



Reprinted
February 26, 2013

SENATE BILL No. 551

DIGEST OF SB 551 (Updated February 25, 2013 5:10 pm - DI 97)

Citations Affected: IC 12-7; 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 certain Medicaid eligibility resource requirements. Specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost sharing amounts. Provides for negotiations between the office of Medicaid policy and planning (office) and the United States Department of Health and Human Services (HHS) concerning a block grant system related to Medicaid. Requires the office to apply to HHS to amend the state Medicaid plan to require Medicaid recipient cost sharing. Provides for implementation of the federal Patient Protection and Affordable Care Act with respect to a health benefit exchange (exchange) in Indiana. Specifies requirements for health plans issued through an exchange, including application of Indiana insurance law. Requires certification of navigators and registration of application organizations related to an 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 certain state agencies to report to the commission related to an exchange in Indiana.

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.
February 21, 2013, amended, reported favorably — Do Pass.
February 25, 2013, read second time, amended, ordered engrossed.

SB 551—LS 7434/DI 104+



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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.

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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 12-7-2-155.3 IS ADDED TO THE INDIANA
2 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
3 [EFFECTIVE JULY 1, 2013]: **Sec. 155.3. "Qualified Medicare**
4 **beneficiary", for purposes of IC 12-15-2-26, has the meaning set**
5 **forth in IC 12-15-2-26(b).**

6 SECTION 2. IC 12-7-2-155.5 IS ADDED TO THE INDIANA
7 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
8 [EFFECTIVE JULY 1, 2013]: **Sec. 155.5. "Qualifying individual",**
9 **for purposes of IC 12-15-2-26, has the meaning set forth in**
10 **IC 12-15-2-26(c).**

11 SECTION 3. IC 12-7-2-180.4 IS ADDED TO THE INDIANA
12 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
13 [EFFECTIVE JULY 1, 2013]: **Sec. 180.4. "Specified low-income**
14 **Medicare beneficiary", for purposes of IC 12-15-2-26, has the**
15 **meaning set forth in IC 12-15-2-26(d).**

16 SECTION 4. IC 12-15-2-3.5 IS ADDED TO THE INDIANA CODE
17 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

SB 551—LS 7434/DI 104+



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.

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

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

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

is eligible to receive Medicaid.

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

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

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

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

SECTION 6. 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

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1 income does not exceed one hundred fifty percent (150%) of the
2 federal income poverty level for the same size family.

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

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

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

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

15 (b) **The office may apply this section only to the following
16 Medicaid applicants or Medicaid recipients:**

17 (1) **An individual whose eligibility for Medicaid does not
18 require a determination of income by the office.**

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

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

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

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

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

31 (C) **Home and community based services.**

32 (D) **Home health services.**

33 (E) **Personal care services.**

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

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

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

42 (2) **enters into an irrevocable prepaid funeral agreement having a**

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1 value of not more than ten thousand dollars (\$10,000); or
 2 (3) owns a life insurance policy with a face value of not more than
 3 ten thousand dollars (\$10,000) and with respect to which
 4 provision is made to pay not more than ten thousand dollars
 5 (\$10,000) toward the applicant's or recipient's funeral expenses;
 6 the value of the trust, prepaid funeral agreement, or life insurance
 7 policy may not be considered as a resource in determining the
 8 applicant's or recipient's eligibility for Medicaid.

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

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

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

- 32 (1) growth in principal;
- 33 (2) accumulation and reinvestment of dividends;
- 34 (3) accumulation and reinvestment of interest; and
- 35 (4) accumulation and reinvestment of distributions;

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

40 SECTION 8. IC 12-15-2-26 IS ADDED TO THE INDIANA CODE
 41 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 42 1, 2013]: **Sec. 26. (a) This section applies beginning the later of the**

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following:

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

(2) January 1, 2014.

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

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

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

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

(1) A qualified Medicare beneficiary whose:

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

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

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

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

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

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

is eligible for coverage of Medicare Part B premiums.

(3) A qualifying individual whose:

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

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

is eligible for coverage of Medicare Part B premiums.

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

SECTION 9. 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

(2) appoints, in writing, an agent of a qualified entity under

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1 section 4 of this chapter as the woman's authorized representative
 2 for purposes of completing all aspects of the Medicaid application
 3 process;

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

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

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

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

17 (2) the applicant or recipient and the applicant's or recipient's
 18 spouse is more than two thousand two hundred fifty dollars
 19 (\$2,250) for medical assistance to the aged, blind, or disabled.

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

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

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

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

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

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

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

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

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

42 (b) **The office shall determine eligibility for a Medicaid**

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1 applicant or Medicaid recipient who is aged, blind, or disabled
2 under IC 12-15-2-3.5.

