1, 2013]: Sec. 9. (a) An individual is eligible for participation in  
16          the plan if the individual meets the following requirements:

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

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

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

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

25                       (B) Beginning January 1, 2014, one hundred thirty-three  
26                       percent (133%) of the federal income poverty level, based on  
27                       the adjusted gross income provisions set forth in Section  
28                       2001(a)(1) of the federal Patient Protection and Affordable  
29                       Care Act.

30               (4) Effective through December 31, 2013, the individual is not  
31               eligible for health insurance coverage through the individual's  
32               employer.

33               (5) Effective through December 31, 2013, the individual has:

34                       **(A)** not had health insurance coverage for at least six (6)  
35                       months; **or**

36                       **(B) had coverage under the Indiana comprehensive health**  
37                       **insurance association (IC 27-8-10) within the immediately**  
38                       **preceding six (6) months and the coverage no longer**  
39                       **applies under IC 27-8-10-0.5.**

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

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

C  
o  
p  
y



- 1 (2) A pregnant woman for purposes of pregnancy related services.  
 2 (3) An individual who is otherwise eligible for medical assistance.  
 3 (c) The eligibility requirements specified in subsection (a) are  
 4 subject to approval for federal financial participation by the United  
 5 States Department of Health and Human Services.  
 6 SECTION 11. IC 12-15-46-1, AS ADDED BY P.L.6-2012,  
 7 SECTION 95, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 8 JULY 1, 2013]: Sec. 1. (a) As used in this section, "family planning  
 9 services" does not include the performance of abortions or the use of  
 10 a drug or device intended to terminate fertilization.  
 11 (b) As used in this section, "fertilization" means the joining of a  
 12 human egg cell with a human sperm cell.  
 13 (c) As used in this section, "state plan amendment" refers to an  
 14 amendment to Indiana's Medicaid State Plan as authorized by Section  
 15 1902(a)(10)(A)(ii)(XXI) of the federal Social Security Act (42 U.S.C.  
 16 1315).  
 17 (d) Before January 1, ~~2012~~, **2014**, the office shall do the following:  
 18 (1) Apply to the United States Department of Health and Human  
 19 Services for approval of a state plan amendment ~~to expand the~~  
 20 ~~population eligible~~ for family planning services and supplies as  
 21 permitted by Section 1902(a)(10)(A)(ii)(XXI) of the federal  
 22 Social Security Act (42 U.S.C. 1315). In determining what  
 23 population is eligible, ~~for this expansion~~, the state must  
 24 incorporate the following:  
 25 (A) Inclusion of women and men.  
 26 (B) Setting income eligibility at one hundred thirty-three  
 27 percent (133%) of the federal income poverty level.  
 28 (C) Adopting presumptive eligibility for services to this  
 29 population.  
 30 (2) Consider the inclusion of additional:  
 31 (A) medical diagnosis; and  
 32 (B) treatment services;  
 33 that are provided for family planning services in a family planning  
 34 setting for the population designated in subdivision (1) in the state  
 35 plan amendment.  
 36 (e) ~~The office shall report concerning its proposed state plan~~  
 37 ~~amendment to the select joint commission on Medicaid oversight~~  
 38 ~~established by IC 2-5-26-3 during the commission's 2011 interim~~  
 39 ~~meetings. The select joint commission on Medicaid oversight shall~~  
 40 ~~review the proposed state plan amendment and may make an advisory~~  
 41 ~~recommendation to the office concerning the proposed state plan~~  
 42 ~~amendment.~~

C  
o  
p  
y

1           ~~(f)~~ (e) The office may adopt rules under IC 4-22-2 to implement this  
2 section.

3           ~~(g)~~ This section expires January 1, 2016.

4           SECTION 12. IC 12-15-46-3 IS ADDED TO THE INDIANA  
5 CODE AS A NEW SECTION TO READ AS FOLLOWS  
6 [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) The office of the  
7 secretary has the authority to negotiate with the United States  
8 Department of Health and Human Services for amendments to the  
9 state Medicaid plan or for any Medicaid waivers necessary to  
10 establish a block grant system for providing services under the  
11 Medicaid program, including providing coverage for individuals  
12 described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

13           (b) A waiver or state plan amendment negotiated under this  
14 section must include the following:

15           (1) Allow the office to withdraw from participating in a  
16 program negotiated under this section at any time.

17           (2) Include federal financial participation at least at the levels  
18 specified in the federal Patient Protection and Affordable  
19 Care Act.

20           (3) Include, when appropriate, consumer driven principles.

21           (4) Include coverage for preventative care services provided  
22 at no cost to the recipient and allow incentives for increasing  
23 preventative care for recipients.

24           (5) Allow for personal responsibility requirements.

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

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

32           (8) Include health care initiatives designed to promote the  
33 general health and well being of recipients and encourage an  
34 understanding of the cost and quality of care.

35           (c) The office of the secretary may not implement a waiver or  
36 Medicaid state plan amendment negotiated under this section until  
37 the office of the secretary has developed a sustainable financing  
38 plan for the Medicaid state plan amendment or waiver.

39           SECTION 13. IC 12-15-46-5 IS ADDED TO THE INDIANA  
40 CODE AS A NEW SECTION TO READ AS FOLLOWS  
41 [EFFECTIVE JULY 1, 2013]: Sec. 5. (a) The office shall apply to the  
42 United States Department of Health and Human Services for an

C  
O  
P  
Y



1 amendment to the state Medicaid plan to require Medicaid  
2 recipients to participate in cost sharing, as allowable under federal  
3 law.

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

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

14 SECTION 14. IC 27-1-3-7 IS AMENDED TO READ AS  
15 FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 7. (a) The department  
16 may promulgate rules and regulations for any of the following  
17 enumerated purposes:

- 18 (1) For the conduct of the work of the department.
- 19 (2) Prescribing the methods and standards to be used in making  
20 the examinations and prescribing the forms of reports of the  
21 several insurance companies to which IC 27-1 is applicable.
- 22 (3) Defining what is a safe or an unsafe manner and a safe or an  
23 unsafe condition for conducting business by any insurance  
24 company to which IC 27-1 is applicable.
- 25 (4) For the establishment of safe and sound methods for the  
26 transaction of business by such insurance companies and for the  
27 purpose of safeguarding the interests of policyholders, creditors,  
28 and shareholders respecting the withdrawal or payment of funds  
29 by any life insurance company in times of emergency. Any rule or  
30 regulation promulgated under this subdivision may apply to one  
31 (1) or more insurance companies as the department may  
32 determine.
- 33 (5) For the administration and termination of the affairs of any  
34 such insurance company which is in involuntary liquidation or  
35 whose business and property have been taken possession of by the  
36 department for the purpose of rehabilitation, liquidation,  
37 conservation, or dissolution under IC 27-1.
- 38 (6) For the regulation of the solicitation or use of proxies, in  
39 general and as they concern consents or authorizations, in respect  
40 of securities issued by any domestic stock company for the  
41 purpose of protecting investors by prescribing the form of proxies,  
42 including such consents or authorizations, and by requiring

C  
o  
p  
y



1 adequate disclosure of information relevant to such proxies,  
2 including such consents or authorizations, and relevant to the  
3 business to be transacted at any meeting of shareholders with  
4 respect to which such proxies, including such consents or  
5 authorizations, may be used, which regulations may, in general,  
6 conform to those prescribed by the National Association of  
7 Insurance Commissioners.

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

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

22 SECTION 15. IC 27-1-3-10.5 IS AMENDED TO READ AS  
23 FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 10.5. (a) As used in this  
24 section, "confidential information" means information that has been  
25 designated as confidential by statute, rule, or regulation issued under  
26 a statute.

27 (b) The commissioner may not:  
28 (1) disclose; or  
29 (2) subject to subpoena;  
30 financial information regarding material transactions disclosed by an  
31 insurer under IC 27-2-18.

32 (c) The commissioner may not disclose any information, including  
33 any document or report received from:  
34 (1) the National Association of Insurance Commissioners; or  
35 (2) an insurance department of another state;  
36 if the information is designated as confidential information in the other  
37 jurisdiction.

38 (d) The commissioner may share confidential information with:  
39 (1) the National Association of Insurance Commissioners; or  
40 (2) an insurance department of another state;  
41 on the condition that the National Association of Insurance  
42 Commissioners and the other state agree to maintain the same level of

C  
o  
p  
y



1 confidentiality that is provided to the information under Indiana law.

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

8 (1) **agrees to maintain the same level of confidentiality that is**  
9 **provided to the confidential information under Indiana law;**  
10 **and**

11 (2) **complies with all applicable confidentiality requirements**  
12 **under federal law.**

13 SECTION 16. IC 27-4-1-4, AS AMENDED BY P.L.67-2011,  
14 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
15 JULY 1, 2013]: Sec. 4. (a) The following are hereby defined as unfair  
16 methods of competition and unfair and deceptive acts and practices in  
17 the business of insurance:

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

20 (A) misrepresenting the terms of any policy issued or to be  
21 issued or the benefits or advantages promised thereby or the  
22 dividends or share of the surplus to be received thereon;

23 (B) making any false or misleading statement as to the  
24 dividends or share of surplus previously paid on similar  
25 policies;

26 (C) making any misleading representation or any  
27 misrepresentation as to the financial condition of any insurer,  
28 or as to the legal reserve system upon which any life insurer  
29 operates;

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

32 (E) making any misrepresentation to any policyholder insured  
33 in any company for the purpose of inducing or tending to  
34 induce such policyholder to lapse, forfeit, or surrender the  
35 policyholder's insurance.

36 (2) Making, publishing, disseminating, circulating, or placing  
37 before the public, or causing, directly or indirectly, to be made,  
38 published, disseminated, circulated, or placed before the public,  
39 in a newspaper, magazine, or other publication, or in the form of  
40 a notice, circular, pamphlet, letter, or poster, or over any radio or  
41 television station, or in any other way, an advertisement,  
42 announcement, or statement containing any assertion,

C  
o  
p  
y



1 representation, or statement with respect to any person in the  
 2 conduct of the person's insurance business, which is untrue,  
 3 deceptive, or misleading.  
 4 (3) Making, publishing, disseminating, or circulating, directly or  
 5 indirectly, or aiding, abetting, or encouraging the making,  
 6 publishing, disseminating, or circulating of any oral or written  
 7 statement or any pamphlet, circular, article, or literature which is  
 8 false, or maliciously critical of or derogatory to the financial  
 9 condition of an insurer, and which is calculated to injure any  
 10 person engaged in the business of insurance.  
 11 (4) Entering into any agreement to commit, or individually or by  
 12 a concerted action committing any act of boycott, coercion, or  
 13 intimidation resulting or tending to result in unreasonable  
 14 restraint of, or a monopoly in, the business of insurance.  
 15 (5) Filing with any supervisory or other public official, or making,  
 16 publishing, disseminating, circulating, or delivering to any person,  
 17 or placing before the public, or causing directly or indirectly, to  
 18 be made, published, disseminated, circulated, delivered to any  
 19 person, or placed before the public, any false statement of  
 20 financial condition of an insurer with intent to deceive. Making  
 21 any false entry in any book, report, or statement of any insurer  
 22 with intent to deceive any agent or examiner lawfully appointed  
 23 to examine into its condition or into any of its affairs, or any  
 24 public official to which such insurer is required by law to report,  
 25 or which has authority by law to examine into its condition or into  
 26 any of its affairs, or, with like intent, willfully omitting to make a  
 27 true entry of any material fact pertaining to the business of such  
 28 insurer in any book, report, or statement of such insurer.  
 29 (6) Issuing or delivering or permitting agents, officers, or  
 30 employees to issue or deliver, agency company stock or other  
 31 capital stock, or benefit certificates or shares in any common law  
 32 corporation, or securities or any special or advisory board  
 33 contracts or other contracts of any kind promising returns and  
 34 profits as an inducement to insurance.  
 35 (7) Making or permitting any of the following:  
 36 (A) Unfair discrimination between individuals of the same  
 37 class and equal expectation of life in the rates or assessments  
 38 charged for any contract of life insurance or of life annuity or  
 39 in the dividends or other benefits payable thereon, or in any  
 40 other of the terms and conditions of such contract. However,  
 41 in determining the class, consideration may be given to the  
 42 nature of the risk, plan of insurance, the actual or expected

C  
o  
p  
y



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

expense of conducting the business, or any other relevant factor.

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

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

- (i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;
- (ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or
- (iii) policies or contracts of any other kind or kinds of insurance whatsoever.

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

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such

C  
O  
P  
Y



1 insurance, or annuity, any rebate of premiums payable on the  
 2 contract, or any special favor or advantage in the dividends,  
 3 savings, or other benefits thereon, or any valuable consideration  
 4 or inducement whatever not specified in the contract or policy; or  
 5 giving, or selling, or purchasing or offering to give, sell, or  
 6 purchase as inducement to such insurance or annuity or in  
 7 connection therewith, any stocks, bonds, or other securities of any  
 8 insurance company or other corporation, association, limited  
 9 liability company, or partnership, or any dividends, savings, or  
 10 profits accrued thereon, or anything of value whatsoever not  
 11 specified in the contract. Nothing in this subdivision and  
 12 subdivision (7) shall be construed as including within the  
 13 definition of discrimination or rebates any of the following  
 14 practices:

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

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

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

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

41 (9) Requiring, as a condition precedent to loaning money upon the  
 42 security of a mortgage upon real property, that the owner of the

C  
o  
p  
y



1 property to whom the money is to be loaned negotiate any policy  
 2 of insurance covering such real property through a particular  
 3 insurance producer or broker or brokers. However, this  
 4 subdivision shall not prevent the exercise by any lender of the  
 5 lender's right to approve or disapprove of the insurance company  
 6 selected by the borrower to underwrite the insurance.