3 (c) If an individual:

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

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

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

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

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

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

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

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

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

42 (1) The individual is at least eighteen (18) years of age and less

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- 1 than sixty-five (65) years of age.
- 2 (2) The individual is a United States citizen and has been a
- 3 resident of Indiana for at least twelve (12) months.
- 4 (3) The individual has an annual household income of not more
- 5 than the following:
- 6 (A) Effective through December 31, 2013, two hundred
- 7 percent (200%) of the federal income poverty level.
- 8 (B) Beginning January 1, 2014, one hundred thirty-three
- 9 percent (133%) of the federal income poverty level, based on
- 10 the adjusted gross income provisions set forth in Section
- 11 2001(a)(1) of the federal Patient Protection and Affordable
- 12 Care Act.
- 13 (4) Effective through December 31, 2013, the individual is not
- 14 eligible for health insurance coverage through the individual's
- 15 employer.
- 16 (5) Effective through December 31, 2013, the individual has:
- 17 (A) not had health insurance coverage for at least six (6)
- 18 months; **or**
- 19 (B) **had coverage under the Indiana comprehensive health**
- 20 **insurance association (IC 27-8-10) within the immediately**
- 21 **preceding six (6) months and the coverage no longer**
- 22 **applies under IC 27-8-10-0.5.**
- 23 (b) The following individuals are not eligible for the plan:
- 24 (1) An individual who participates in the federal Medicare
- 25 program (42 U.S.C. 1395 et seq.).
- 26 (2) A pregnant woman for purposes of pregnancy related services.
- 27 (3) An individual who is otherwise eligible for medical assistance.
- 28 (c) The eligibility requirements specified in subsection (a) are
- 29 subject to approval for federal financial participation by the United
- 30 States Department of Health and Human Services.
- 31 SECTION 15. IC 12-15-46-1, AS ADDED BY P.L.6-2012,
- 32 SECTION 95, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 33 JULY 1, 2013]: Sec. 1. (a) As used in this section, "family planning
- 34 services" does not include the performance of abortions or the use of
- 35 a drug or device intended to terminate fertilization.
- 36 (b) As used in this section, "fertilization" means the joining of a
- 37 human egg cell with a human sperm cell.
- 38 (c) As used in this section, "state plan amendment" refers to an
- 39 amendment to Indiana's Medicaid State Plan as authorized by Section
- 40 1902(a)(10)(A)(ii)(XXI) of the federal Social Security Act (42 U.S.C.
- 41 1315).
- 42 (d) Before January 1, ~~2012~~, **2014**, the office shall do the following:

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1 (1) Apply to the United States Department of Health and Human
 2 Services for approval of a state plan amendment to ~~expand the~~
 3 ~~population eligible~~ for family planning services and supplies as
 4 permitted by Section 1902(a)(10)(A)(ii)(XXI) of the federal
 5 Social Security Act (42 U.S.C. 1315). In determining what
 6 population is eligible, ~~for this expansion~~, the state must
 7 incorporate the following:

8 (A) Inclusion of women and men.

9 (B) Setting income eligibility at one hundred thirty-three
 10 percent (133%) of the federal income poverty level.

11 (C) Adopting presumptive eligibility for services to this
 12 population.

13 (2) Consider the inclusion of additional:

14 (A) medical diagnosis; and

15 (B) treatment services;

16 that are provided for family planning services in a family planning
 17 setting for the population designated in subdivision (1) in the state
 18 plan amendment.

19 (e) The office shall report concerning its proposed state plan
 20 amendment to the select joint commission on Medicaid oversight
 21 established by IC 2-5-26-3 during the commission's 2011 interim
 22 meetings. The select joint commission on Medicaid oversight shall
 23 review the proposed state plan amendment and may make an advisory
 24 recommendation to the office concerning the proposed state plan
 25 amendment.

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

28 (g) This section expires January 1, 2016.

29 SECTION 16. IC 12-15-46-3 IS ADDED TO THE INDIANA
 30 CODE AS A NEW SECTION TO READ AS FOLLOWS
 31 [EFFECTIVE UPON PASSAGE]: **Sec. 3. (a) The office of the**
 32 **secretary has the authority to negotiate with the United States**
 33 **Department of Health and Human Services for amendments to the**
 34 **state Medicaid plan or for any Medicaid waivers necessary to**
 35 **establish a block grant system for providing services under the**
 36 **Medicaid program, including providing coverage for individuals**
 37 **described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).**

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

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

42 (2) Include federal financial participation at least at the levels

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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 and the plan has been reviewed by the state budget committee.

SECTION 17. 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.

SECTION 18. IC 27-1-3-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 7. (a) The department may promulgate rules and regulations for any of the following

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enumerated purposes:

- (1) For the conduct of the work of the department.
 - (2) Prescribing the methods and standards to be used in making the examinations and prescribing the forms of reports of the several insurance companies to which IC 27-1 is applicable.
 - (3) Defining what is a safe or an unsafe manner and a safe or an unsafe condition for conducting business by any insurance company to which IC 27-1 is applicable.
 - (4) For the establishment of safe and sound methods for the transaction of business by such insurance companies and for the purpose of safeguarding the interests of policyholders, creditors, and shareholders respecting the withdrawal or payment of funds by any life insurance company in times of emergency. Any rule or regulation promulgated under this subdivision may apply to one (1) or more insurance companies as the department may determine.
 - (5) For the administration and termination of the affairs of any such insurance company which is in involuntary liquidation or whose business and property have been taken possession of by the department for the purpose of rehabilitation, liquidation, conservation, or dissolution under IC 27-1.
 - (6) For the regulation of the solicitation or use of proxies, in general and as they concern consents or authorizations, in respect of securities issued by any domestic stock company for the purpose of protecting investors by prescribing the form of proxies, including such consents or authorizations, and by requiring adequate disclosure of information relevant to such proxies, including such consents or authorizations, and relevant to the business to be transacted at any meeting of shareholders with respect to which such proxies, including such consents or authorizations, may be used, which regulations may, in general, conform to those prescribed by the National Association of Insurance Commissioners.
 - (7) For regulation related to a health benefit exchange established under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and operating in Indiana.**
- (b) The department may adopt a rule under IC 4-22-2 to provide reasonable simplification of the terms and coverage of individual and group Medicare supplement accident and sickness insurance policies and individual and group Medicare supplement subscriber contracts in

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1 order to facilitate public understanding and comparison and to
2 eliminate provisions contained in those policies or contracts which may
3 be misleading or confusing in connection either with the purchase of
4 those coverages or with the settlement of claims and to provide for full
5 disclosure in the sale of those coverages.