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

10 (11) Monopolizing or attempting to monopolize or combining or  
 11 conspiring with any other person or persons to monopolize any  
 12 part of commerce in the business of insurance. However,  
 13 participation as a member, director, or officer in the activities of  
 14 any nonprofit organization of insurance producers or other  
 15 workers in the insurance business shall not be interpreted, in  
 16 itself, to constitute a combination in restraint of trade or as  
 17 combining to create a monopoly as provided in this subdivision  
 18 and subdivision (10). The enumeration in this chapter of specific  
 19 unfair methods of competition and unfair or deceptive acts and  
 20 practices in the business of insurance is not exclusive or  
 21 restrictive or intended to limit the powers of the commissioner or  
 22 department or of any court of review under section 8 of this  
 23 chapter.

24 (12) Requiring as a condition precedent to the sale of real or  
 25 personal property under any contract of sale, conditional sales  
 26 contract, or other similar instrument or upon the security of a  
 27 chattel mortgage, that the buyer of such property negotiate any  
 28 policy of insurance covering such property through a particular  
 29 insurance company, insurance producer, or broker or brokers.  
 30 However, this subdivision shall not prevent the exercise by any  
 31 seller of such property or the one making a loan thereon of the  
 32 right to approve or disapprove of the insurance company selected  
 33 by the buyer to underwrite the insurance.

34 (13) Issuing, offering, or participating in a plan to issue or offer,  
 35 any policy or certificate of insurance of any kind or character as  
 36 an inducement to the purchase of any property, real, personal, or  
 37 mixed, or services of any kind, where a charge to the insured is  
 38 not made for and on account of such policy or certificate of  
 39 insurance. However, this subdivision shall not apply to any of the  
 40 following:

41 (A) Insurance issued to credit unions or members of credit  
 42 unions in connection with the purchase of shares in such credit

C  
o  
p  
y



- 1 unions.
- 2 (B) Insurance employed as a means of guaranteeing the
- 3 performance of goods and designed to benefit the purchasers
- 4 or users of such goods.
- 5 (C) Title insurance.
- 6 (D) Insurance written in connection with an indebtedness and
- 7 intended as a means of repaying such indebtedness in the
- 8 event of the death or disability of the insured.
- 9 (E) Insurance provided by or through motorists service clubs
- 10 or associations.
- 11 (F) Insurance that is provided to the purchaser or holder of an
- 12 air transportation ticket and that:
  - 13 (i) insures against death or nonfatal injury that occurs during
  - 14 the flight to which the ticket relates;
  - 15 (ii) insures against personal injury or property damage that
  - 16 occurs during travel to or from the airport in a common
  - 17 carrier immediately before or after the flight;
  - 18 (iii) insures against baggage loss during the flight to which
  - 19 the ticket relates; or
  - 20 (iv) insures against a flight cancellation to which the ticket
  - 21 relates.
- 22 (14) Refusing, because of the for-profit status of a hospital or
- 23 medical facility, to make payments otherwise required to be made
- 24 under a contract or policy of insurance for charges incurred by an
- 25 insured in such a for-profit hospital or other for-profit medical
- 26 facility licensed by the state department of health.
- 27 (15) Refusing to insure an individual, refusing to continue to issue
- 28 insurance to an individual, limiting the amount, extent, or kind of
- 29 coverage available to an individual, or charging an individual a
- 30 different rate for the same coverage, solely because of that
- 31 individual's blindness or partial blindness, except where the
- 32 refusal, limitation, or rate differential is based on sound actuarial
- 33 principles or is related to actual or reasonably anticipated
- 34 experience.
- 35 (16) Committing or performing, with such frequency as to
- 36 indicate a general practice, unfair claim settlement practices (as
- 37 defined in section 4.5 of this chapter).
- 38 (17) Between policy renewal dates, unilaterally canceling an
- 39 individual's coverage under an individual or group health
- 40 insurance policy solely because of the individual's medical or
- 41 physical condition.
- 42 (18) Using a policy form or rider that would permit a cancellation

COPY



- 1 of coverage as described in subdivision (17).  
 2 (19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1  
 3 concerning motor vehicle insurance rates.  
 4 (20) Violating IC 27-8-21-2 concerning advertisements referring  
 5 to interest rate guarantees.  
 6 (21) Violating IC 27-8-24.3 concerning insurance and health plan  
 7 coverage for victims of abuse.  
 8 (22) Violating IC 27-8-26 concerning genetic screening or testing.  
 9 (23) Violating IC 27-1-15.6-3(b) concerning licensure of  
 10 insurance producers.  
 11 (24) Violating IC 27-1-38 concerning depository institutions.  
 12 (25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning  
 13 the resolution of an appealed grievance decision.  
 14 (26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired  
 15 July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1,  
 16 2007, and repealed).  
 17 (27) Violating IC 27-2-21 concerning use of credit information.  
 18 (28) Violating IC 27-4-9-3 concerning recommendations to  
 19 consumers.  
 20 (29) Engaging in dishonest or predatory insurance practices in  
 21 marketing or sales of insurance to members of the United States  
 22 Armed Forces as:  
 23 (A) described in the federal Military Personnel Financial  
 24 Services Protection Act, P.L.109-290; or  
 25 (B) defined in rules adopted under subsection (b).  
 26 (30) Violating IC 27-8-19.8-20.1 concerning stranger originated  
 27 life insurance.  
 28 (31) Violating IC 27-2-22 concerning retained asset accounts.  
 29 **(32) Violating IC 27-8-5-29 concerning health plans offered**  
 30 **through a health benefit exchange (as defined in**  
 31 **IC 27-19-2-8).**  
 32 **(33) Violating a requirement of the federal Patient Protection**  
 33 **and Affordable Care Act (P.L. 111-148), as amended by the**  
 34 **federal Health Care and Education Reconciliation Act of 2010**  
 35 **(P.L. 111-152), that is enforceable by the state.**  
 36 (b) Except with respect to federal insurance programs under  
 37 Subchapter III of Chapter 19 of Title 38 of the United States Code, the  
 38 commissioner may, consistent with the federal Military Personnel  
 39 Financial Services Protection Act (P.L.109-290), adopt rules under  
 40 IC 4-22-2 to:  
 41 (1) define; and  
 42 (2) while the members are on a United States military installation

C  
o  
p  
y

1 or elsewhere in Indiana, protect members of the United States  
2 Armed Forces from;  
3 dishonest or predatory insurance practices.

4 SECTION 17. IC 27-8-5-1, AS AMENDED BY P.L.160-2011,  
5 SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
6 JULY 1, 2013]: Sec. 1. (a) The term "policy of accident and sickness  
7 insurance", as used in this chapter, includes any policy or contract  
8 covering one (1) or more of the kinds of insurance described in Class  
9 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual  
10 basis under this section and sections 2 through 9 of this chapter, on the  
11 group basis under this section and sections 16 through 19 of this  
12 chapter, on the franchise basis under this section and section 11 of this  
13 chapter, or on a blanket basis under section 15 of this chapter and  
14 (except as otherwise expressly provided in this chapter) shall be  
15 exclusively governed by this chapter.

16 (b) No policy of accident and sickness insurance may be issued or  
17 delivered to any person in this state, nor may any application, rider, or  
18 endorsement be used in connection with an accident and sickness  
19 insurance policy, until a copy of the form of the policy and of the  
20 classification of risks and the premium rates, or, in the case of  
21 assessment companies, the estimated cost pertaining thereto, have been  
22 filed with and reviewed by the commissioner under section 1.5 of this  
23 chapter. This section is applicable also to assessment companies and  
24 fraternal benefit associations or societies.

25 (c) This chapter shall be applied in conformity with the  
26 requirements of the federal Patient Protection and Affordable Care Act  
27 (P.L. 111-148), as amended by the federal Health Care and Education  
28 Reconciliation Act of 2010 (P.L. 111-152), as in effect on September  
29 23, 2010.

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

- 38 (1) certification or decertification of a qualified health plan
- 39 (as defined in IC 27-19-2-15); and
- 40 (2) open enrollment.

41 SECTION 18. IC 27-8-5-1.5, AS AMENDED BY P.L.111-2008,  
42 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

C  
o  
p  
y



1 JULY 1, 2013]: Sec. 1.5. (a) This section applies to a policy of accident  
2 and sickness insurance issued on an individual, a group, a franchise, or  
3 a blanket basis, including a policy issued by an assessment company or  
4 a fraternal benefit society.

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

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

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

11 (2) that demonstrates an insufficient understanding of applicable  
12 legal requirements.

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

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

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

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

32 (h) The commissioner shall do the following:

33 (1) Create a document containing a list of all product filing  
34 requirements for each type of insurance, with appropriate  
35 citations to the law, administrative rule, or bulletin that specifies  
36 the requirement, including the citation for the type of insurance  
37 to which the requirement applies.

38 (2) Make the document described in subdivision (1) available on  
39 the department of insurance Internet site.

40 (3) Update the document described in subdivision (1) at least  
41 annually and not more than thirty (30) days following any change  
42 in a filing requirement.

C  
O  
P  
Y

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

COPY



1 A written notice of disapproval provided by the commissioner  
 2 under clause (B) must be based only on the requirements set forth  
 3 in the document described in subsection (h), must cite the specific  
 4 requirements not met by the filing, and must state the reasons for  
 5 the commissioner's determination in detail. The commissioner's  
 6 approval or disapproval of a resubmitted policy form under this  
 7 subdivision is final, except that the commissioner may allow the  
 8 filer to resubmit a further revised policy form if the filer, in the  
 9 filer's resubmission under subdivision (3), introduced new  
 10 provisions or materially modified a substantive provision of the  
 11 policy form. If the commissioner allows a filer to resubmit a  
 12 further revised policy form under this subdivision, the filer must  
 13 resubmit the further revised policy form not more than thirty (30)  
 14 days after the filer receives notice under clause (B), and the  
 15 commissioner shall issue a final determination on the further  
 16 revised policy form not more than thirty (30) days after the  
 17 commissioner receives the further revised policy form.

18 (5) If the commissioner disapproves a policy form filing under  
 19 this subsection, the commissioner shall notify the filer, in writing,  
 20 of the filer's right to a hearing as described in subsection (m). A  
 21 disapproved policy form filing may not be used for a policy of  
 22 accident and sickness insurance unless the disapproval is  
 23 overturned in a hearing conducted under this subsection.

24 (6) If the commissioner does not take any action on a policy form  
 25 that is filed or resubmitted under this subsection in accordance  
 26 with any applicable period specified in subdivision (2), (3), or (4),  
 27 the policy form filing is considered to be approved.

28 (j) Except as provided in this subsection, the commissioner may not  
 29 disapprove a policy form resubmitted under subsection (i)(3) or (i)(4)  
 30 for a reason other than a reason specified in the original notice of  
 31 determination under subsection (i)(2)(B). The commissioner may  
 32 disapprove a resubmitted policy form for a reason other than a reason  
 33 specified in the original notice of determination under subsection (i)(2)  
 34 if:

- 35 (1) the filer has introduced a new provision in the resubmission;
- 36 (2) the filer has materially modified a substantive provision of the  
 37 policy form in the resubmission;
- 38 (3) there has been a change in requirements applying to the policy  
 39 form; or
- 40 (4) there has been reviewer error and the written disapproval fails  
 41 to state a specific requirement with which the policy form does  
 42 not comply.

C  
o  
p  
y



1 (k) The commissioner may return a grossly inadequate filing to the  
2 filer without triggering a deadline set forth in this section.

3 (l) The commissioner may disapprove a policy form if:  
4 (1) the benefits provided under the policy form are not reasonable  
5 in relation to the premium charged; or  
6 (2) the policy form contains provisions that are unjust, unfair,  
7 inequitable, misleading, or deceptive, or that encourage  
8 misrepresentation of the policy.

9 (m) Upon disapproval of a filing under this section, the  
10 commissioner shall provide written notice to the filer or insurer of the  
11 right to a hearing within twenty (20) days of a request for a hearing.

12 (n) Unless a policy form approved under this chapter contains a  
13 material error or omission, the commissioner may not:

- 14 (1) retroactively disapprove the policy form; or
- 15 (2) examine the filer of the policy form during a routine or  
16 targeted market conduct examination for compliance with a policy  
17 form filing requirement that was not in existence at the time the  
18 policy form was filed.

19 SECTION 19. IC 27-8-5-29 IS ADDED TO THE INDIANA CODE  
20 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
21 1, 2013]: **Sec. 29. (a) The definitions in IC 27-19-2 apply throughout  
22 this section.**

23 **(b) A health plan may not be offered to any person in Indiana  
24 through a health benefit exchange unless:**

- 25 **(1) the form of the policy, classification of risks, and premium  
26 rates that apply to the health plan have been filed with and  
27 reviewed and approved by the commissioner under this  
28 chapter; and**
- 29 **(2) the insurer is authorized under this title to engage in the  
30 business of insurance in Indiana.**

31 **(c) An insurer that offers a multistate health plan under Section  
32 1334 of PPACA through a health benefit exchange shall file, for  
33 review and approval, the form of the policy, classification of risks,  
34 and premium rates that apply to the multistate health plan with the  
35 commissioner and the federal government on the same business  
36 day.**

37 SECTION 20. IC 27-8-10-0.5 IS ADDED TO THE INDIANA  
38 CODE AS A NEW SECTION TO READ AS FOLLOWS  
39 [EFFECTIVE UPON PASSAGE]: **Sec. 0.5. (a) Except as provided in  
40 this section, the insurance operations of the association cease on the  
41 later of:**