6 SECTION 19. IC 27-1-3-10.5 IS AMENDED TO READ AS
7 FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 10.5. (a) As used in this
8 section, "confidential information" means information that has been
9 designated as confidential by statute, rule, or regulation issued under
10 a statute.

11 (b) The commissioner may not:
12 (1) disclose; or
13 (2) subject to subpoena;
14 financial information regarding material transactions disclosed by an
15 insurer under IC 27-2-18.

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

18 (1) the National Association of Insurance Commissioners; or
19 (2) an insurance department of another state;
20 if the information is designated as confidential information in the other
21 jurisdiction.

22 (d) The commissioner may share confidential information with:
23 (1) the National Association of Insurance Commissioners; or
24 (2) an insurance department of another state;
25 on the condition that the National Association of Insurance
26 Commissioners and the other state agree to maintain the same level of
27 confidentiality that is provided to the information under Indiana law.

28 **(e) The commissioner may share confidential information**
29 **related to a health benefit exchange established under the federal**
30 **Patient Protection and Affordable Care Act (P.L. 111-148), as**
31 **amended by the federal Health Care and Education Reconciliation**
32 **Act of 2010 (P.L. 111-152), with the health benefit exchange if the**
33 **health benefit exchange:**

34 **(1) agrees to maintain the same level of confidentiality that is**
35 **provided to the confidential information under Indiana law;**
36 **and**
37 **(2) complies with all applicable confidentiality requirements**
38 **under federal law.**

39 SECTION 20. IC 27-4-1-4, AS AMENDED BY P.L.67-2011,
40 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
41 JULY 1, 2013]: Sec. 4. (a) The following are hereby defined as unfair
42 methods of competition and unfair and deceptive acts and practices in

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- 1 the business of insurance:
- 2 (1) Making, issuing, circulating, or causing to be made, issued, or
- 3 circulated, any estimate, illustration, circular, or statement:
- 4 (A) misrepresenting the terms of any policy issued or to be
- 5 issued or the benefits or advantages promised thereby or the
- 6 dividends or share of the surplus to be received thereon;
- 7 (B) making any false or misleading statement as to the
- 8 dividends or share of surplus previously paid on similar
- 9 policies;
- 10 (C) making any misleading representation or any
- 11 misrepresentation as to the financial condition of any insurer,
- 12 or as to the legal reserve system upon which any life insurer
- 13 operates;
- 14 (D) using any name or title of any policy or class of policies
- 15 misrepresenting the true nature thereof; or
- 16 (E) making any misrepresentation to any policyholder insured
- 17 in any company for the purpose of inducing or tending to
- 18 induce such policyholder to lapse, forfeit, or surrender the
- 19 policyholder's insurance.
- 20 (2) Making, publishing, disseminating, circulating, or placing
- 21 before the public, or causing, directly or indirectly, to be made,
- 22 published, disseminated, circulated, or placed before the public,
- 23 in a newspaper, magazine, or other publication, or in the form of
- 24 a notice, circular, pamphlet, letter, or poster, or over any radio or
- 25 television station, or in any other way, an advertisement,
- 26 announcement, or statement containing any assertion,
- 27 representation, or statement with respect to any person in the
- 28 conduct of the person's insurance business, which is untrue,
- 29 deceptive, or misleading.
- 30 (3) Making, publishing, disseminating, or circulating, directly or
- 31 indirectly, or aiding, abetting, or encouraging the making,
- 32 publishing, disseminating, or circulating of any oral or written
- 33 statement or any pamphlet, circular, article, or literature which is
- 34 false, or maliciously critical of or derogatory to the financial
- 35 condition of an insurer, and which is calculated to injure any
- 36 person engaged in the business of insurance.
- 37 (4) Entering into any agreement to commit, or individually or by
- 38 a concerted action committing any act of boycott, coercion, or
- 39 intimidation resulting or tending to result in unreasonable
- 40 restraint of, or a monopoly in, the business of insurance.
- 41 (5) Filing with any supervisory or other public official, or making,
- 42 publishing, disseminating, circulating, or delivering to any person,

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1 or placing before the public, or causing directly or indirectly, to
 2 be made, published, disseminated, circulated, delivered to any
 3 person, or placed before the public, any false statement of
 4 financial condition of an insurer with intent to deceive. Making
 5 any false entry in any book, report, or statement of any insurer
 6 with intent to deceive any agent or examiner lawfully appointed
 7 to examine into its condition or into any of its affairs, or any
 8 public official to which such insurer is required by law to report,
 9 or which has authority by law to examine into its condition or into
 10 any of its affairs, or, with like intent, willfully omitting to make a
 11 true entry of any material fact pertaining to the business of such
 12 insurer in any book, report, or statement of such insurer.