- 42 **(1) the date on which a health benefit exchange (as defined in**

C  
O  
P  
Y



- 1           **IC 27-19-2-8) begins operating in Indiana; or**  
 2           **(2) December 31, 2013.**  
 3           **(b) A claim for payment under an association policy must be**  
 4 **made to the association not later than the later of:**  
 5           **(1) sixty (60) days after the date on which the insurance**  
 6 **operations cease under subsection (a); or**  
 7           **(2) March 1, 2014.**  
 8           **(c) An appeal or grievance under this chapter must be resolved**  
 9 **not later than ninety (90) days after the date on which the**  
 10 **insurance operations cease under subsection (a).**  
 11           **(d) Balance billing under this chapter by a health care provider**  
 12 **that is not a member of a health care provider network**  
 13 **arrangement used by the association is prohibited after the later**  
 14 **of:**  
 15           **(1) ninety (90) days after the date on which the insurance**  
 16 **operations cease under subsection (a); or**  
 17           **(2) March 30, 2014.**  
 18           **(e) The association shall, not later than June 30, 2013, submit to**  
 19 **the commissioner a plan of dissolution for the association. The**  
 20 **following apply to a plan of dissolution submitted under this**  
 21 **subsection:**  
 22           **(1) The plan of dissolution must provide for the following:**  
 23           **(A) Continuity of care for an individual who is covered**  
 24 **under an association policy and is an inpatient on the date**  
 25 **on which the insurance operations cease under subsection**  
 26 **(a).**  
 27           **(B) A final accounting described in section 2.1(g) of this**  
 28 **chapter of the:**  
 29           **(i) assessments; and**  
 30           **(ii) cessation of the liability;**  
 31 **of members of the association.**  
 32           **(C) Resolution of any net asset deficiency.**  
 33           **(D) Cessation of all liability of the association.**  
 34           **(E) Final dissolution of the association.**  
 35           **(2) The plan of dissolution may provide that, with the**  
 36 **approval of the board and the commissioner, a power or duty**  
 37 **of the association may be delegated to a person that is to**  
 38 **perform functions similar to the functions of the association.**  
 39           **(f) The commissioner shall, after notice and hearing, approve a**  
 40 **plan of dissolution submitted under subsection (e) if the**  
 41 **commissioner determines that the plan:**  
 42           **(1) is suitable to assure the fair, reasonable, and equitable**

C  
o  
p  
y



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

dissolution of the association; and

(2) complies with subsection (e).

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

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

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

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

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

SECTION 21. IC 27-19 IS ADDED TO THE INDIANA CODE AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]:

**ARTICLE 19. HEALTH BENEFIT EXCHANGE**

**Chapter 1. General Provisions**

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

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

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

(1) The complete repeal of PPACA.

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

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

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

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

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

C  
o  
p  
y



- 1           **(2) Enter into a contract, agreement, or memorandum of**
- 2           **understanding with the following:**
- 3           **(A) A health benefit exchange.**
- 4           **(B) An entity that contracts with, or is a subcontractor of,**
- 5           **a health benefit exchange.**
- 6           **(C) A federal or state agency.**
- 7           **(D) A health benefit exchange operating in another state.**
- 8           **(E) An agency of another state.**
- 9           **(F) A health plan.**
- 10           **(G) Another person, for purposes of the performance of**
- 11           **necessary functions, as determined by the commissioner.**
- 12           **(3) Enter with a person described in subdivision (2) into an**
- 13           **information sharing agreement:**
- 14           **(A) that concerns the disclosure and receiving of data**
- 15           **necessary to implement this article or PPACA; and**
- 16           **(B) that:**
- 17           **(i) includes adequate protections with respect to**
- 18           **confidentiality of the shared information; and**
- 19           **(ii) complies with applicable state and federal law.**

**Chapter 2. Definitions**

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

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

**Sec. 3. (a) "Assister" means a person that:**

- (1) does not meet the standards established for a navigator under Section 1311(i) of PPACA (42 U.S.C. 18031(i)); and**
- (2) performs the functions of a navigator with respect to a health benefit exchange as established by the commissioner.**

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

- (1) A Medicaid authorized representative.**
- (2) A person that only provides assistance to consumers regarding public assistance that is unrelated to an application for participation in:**
  - (A) Medicaid; or**
  - (B) a health benefit exchange.**

**Sec. 4. "CHIP office" refers to the office of the children's health insurance program established by IC 12-17.6-2-1.**

**Sec. 5. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.**

**Sec. 6. "Department" refers to the department of insurance created by IC 27-1-1-1.**

C  
O  
P  
Y



- 1       **Sec. 7. "Group health plan" means a group health plan (as**
- 2 **defined in Section 2791 of the federal Public Health Service Act (42**
- 3 **U.S.C. 300gg-91)) that provides health insurance coverage.**
- 4       **Sec. 8. "Health benefit exchange" means an American health**
- 5 **benefit exchange operating in Indiana under PPACA.**
- 6       **Sec. 9. "Health insurance coverage" has the meaning set forth**
- 7 **in Section 2791 of the federal Public Health Service Act (42 U.S.C.**
- 8 **300gg-91).**
- 9       **Sec. 10. (a) "Health plan" means a policy or contract that**
- 10 **provides health insurance coverage.**
- 11       **(b) The term includes a group health plan.**
- 12       **Sec. 11. (a) "Navigator" means a person that:**
- 13           **(1) meets the grant funding requirements of Section 1311(i) of**
- 14 **PPACA (42 U.S.C. 18031(i)); and**
- 15           **(2) performs the functions of a navigator with respect to a**
- 16 **health benefit exchange as established by the commissioner.**
- 17       **(b) The term does not include the following:**
- 18           **(1) A Medicaid authorized representative.**
- 19           **(2) A person that only provides assistance to consumers**
- 20 **regarding public assistance that is unrelated to an application**
- 21 **for participation in:**
- 22           **(A) Medicaid; or**
- 23           **(B) a health benefit exchange.**
- 24       **Sec. 12. "Person" means an individual or an entity.**
- 25       **Sec. 13. "PPACA" refers to the federal Patient Protection and**
- 26 **Affordable Care Act (P.L. 111-148), as amended by the federal**
- 27 **Health Care and Education Reconciliation Act of 2010 (P.L.**
- 28 **111-152).**
- 29       **Sec. 14. (a) "Public health insurance program" refers to health**
- 30 **coverage provided under a state or federal government program.**
- 31       **(b) The term includes the following:**
- 32           **(1) Medicaid (42 U.S. C. 1396 et seq.).**
- 33           **(2) The Indiana check-up plan established by IC 12-15-44.2-3.**
- 34           **(3) The children's health insurance program established**
- 35 **under IC 12-17.6.**
- 36       **Sec. 15. "Qualified health plan" means a health plan that has**
- 37 **been certified under Section 1301 of PPACA (42 U.S.C. 18021(a))**
- 38 **to meet the criteria for availability through a health benefit**
- 39 **exchange operated in Indiana.**
- 40       **Sec. 16. "Secretary" refers to the secretary of family and social**
- 41 **services appointed under IC 12-8-1.5-2.**
- 42       **Chapter 3. Health Benefit Exchange Authority**

C  
o  
p  
y



1           **Sec. 1. This chapter applies to a health benefit exchange**  
 2 **operating in Indiana.**

3           **Sec. 2. (a) The commissioner and department may implement**  
 4 **and enforce the insurance law of this state in connection with a**  
 5 **health benefit exchange.**