13 (6) Issuing or delivering or permitting agents, officers, or
 14 employees to issue or deliver, agency company stock or other
 15 capital stock, or benefit certificates or shares in any common law
 16 corporation, or securities or any special or advisory board
 17 contracts or other contracts of any kind promising returns and
 18 profits as an inducement to insurance.

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

20 (A) Unfair discrimination between individuals of the same
 21 class and equal expectation of life in the rates or assessments
 22 charged for any contract of life insurance or of life annuity or
 23 in the dividends or other benefits payable thereon, or in any
 24 other of the terms and conditions of such contract. However,
 25 in determining the class, consideration may be given to the
 26 nature of the risk, plan of insurance, the actual or expected
 27 expense of conducting the business, or any other relevant
 28 factor.

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

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

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- 1 policy fees, assessments, or rates charged or made for:
- 2 (i) policies or contracts of reinsurance or joint reinsurance,
- 3 or abstract and title insurance;
- 4 (ii) policies or contracts of insurance against loss or damage
- 5 to aircraft, or against liability arising out of the ownership,
- 6 maintenance, or use of any aircraft, or of vessels or craft,
- 7 their cargoes, marine builders' risks, marine protection and
- 8 indemnity, or other risks commonly insured under marine,
- 9 as distinguished from inland marine, insurance; or
- 10 (iii) policies or contracts of any other kind or kinds of
- 11 insurance whatsoever.

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

20 (8) Except as otherwise expressly provided by law, knowingly
 21 permitting or offering to make or making any contract or policy
 22 of insurance of any kind or kinds whatsoever, including but not in
 23 limitation, life annuities, or agreement as to such contract or
 24 policy other than as plainly expressed in such contract or policy
 25 issued thereon, or paying or allowing, or giving or offering to pay,
 26 allow, or give, directly or indirectly, as inducement to such
 27 insurance, or annuity, any rebate of premiums payable on the
 28 contract, or any special favor or advantage in the dividends,
 29 savings, or other benefits thereon, or any valuable consideration
 30 or inducement whatever not specified in the contract or policy; or
 31 giving, or selling, or purchasing or offering to give, sell, or
 32 purchase as inducement to such insurance or annuity or in
 33 connection therewith, any stocks, bonds, or other securities of any
 34 insurance company or other corporation, association, limited
 35 liability company, or partnership, or any dividends, savings, or
 36 profits accrued thereon, or anything of value whatsoever not
 37 specified in the contract. Nothing in this subdivision and
 38 subdivision (7) shall be construed as including within the
 39 definition of discrimination or rebates any of the following
 40 practices:

- 41 (A) Paying bonuses to policyholders or otherwise abating their
- 42 premiums in whole or in part out of surplus accumulated from

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1 nonparticipating insurance, so long as any such bonuses or
 2 abatement of premiums are fair and equitable to policyholders
 3 and for the best interests of the company and its policyholders.
 4 (B) In the case of life insurance policies issued on the
 5 industrial debit plan, making allowance to policyholders who
 6 have continuously for a specified period made premium
 7 payments directly to an office of the insurer in an amount
 8 which fairly represents the saving in collection expense.
 9 (C) Readjustment of the rate of premium for a group insurance
 10 policy based on the loss or expense experience thereunder, at
 11 the end of the first year or of any subsequent year of insurance
 12 thereunder, which may be made retroactive only for such
 13 policy year.
 14 (D) Paying by an insurer or insurance producer thereof duly
 15 licensed as such under the laws of this state of money,
 16 commission, or brokerage, or giving or allowing by an insurer
 17 or such licensed insurance producer thereof anything of value,
 18 for or on account of the solicitation or negotiation of policies
 19 or other contracts of any kind or kinds, to a broker, an
 20 insurance producer, or a solicitor duly licensed under the laws
 21 of this state, but such broker, insurance producer, or solicitor
 22 receiving such consideration shall not pay, give, or allow
 23 credit for such consideration as received in whole or in part,
 24 directly or indirectly, to the insured by way of rebate.
 25 (9) Requiring, as a condition precedent to loaning money upon the
 26 security of a mortgage upon real property, that the owner of the
 27 property to whom the money is to be loaned negotiate any policy
 28 of insurance covering such real property through a particular
 29 insurance producer or broker or brokers. However, this
 30 subdivision shall not prevent the exercise by any lender of the
 31 lender's right to approve or disapprove of the insurance company
 32 selected by the borrower to underwrite the insurance.
 33 (10) Entering into any contract, combination in the form of a trust
 34 or otherwise, or conspiracy in restraint of commerce in the
 35 business of insurance.
 36 (11) Monopolizing or attempting to monopolize or combining or
 37 conspiring with any other person or persons to monopolize any
 38 part of commerce in the business of insurance. However,
 39 participation as a member, director, or officer in the activities of
 40 any nonprofit organization of insurance producers or other
 41 workers in the insurance business shall not be interpreted, in
 42 itself, to constitute a combination in restraint of trade or as

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combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

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

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

- (A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.
- (B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.
- (C) Title insurance.
- (D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.
- (E) Insurance provided by or through motorists service clubs or associations.
- (F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:
 - (i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;
 - (ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common