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

9           **(c) This section does not require the department to perform any**  
 10 **function related to a health benefit exchange without being**  
 11 **appropriately compensated for the performance of the function.**

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

15           **(b) A law of this state concerning a health benefit exchange does**  
 16 **not preempt or supersede the authority of the secretary, the**  
 17 **administrator, or the CHIP office to administer and regulate social**  
 18 **services in Indiana.**

19           **(c) This section does not require the secretary, the**  
 20 **administrator, or the CHIP office to perform any function related**  
 21 **to a health benefit exchange without being appropriately**  
 22 **compensated for the performance of the function.**

23           **(d) The secretary may adopt rules under IC 4-22-2 to implement**  
 24 **this section.**

25           **(e) The administrator and the CHIP office may do the following**  
 26 **to implement this section:**

27           **(1) Enter into a contract, agreement, or memorandum of**  
 28 **understanding with the following:**

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

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

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

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

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

35           **(F) A health plan.**

36           **(2) Enter with a person described in subdivision (1) into an**  
 37 **information sharing agreement:**

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

40           **(B) that:**

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

C  
O  
P  
Y



1 (ii) complies with applicable state and federal law.  
 2 Chapter 4. Health Benefit Exchange Navigators and Assisters  
 3 Sec. 1. (a) This chapter applies to a person that acts as a  
 4 navigator or an assister for a health benefit exchange in Indiana.  
 5 This chapter must be applied in conformity with PPACA.  
 6 (b) An individual who intends to act as a navigator or an assister  
 7 shall obtain certification under this chapter before acting as a  
 8 navigator or an assister.  
 9 (c) An entity that intends to act as a navigator or an assister  
 10 shall obtain registration under this chapter before acting as a  
 11 navigator or an assister.  
 12 (d) An individual or entity that is a navigator or an assister is  
 13 subject to regulation by the commissioner and the secretary.  
 14 Sec. 2. A navigator or an assister is not subject to the licensing  
 15 requirements of IC 27-1-15.6.  
 16 Sec. 3. (a) A navigator or an assister must meet all of the  
 17 following:  
 18 (1) Shall not provide incorrect, misleading, incomplete, or  
 19 materially untrue information in an application for  
 20 certification or registration.  
 21 (2) Shall not violate any of the following:  
 22 (A) An insurance law.  
 23 (B) A regulation.  
 24 (C) A subpoena of the commissioner.  
 25 (D) An order of the commissioner.  
 26 (E) A rule of a health benefit exchange operating in  
 27 Indiana.  
 28 (F) A rule adopted under IC 27-19-3-3(d).  
 29 (3) Shall not intentionally misrepresent the terms of an actual  
 30 or proposed insurance contract or application for insurance.  
 31 (4) Must not have had:  
 32 (A) an insurance producer or consultant license;  
 33 (B) a navigator or an assister certification or registration;  
 34 or  
 35 (C) an equivalent to a license, certification, or registration  
 36 described in clause (A) or (B);  
 37 denied, suspended, or revoked in any state, province, district,  
 38 or territory.  
 39 (5) Shall not fail to satisfy the continuing education  
 40 requirements established under section 12 of this chapter.  
 41 (6) Shall not obtain or attempt to obtain a license,  
 42 certification, or registration through misrepresentation or

COPY



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

- fraud.
- (7) Shall not fail to disclose a conflict of interest to the commissioner:

  - (A) in an application under this chapter; or
  - (B) arising after application is made under this chapter.

- (8) Must not have been convicted of a felony or other crimes determined by the commissioner or secretary.
- (9) Must not have admitted to committing or have been found to have committed an unfair trade practice or fraud in the business of insurance.
- (10) Shall not use fraudulent, coercive, or dishonest practices, or demonstrate incompetence or untrustworthiness, in acting as a navigator or an assister.
- (11) Shall not improperly use notes or other reference material to complete an examination for certification as a navigator or an assister.
- (12) Must not have failed, and shall not fail, to comply with an administrative or court order imposing a child support obligation.
- (13) Must not have failed, and shall not fail, to pay state income tax or comply with any administrative or court order directing payment of state income tax.
- (14) Shall not fail to timely inform the commissioner of a change in legal name or address.
- (15) If the navigator or assister is an entity, shall not fail to verify that each navigator and assister who is an individual working for the entity meets the following requirements:
  - (A) The navigator or assister is certified under this chapter.
  - (B) The navigator or assister has not committed an act that would be grounds for denial, suspension, or revocation of certification under this chapter.
- (b) The commissioner may:
  - (1) reprimand a navigator or an assister;
  - (2) levy a civil penalty against a navigator or an assister;
  - (3) place a navigator or an assister on probation;
  - (4) suspend a navigator's or an assister's certificate or registration;
  - (5) revoke a navigator's or an assister's certificate or registration for a period of years;
  - (6) permanently revoke a navigator's or an assister's certificate or registration;

C  
O  
P  
Y



- 1 (7) issue a cease and desist order to a navigator or an assister;
- 2 or
- 3 (8) take any combination of the actions described in
- 4 subdivisions (1) through (7);
- 5 for a violation described in subsection (a).

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

- 8 (1) Develop a policy concerning conflicts of interest affecting
- 9 navigators and assisters, including conflicts of interest
- 10 involving financial and nonfinancial considerations.
- 11 (2) Develop a consumer complaint procedure and applicable
- 12 forms for filing a complaint.
- 13 (3) Define a reasonable period for the duration of navigator
- 14 or assister certification, after which the navigator or assister
- 15 must pay a renewal fee, complete continuing education, and
- 16 reapply for certification.

17 Sec. 5. (a) Before acting as a navigator or an assister in Indiana,  
 18 an individual must:

- 19 (1) apply for certification as a navigator or an assister on a
- 20 form prescribed by the commissioner; and
- 21 (2) declare, under penalty of denial, suspension, or revocation
- 22 of the certification, that the statements made in the
- 23 application are true, correct, and complete to the best of the
- 24 individual's knowledge and belief.

25 (b) Before approving an application submitted under subsection  
 26 (a), the commissioner shall determine whether the individual meets  
 27 the following requirements:

- 28 (1) The individual is at least eighteen (18) years of age.
- 29 (2) The individual has not committed any act described in
- 30 section 3 of this chapter that would be grounds for denial,
- 31 suspension, or revocation of certification.
- 32 (3) The individual has completed a precertification course of
- 33 study prescribed by the commissioner.
- 34 (4) The individual has paid the nonrefundable fees established
- 35 under section 7 of this chapter.
- 36 (5) The individual has successfully passed the examination
- 37 required by section 11 of this chapter.