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- 1 carrier immediately before or after the flight;
 2 (iii) insures against baggage loss during the flight to which
 3 the ticket relates; or
 4 (iv) insures against a flight cancellation to which the ticket
 5 relates.
- 6 (14) Refusing, because of the for-profit status of a hospital or
 7 medical facility, to make payments otherwise required to be made
 8 under a contract or policy of insurance for charges incurred by an
 9 insured in such a for-profit hospital or other for-profit medical
 10 facility licensed by the state department of health.
- 11 (15) Refusing to insure an individual, refusing to continue to issue
 12 insurance to an individual, limiting the amount, extent, or kind of
 13 coverage available to an individual, or charging an individual a
 14 different rate for the same coverage, solely because of that
 15 individual's blindness or partial blindness, except where the
 16 refusal, limitation, or rate differential is based on sound actuarial
 17 principles or is related to actual or reasonably anticipated
 18 experience.
- 19 (16) Committing or performing, with such frequency as to
 20 indicate a general practice, unfair claim settlement practices (as
 21 defined in section 4.5 of this chapter).
- 22 (17) Between policy renewal dates, unilaterally canceling an
 23 individual's coverage under an individual or group health
 24 insurance policy solely because of the individual's medical or
 25 physical condition.
- 26 (18) Using a policy form or rider that would permit a cancellation
 27 of coverage as described in subdivision (17).
- 28 (19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1
 29 concerning motor vehicle insurance rates.
- 30 (20) Violating IC 27-8-21-2 concerning advertisements referring
 31 to interest rate guarantees.
- 32 (21) Violating IC 27-8-24.3 concerning insurance and health plan
 33 coverage for victims of abuse.
- 34 (22) Violating IC 27-8-26 concerning genetic screening or testing.
- 35 (23) Violating IC 27-1-15.6-3(b) concerning licensure of
 36 insurance producers.
- 37 (24) Violating IC 27-1-38 concerning depository institutions.
- 38 (25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning
 39 the resolution of an appealed grievance decision.
- 40 (26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired
 41 July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1,
 42 2007, and repealed).

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- 1 (27) Violating IC 27-2-21 concerning use of credit information.
- 2 (28) Violating IC 27-4-9-3 concerning recommendations to
- 3 consumers.
- 4 (29) Engaging in dishonest or predatory insurance practices in
- 5 marketing or sales of insurance to members of the United States
- 6 Armed Forces as:
 - 7 (A) described in the federal Military Personnel Financial
 - 8 Services Protection Act, P.L.109-290; or
 - 9 (B) defined in rules adopted under subsection (b).
- 10 (30) Violating IC 27-8-19.8-20.1 concerning stranger originated
- 11 life insurance.
- 12 (31) Violating IC 27-2-22 concerning retained asset accounts.
- 13 **(32) Violating IC 27-8-5-29 concerning health plans offered**
- 14 **through a health benefit exchange (as defined in**
- 15 **IC 27-19-2-8).**
- 16 **(33) Violating a requirement of the federal Patient Protection**
- 17 **and Affordable Care Act (P.L. 111-148), as amended by the**
- 18 **federal Health Care and Education Reconciliation Act of 2010**
- 19 **(P.L. 111-152), that is enforceable by the state.**
- 20 (b) Except with respect to federal insurance programs under
- 21 Subchapter III of Chapter 19 of Title 38 of the United States Code, the
- 22 commissioner may, consistent with the federal Military Personnel
- 23 Financial Services Protection Act (P.L.109-290), adopt rules under
- 24 IC 4-22-2 to:
 - 25 (1) define; and
 - 26 (2) while the members are on a United States military installation
 - 27 or elsewhere in Indiana, protect members of the United States
 - 28 Armed Forces from;
- 29 dishonest or predatory insurance practices.
- 30 SECTION 21. IC 27-8-5-1, AS AMENDED BY P.L.160-2011,
- 31 SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 32 JULY 1, 2013]: Sec. 1. (a) The term "policy of accident and sickness
- 33 insurance", as used in this chapter, includes any policy or contract
- 34 covering one (1) or more of the kinds of insurance described in Class
- 35 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual
- 36 basis under this section and sections 2 through 9 of this chapter, on the
- 37 group basis under this section and sections 16 through 19 of this
- 38 chapter, on the franchise basis under this section and section 11 of this
- 39 chapter, or on a blanket basis under section 15 of this chapter and
- 40 (except as otherwise expressly provided in this chapter) shall be
- 41 exclusively governed by this chapter.
- 42 (b) No policy of accident and sickness insurance may be issued or

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1 delivered to any person in this state, nor may any application, rider, or
2 endorsement be used in connection with an accident and sickness
3 insurance policy, until a copy of the form of the policy and of the
4 classification of risks and the premium rates, or, in the case of
5 assessment companies, the estimated cost pertaining thereto, have been
6 filed with and reviewed by the commissioner under section 1.5 of this
7 chapter. This section is applicable also to assessment companies and
8 fraternal benefit associations or societies.

9 (c) This chapter shall be applied in conformity with the
10 requirements of the federal Patient Protection and Affordable Care Act
11 (P.L. 111-148), as amended by the federal Health Care and Education
12 Reconciliation Act of 2010 (P.L. 111-152), as in effect on September
13 23, 2010.