38 Sec. 6. (a) Before acting as a navigator or assister in Indiana, an  
 39 entity must be registered as a navigator or an assister as follows:

- 40 (1) The entity must apply for registration as a navigator or an
- 41 assister on a form prescribed by the commissioner.
- 42 (2) The entity's application for registration:

C  
O  
P  
Y



- 1 (A) must be signed by an individual who is an owner,
- 2 partner, officer, director, member, or manager of the
- 3 entity, under penalty of denial, suspension, or revocation
- 4 of registration; and
- 5 (B) must declare that the statements made in the
- 6 application are true, correct, and complete to the best of
- 7 the signing individual's knowledge and belief.
- 8 (b) Before approving an application submitted under subsection
- 9 (a), the commissioner shall:
- 10 (1) verify that the entity is in good standing with the Indiana
- 11 secretary of state; and
- 12 (2) determine whether the entity meets the following
- 13 requirements:
- 14 (A) The entity has paid the nonrefundable fees established
- 15 under section 7 of this chapter.
- 16 (B) The entity has designated a certified individual
- 17 navigator or assister to be responsible for the entity's
- 18 compliance with this chapter.
- 19 (C) The entity has not committed any act described in
- 20 section 3 of this chapter that would be grounds for denial,
- 21 suspension, or revocation of registration.
- 22 (D) No owner, partner, officer, director, member, or
- 23 manager of the entity has committed an act described in
- 24 clause (C).
- 25 Sec. 7. (a) The commissioner may require the production of any
- 26 document that is reasonably necessary to verify the information
- 27 contained in an application submitted under section 5 or 6 of this
- 28 chapter.
- 29 (b) The commissioner shall collect from each applicant for
- 30 certification or registration under this chapter a nonrefundable
- 31 application fee established by the commissioner in an amount
- 32 expected to generate revenue sufficient to cover the costs incurred
- 33 by the commissioner in implementing this chapter.
- 34 Sec. 8. (a) An individual navigator or assister who works for an
- 35 entity that is a navigator or an assister must be appointed by the
- 36 entity in writing.
- 37 (b) If an entity, because of a violation described in section 3 of
- 38 this chapter, revokes the appointment of an individual navigator
- 39 or assister described in subsection (a) who works for the entity, the
- 40 entity shall, not more than thirty (30) days after the revocation
- 41 occurs:
- 42 (1) submit a written report to the commissioner concerning

COPY



1 the revocation; and

2 (2) provide a copy of the report to the individual at the  
3 individual's last known address by:

4 (A) certified mail, return receipt requested, postage  
5 prepaid; or

6 (B) overnight delivery using a nationally recognized  
7 carrier.

8 **Sec. 9.** A certified individual navigator or assister who is unable  
9 to comply with the certification renewal procedures under this  
10 chapter due to military service or another extenuating  
11 circumstance may request from the commissioner:

12 (1) a temporary waiver of:

13 (A) the renewal procedure; or

14 (B) an examination requirement; or

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

17 **Sec. 10.** (a) A navigator or an assister certification or  
18 registration must contain the navigator's or assister's name and  
19 address, the date of issuance, the expiration date, and any other  
20 information the commissioner considers necessary.

21 (b) A navigator or an assister shall inform the commissioner of  
22 a change of address or legal name:

23 (1) not more than thirty (30) days after the change occurs;  
24 and

25 (2) by any means acceptable to the commissioner.

26 **Sec. 11.** (a) An individual who applies for certification as a  
27 navigator or an assister in Indiana must complete a course of study  
28 and pass a written examination as prescribed by the commissioner  
29 in consultation with the secretary.

30 (b) The course of study required under subsection (a) must  
31 provide instruction in:

32 (1) the functions of a health benefit exchange;

33 (2) the duties and responsibilities of a navigator or an assister;  
34 and

35 (3) the insurance laws of Indiana that apply to the functions  
36 of a navigator or an assister with respect to a health benefit  
37 exchange, including rules related to public health insurance  
38 programs.

39 (c) The examination required by subsection (a) must test the  
40 knowledge of the individual concerning the applicable:

41 (1) functions of a health benefit exchange;

42 (2) duties and responsibilities of a navigator or assister; and

C  
O  
P  
Y



1 (3) insurance laws of Indiana that apply to the functions of a  
 2 navigator or an assister with respect to a health benefit  
 3 exchange, including rules related to public health insurance  
 4 programs.

5 (d) The commissioner:

6 (1) in consultation with the secretary, shall develop a  
 7 curriculum for a course of study for navigators and assisters;  
 8 and

9 (2) may contract with a third party organization to:

10 (A) develop examinations and course materials;

11 (B) administer examinations and courses of study; and

12 (C) collect nonrefundable course and examination fees;

13 for the course of study for navigators and assisters.

14 (e) All examinations, course materials, and examination fees  
 15 referred to in subsection (d)(2) must be approved in advance by the  
 16 commissioner in consultation with the secretary.

17 Sec. 12. (a) The commissioner:

18 (1) in consultation with the secretary, shall develop continuing  
 19 education requirements for navigators and assisters; and

20 (2) may contract with a third party organization to:

21 (A) develop continuing education materials to meet the  
 22 requirements developed under subdivision (1);

23 (B) administer continuing education programs; and

24 (C) collect nonrefundable continuing education program  
 25 fees.

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

29 (c) The commissioner may require a navigator or an assister to  
 30 complete specific continuing education requirements, as prescribed  
 31 by the commissioner in consultation with the secretary, as a  
 32 prerequisite to the authority to perform specific functions with  
 33 respect to a health benefit exchange.

34 Sec. 13. An individual who fails to:

35 (1) appear for a scheduled examination required under  
 36 section 11(a) of this chapter; or

37 (2) pass the examination;

38 may not be rescheduled for the examination unless the individual  
 39 reapplies for the examination and remits all required fees and  
 40 forms.

41 Sec. 14. (a) An insurance producer or insurance consultant:

42 (1) may not act as a navigator or an assister unless the

C  
O  
P  
Y



1 insurance producer or insurance consultant has completed the  
 2 continuing education requirements that apply to a navigator  
 3 or an assister; and  
 4 (2) shall receive a designation from the commissioner as a  
 5 navigator or an assister upon completion of the continuing  
 6 education requirements;  
 7 under this chapter.

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

13 SECTION 22. [EFFECTIVE JULY 1, 2013] (a) As used in this  
 14 SECTION, "commission" refers to the health finance commission  
 15 established by IC 2-5-23-3.

16 (b) Before August 1, 2013, the office of Medicaid policy and  
 17 planning shall present a plan to the Indiana general assembly and  
 18 the commission concerning the following:

- 19 (1) Whether to require a Medicaid recipient who is eligible for  
 20 Medicaid based on the individual's aged, blind, or disabled  
 21 status to enroll in the risk-based managed care program.
- 22 (2) How to address the provision of health care for the  
 23 following populations:
  - 24 (A) Individuals who currently participate in the Indiana  
 25 check-up plan (IC 12-15-44.2).
  - 26 (B) Individuals who are dually eligible for the federal  
 27 Medicare program (42 U.S.C. 1395 et seq.) and the  
 28 Medicaid program (IC 12-15).
- 29 (3) Information concerning the number of individuals  
 30 participating in a program described in subdivision (2)(A) and  
 31 (2)(B) who would be eligible for a tax credit under the federal  
 32 Patient Protection and Affordable Care Act (P.L. 111-148).

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

34 SECTION 23. [EFFECTIVE UPON PASSAGE] (a) As used in this  
 35 SECTION, "Affordable Care Act" refers to the federal Patient  
 36 Protection and Affordable Care Act (P.L. 111-148), as amended by  
 37 the federal Health Care and Education Reconciliation Act of 2010  
 38 (P.L. 111-152).

39 (b) As used in this SECTION, "commission" refers to the health  
 40 finance commission established by IC 2-5-23-3.

41 (c) As used in this SECTION, "exchange" refers to an American  
 42 health benefit exchange established under the Affordable Care Act.

C  
 o  
 p  
 y



1           (d) Before August 1, 2013, the department of insurance, the  
2 office of the secretary of family and social services, and the state  
3 department of health shall work together to prepare a report for  
4 the commission concerning the following:  
5           (1) The establishment and implementation of an exchange in  
6 Indiana.  
7           (2) The definition of "essential health benefits" for use in  
8 Indiana under the Affordable Care Act, including ensuring  
9 that the definition results in adequate benefits.  
10          (e) This chapter expires December 31, 2013.  
11 SECTION 24. An emergency is declared for this act.

C  
o  
p  
y



## COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 551, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

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

**(1) who is:**

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

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

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

Page 2, between lines 6 and 7, begin a new paragraph and insert:

"SECTION 3. IC 12-15-2-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 14. (a) An individual:

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

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

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

is eligible to receive Medicaid.

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

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

Page 3, between lines 34 and 35, begin a new paragraph and insert:

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

(1) is determined to be presumptively eligible for Medicaid under this chapter; and

C  
O  
P  
Y



(2) appoints, in writing, an agent of a qualified entity under section 4 of this chapter as the woman's authorized representative for purposes of completing all aspects of the Medicaid application process;

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

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

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

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

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

(c) In the case of an individual who:

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

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

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

SECTION 8. IC 12-15-3-1.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 1.5. (a) Beginning January 1, 2014, the office shall determine eligibility for a Medicaid applicant or Medicaid recipient who is aged, blind, or disabled under IC 12-15-2-3.5.**

**(b) If an individual:**

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

C  
O  
P  
Y



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

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

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

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

SECTION 10. IC 12-15-3-3, AS AMENDED BY P.L.196-2011, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 3. (a) Except as provided in section 7 of this chapter, if the parents of an applicant for or a recipient of assistance to the blind or disabled who is less than eighteen (18) years of age own money, stock, bonds, and life insurance whose total cash value is more than two thousand two hundred fifty dollars (\$2,250), the amount of the excess shall be added to the total cash value of money, stock, bonds, and life insurance owned by the applicant or recipient to determine the recipient's eligibility for Medicaid under section 1 of this chapter.

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

Page 5, between lines 25 and 26, begin a new paragraph and insert:  
"SECTION 12. IC 12-15-46-3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) **The office of the secretary has the authority to negotiate with the United States Department of Health and Human Services for amendments to the state Medicaid plan or for any Medicaid waivers necessary to establish a block grant system for providing services under the Medicaid program, including providing coverage for individuals described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).**

**(b) A waiver or state plan amendment negotiated under this**



C  
o  
p  
y

section must include the following:

- (1) Allow the office to withdraw from participating in a program negotiated under this section at any time.
- (2) Include federal financial participation at least at the levels specified in the federal Patient Protection and Affordable Care Act.
- (3) Include, when appropriate, consumer driven principles.
- (4) Include coverage for preventative care services provided at no cost to the recipient and allow incentives for increasing preventative care for recipients.
- (5) Allow for personal responsibility requirements.
- (6) Require a recipient to make out-of-pocket payments related to coverage for health care expenses provided under the program.
- (7) Require a health care account to be used to pay the recipient's out-of-pocket health care expenses associated with health care coverage provided as part of the recipient's participation in the program described in this section.
- (8) Include health care initiatives designed to promote the general health and well being of recipients and encourage an understanding of the cost and quality of care.

(c) The office of the secretary may not implement a waiver or Medicaid state plan amendment negotiated under this section until the office of the secretary has developed a sustainable financing plan for the Medicaid state plan amendment or waiver.

SECTION 13. IC 12-15-46-5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 5. (a) The office shall apply to the United States Department of Health and Human Services for an amendment to the state Medicaid plan to require Medicaid recipients to participate in cost sharing, as allowable under federal law.

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

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



C  
O  
P  
Y

Page 19, delete lines 15 through 16.

Page 19, line 17, delete "(c)" and insert "(b)".

Page 19, line 22, delete "(d)" and insert "(c)".

Page 19, line 25, delete "(e)" and insert "(d)".

Page 19, line 32, delete "(f)" and insert "(e)".

Page 20, line 11, delete "(g)" and insert "(f)".

Page 20, line 12, delete "(f)" and insert "(e)".

Page 20, line 16, delete "(f)." and insert "(e)".

Page 20, line 17, delete "(h)" and insert "(g)".

Page 20, line 17, delete "(f)" and insert "(e)".

Page 20, line 19, delete "(i)" and insert "(h)".

Page 20, line 22, delete "(j)" and insert "(i)".

Page 20, line 24, delete "(g)." and insert "(f)".

Page 20, line 25, delete "(k)" and insert "(j)".

Page 20, line 28, delete "(l)" and insert "(k)".

Page 20, line 29, delete "(f)," and insert "(e)".

Page 20, line 31, delete "(g)." and insert "(f)".

Page 30, between lines 26 and 27, begin a new paragraph and insert:

"SECTION 14. [EFFECTIVE JULY 1, 2013] (a) **As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.**

(b) **Before August 1, 2013, the office of Medicaid policy and planning shall present a plan to the Indiana general assembly and the commission concerning the following:**

(1) **Whether to require a Medicaid recipient who is eligible for Medicaid based on the individual's aged, blind, or disabled status to enroll in the risk-based managed care program.**

(2) **How to address the provision of health care for the following populations:**

(A) **Individuals who currently participate in the Indiana check-up plan (IC 12-15-44.2).**

(B) **Individuals who are dually eligible for the federal Medicare program (42 U.S.C. 1395 et seq.) and the Medicaid program (IC 12-15).**

(3) **Information concerning the number of individuals participating in a program described in subdivision (2)(A) and (2)(B) who would be eligible for a tax credit under the federal Patient Protection and Affordable Care Act (P.L. 111-148).**

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

SECTION 18. [EFFECTIVE UPON PASSAGE] (a) **As used in this SECTION, "Affordable Care Act" refers to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by**

C  
o  
p  
y



the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(b) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.

(c) As used in this SECTION, "exchange" refers to an American health benefit exchange established under the Affordable Care Act.

(d) Before August 1, 2013, the department of insurance, the office of the secretary of family and social services, and the state department of health shall work together to prepare a report for the commission concerning the following:

(1) The establishment and implementation of an exchange in Indiana.

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

(e) This chapter expires December 31, 2013."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 551 as introduced.)

MILLER PATRICIA, Chairperson

Committee Vote: Yeas 9, Nays 3.

C  
O  
P  
Y