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

22 **(1) certification or decertification of a qualified health plan**
23 **(as defined in IC 27-19-2-15); and**

24 **(2) open enrollment.**

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

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

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

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

37 (2) that demonstrates an insufficient understanding of applicable
38 legal requirements.

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

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

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

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

16 (h) The commissioner shall do the following:

17 (1) Create a document containing a list of all product filing
 18 requirements for each type of insurance, with appropriate
 19 citations to the law, administrative rule, or bulletin that specifies
 20 the requirement, including the citation for the type of insurance
 21 to which the requirement applies.

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

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

27 (i) The filing process is as follows:

28 (1) A filer shall submit a policy form filing that:

29 (A) includes a copy of the document described in subsection
 30 (h);

31 (B) indicates the location within the policy form or supplement
 32 that relates to each requirement contained in the document
 33 described in subsection (h); and

34 (C) certifies that the policy form meets all requirements of
 35 state law.

36 (2) The commissioner shall review a policy form filing and, not
 37 more than thirty (30) days after the commissioner receives the
 38 filing under subdivision (1):

39 (A) approve the filing; or

40 (B) provide written notice of a determination:

41 (i) that deficiencies exist in the filing; or

42 (ii) that the commissioner disapproves the filing.

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1 A written notice provided by the commissioner under clause (B)
 2 must be based only on the requirements set forth in the document
 3 described in subsection (h) and must cite the specific
 4 requirements not met by the filing. A written notice provided by
 5 the commissioner under clause (B)(i) must state the reasons for
 6 the commissioner's determination in sufficient detail to enable the
 7 filer to bring the policy form into compliance with the
 8 requirements not met by the filing.

9 (3) A filer may resubmit a policy form that:

10 (A) was determined deficient under subdivision (2) and has
 11 been amended to correct the deficiencies; or

12 (B) was disapproved under subdivision (2) and has been
 13 revised.

14 A policy form resubmitted under this subdivision must meet the
 15 requirements set forth as described in subdivision (1) and must be
 16 resubmitted not more than thirty (30) days after the filer receives
 17 the commissioner's written notice of deficiency or disapproval. If
 18 a policy form is not resubmitted within thirty (30) days after
 19 receipt of the written notice, the commissioner's determination
 20 regarding the policy form is final.

21 (4) The commissioner shall review a policy form filing
 22 resubmitted under subdivision (3) and, not more than thirty (30)
 23 days after the commissioner receives the resubmission:

24 (A) approve the resubmitted policy form; or

25 (B) provide written notice that the commissioner disapproves
 26 the resubmitted policy form.

27 A written notice of disapproval provided by the commissioner
 28 under clause (B) must be based only on the requirements set forth
 29 in the document described in subsection (h), must cite the specific
 30 requirements not met by the filing, and must state the reasons for
 31 the commissioner's determination in detail. The commissioner's
 32 approval or disapproval of a resubmitted policy form under this
 33 subdivision is final, except that the commissioner may allow the
 34 filer to resubmit a further revised policy form if the filer, in the
 35 filer's resubmission under subdivision (3), introduced new
 36 provisions or materially modified a substantive provision of the
 37 policy form. If the commissioner allows a filer to resubmit a
 38 further revised policy form under this subdivision, the filer must
 39 resubmit the further revised policy form not more than thirty (30)
 40 days after the filer receives notice under clause (B), and the
 41 commissioner shall issue a final determination on the further
 42 revised policy form not more than thirty (30) days after the

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1 commissioner receives the further revised policy form.

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

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

12 (j) Except as provided in this subsection, the commissioner may not
13 disapprove a policy form resubmitted under subsection (i)(3) or (i)(4)
14 for a reason other than a reason specified in the original notice of
15 determination under subsection (i)(2)(B). The commissioner may
16 disapprove a resubmitted policy form for a reason other than a reason
17 specified in the original notice of determination under subsection (i)(2)
18 if:

- 19 (1) the filer has introduced a new provision in the resubmission;
20 (2) the filer has materially modified a substantive provision of the
21 policy form in the resubmission;
22 (3) there has been a change in requirements applying to the policy
23 form; or
24 (4) there has been reviewer error and the written disapproval fails
25 to state a specific requirement with which the policy form does
26 not comply.

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

29 (l) The commissioner may disapprove a policy form if:

- 30 (1) the benefits provided under the policy form are not reasonable
31 in relation to the premium charged; or
32 (2) the policy form contains provisions that are unjust, unfair,
33 inequitable, misleading, or deceptive, or that encourage
34 misrepresentation of the policy.

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

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

- 40 (1) retroactively disapprove the policy form; or
41 (2) examine the filer of the policy form during a routine or
42 targeted market conduct examination for compliance with a policy

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1 form filing requirement that was not in existence at the time the
2 policy form was filed.

3 SECTION 23. IC 27-8-5-29 IS ADDED TO THE INDIANA CODE
4 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
5 1, 2013]: **Sec. 29. (a) The definitions in IC 27-19-2 apply throughout
6 this section.**

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

9 **(1) the form of the policy, classification of risks, and premium
10 rates that apply to the health plan have been filed with and
11 reviewed and approved by the commissioner under this
12 chapter; and**

13 **(2) the insurer is authorized under this title to engage in the
14 business of insurance in Indiana.**

15 **(c) An insurer that offers a multistate health plan under Section
16 1334 of PPACA through a health benefit exchange shall file, for
17 review and approval, the form of the policy, classification of risks,
18 and premium rates that apply to the multistate health plan with the
19 commissioner and the federal government on the same business
20 day.**

21 **(d) This title, in conformity with PPACA, applies to a health
22 plan offered through a health benefit exchange to the same extent
23 that this title would apply if the health plan were offered
24 independent of a health benefit exchange.**

25 SECTION 24. IC 27-8-10-0.5 IS ADDED TO THE INDIANA
26 CODE AS A NEW SECTION TO READ AS FOLLOWS
27 [EFFECTIVE UPON PASSAGE]: **Sec. 0.5. (a) Except as provided in
28 this section, the insurance operations of the association cease on the
29 later of:**

30 **(1) the date on which a health benefit exchange (as defined in
31 IC 27-19-2-8) begins operating in Indiana; or**

32 **(2) December 31, 2013.**

33 **(b) A claim for payment under an association policy must be
34 made to the association not later than the later of:**

35 **(1) sixty (60) days after the date on which the insurance
36 operations cease under subsection (a); or**

37 **(2) March 1, 2014.**

38 **(c) An appeal or grievance under this chapter must be resolved
39 not later than ninety (90) days after the date on which the
40 insurance operations cease under subsection (a).**

41 **(d) Balance billing under this chapter by a health care provider
42 that is not a member of a health care provider network**

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1 arrangement used by the association is prohibited after the later
2 of:

3 (1) ninety (90) days after the date on which the insurance
4 operations cease under subsection (a); or

5 (2) March 30, 2014.

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

10 (1) The plan of dissolution must provide for the following:

11 (A) Continuity of care for an individual who is covered
12 under an association policy and is an inpatient on the date
13 on which the insurance operations cease under subsection
14 (a).

15 (B) A final accounting described in section 2.1(g) of this
16 chapter of the:

17 (i) assessments; and

18 (ii) cessation of the liability;

19 of members of the association.

20 (C) Resolution of any net asset deficiency.

21 (D) Cessation of all liability of the association.

22 (E) Final dissolution of the association.

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

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

30 (1) is suitable to assure the fair, reasonable, and equitable
31 dissolution of the association; and

32 (2) complies with subsection (e).

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

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

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

41 (j) Funds remaining in the association on the date on which final
42 dissolution of the association occurs must be transferred into the

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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 25. 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.
- (2) Enter into a contract, agreement, or memorandum of understanding with the following:
 - (A) A health benefit exchange.
 - (B) An entity that contracts with, or is a subcontractor of, a health benefit exchange.
 - (C) A federal or state agency.
 - (D) A health benefit exchange operating in another state.
 - (E) An agency of another state.
 - (F) A health plan.
 - (G) Another person, for purposes of the performance of necessary functions, as determined by the commissioner.
- (3) Enter with a person described in subdivision (2) into an

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information sharing agreement:

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

(B) that:

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

(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. "Application organization" means an entity that:

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

(2) assists individuals with application for and enrollment in a health benefit exchange or public health insurance program, including an entity that makes presumptive eligibility determinations; and

(3) performs the functions of a navigator with respect to a health benefit exchange as established by the commissioner.

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.

Sec. 7. "Group health plan" means a group health plan (as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. 300gg-91)) that provides health insurance coverage.

Sec. 8. "Health benefit exchange" means an American health benefit exchange operating in Indiana under PPACA.

Sec. 9. "Health insurance coverage" has the meaning set forth in Section 2791 of the federal Public Health Service Act (42 U.S.C. 300gg-91).

Sec. 10. (a) "Health plan" means a policy or contract that provides health insurance coverage.

(b) The term includes a group health plan.

Sec. 11. (a) "Navigator" means an individual who:

(1) is described in Section 1311(i) of PPACA (42 U.S.C. 18031(i));

(2) assists other individuals with application for and

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1 enrollment in a health benefit exchange or public health
 2 insurance program, including an individual who makes
 3 presumptive eligibility determinations; and
 4 (3) performs the functions of a navigator with respect to a
 5 health benefit exchange as established by the commissioner.
 6 (b) The term does not include a representative authorized by an
 7 individual to perform functions on behalf of the individual in
 8 connection with Medicaid.

9 Sec. 12. "Person" means an individual or an entity.

10 Sec. 13. "PPACA" refers to the federal Patient Protection and
 11 Affordable Care Act (P.L. 111-148), as amended by the federal
 12 Health Care and Education Reconciliation Act of 2010 (P.L.
 13 111-152).

14 Sec. 14. (a) "Public health insurance program" refers to health
 15 coverage provided under a state or federal government program.
 16 (b) The term includes the following:
 17 (1) Medicaid (42 U.S. C. 1396 et seq.).
 18 (2) The Indiana check-up plan established by IC 12-15-44.2-3.
 19 (3) The children's health insurance program established
 20 under IC 12-17.6.

21 Sec. 15. "Qualified health plan" means a health plan that has
 22 been certified under Section 1301 of PPACA (42 U.S.C. 18021(a))
 23 to meet the criteria for availability through a health benefit
 24 exchange operated in Indiana.

25 Sec. 16. "Secretary" refers to the secretary of family and social
 26 services appointed under IC 12-8-1.5-2.

27 Chapter 3. Health Benefit Exchange Authority

28 Sec. 1. This chapter applies to a health benefit exchange
 29 operating in Indiana.

30 Sec. 2. (a) The commissioner and department may implement
 31 and enforce the insurance law of this state in connection with a
 32 health benefit exchange.
 33 (b) A law of this state concerning a health benefit exchange does
 34 not preempt or supersede the authority of the commissioner or
 35 department to regulate the business of insurance in Indiana.
 36 (c) This section does not require the department to perform any
 37 function related to a health benefit exchange without being
 38 appropriately compensated for the performance of the function.

39 Sec. 3. (a) The secretary, the administrator, and the CHIP office
 40 may implement and enforce the social services law of this state in
 41 connection with a health benefit exchange.
 42 (b) A law of this state concerning a health benefit exchange does

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1 not preempt or supersede the authority of the secretary, the
2 administrator, or the CHIP office to administer and regulate social
3 services in Indiana.

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

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

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

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

- 14 (A) A health benefit exchange.
- 15 (B) An entity that contracts with, or is a subcontractor of,
16 a health benefit exchange.
- 17 (C) A federal or state agency.
- 18 (D) A health benefit exchange operating in another state.
- 19 (E) An agency of another state.
- 20 (F) A health plan.

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

- 23 (A) that concerns the disclosure and receiving of data
24 necessary to implement this section or PPACA; and
- 25 (B) that:
 - 26 (i) includes adequate protections with respect to
27 confidentiality of the shared information; and
 - 28 (ii) complies with applicable state and federal law.

29 **Chapter 4. Health Benefit Exchange Navigators and Application**
30 **Organizations**

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

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

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

40 (d) The following are subject to regulation by the commissioner
41 and the secretary:

- 42 (1) A navigator.

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- (2) An application organization.**
- Sec. 2. Neither a navigator nor an application organization is subject to the licensing requirements of IC 27-1-15.6.**
- Sec. 3. (a) A person that is a navigator or an application organization must meet all of the following:**
 - (1) Shall not provide incorrect, misleading, incomplete, or materially untrue information in an application for certification or registration.**
 - (2) Shall not violate any of the following:**
 - (A) An insurance law.**
 - (B) A regulation.**
 - (C) A subpoena of the commissioner.**
 - (D) An order of the commissioner.**
 - (E) A rule of a health benefit exchange operating in Indiana.**
 - (F) A rule adopted under IC 27-19-3-3(d).**
 - (G) PPACA or a federal regulation adopted under PPACA.**
 - (3) Shall not intentionally misrepresent the terms of an actual or proposed insurance contract or application for insurance.**
 - (4) Must not have had:**
 - (A) an insurance producer or consultant license;**
 - (B) a navigator certification or an application organization registration; or**
 - (C) an equivalent to a license, certification, or registration described in clause (A) or (B);****denied, suspended, or revoked in any state, province, district, or territory.**
 - (5) If the person is a navigator, shall not fail to satisfy the continuing education requirements established under section 12 of this chapter.**
 - (6) Shall not obtain or attempt to obtain a license, certification, or registration through misrepresentation or 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) If the person is a navigator, 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**

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- business of insurance.
- (10) Shall not use fraudulent, coercive, or dishonest practices, or demonstrate incompetence or untrustworthiness, in acting as a navigator or an application organization.
- (11) Shall not improperly use notes or other reference material to complete an examination for certification under this chapter.
- (12) If the person is a navigator, 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 person is an application organization, shall not fail to verify that each navigator working for the application organization meets the following requirements:
 - (A) The navigator is certified under this chapter.
 - (B) The navigator has not committed an act that would be grounds for denial, suspension, or revocation of certification under this chapter.
- (16) Shall not receive consideration from a health insurance issuer (as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. 300gg-91)) in connection with the enrollment of an individual in a health plan.
- (b) The commissioner may:
 - (1) reprimand a navigator or an application organization;
 - (2) levy a civil penalty against a navigator or an application organization;
 - (3) place a navigator or an application organization on probation;
 - (4) suspend a navigator's certification or an application organization's registration;
 - (5) revoke a navigator's certification or an application organization's registration for a period of years;
 - (6) permanently revoke a navigator's certification or an application organization's registration;
 - (7) issue a cease and desist order to a navigator or an application organization; or
 - (8) take any combination of the actions described in subdivisions (1) through (7);

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for a violation described in subsection (a).

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

- (1) Develop a policy concerning conflicts of interest affecting navigators and application organizations, including conflicts of interest involving financial and nonfinancial considerations.**
- (2) Develop a consumer complaint procedure and applicable forms for filing a complaint.**
- (3) Define a reasonable period for the duration of navigator certification, after which the navigator must pay a renewal fee, complete continuing education, and reapply for certification.**
- (4) Define a reasonable period for the duration of application organization registration, after which the application organization must pay a renewal fee and reapply for registration.**
- (5) Develop a policy, procedure, and form for use by an application organization to attest to the commissioner that a navigator who provides the navigator's services on behalf of the application organization meets the requirements of section 3 of this chapter.**

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

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

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

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

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1 **Sec. 6. (a) Before acting as an application organization in**
 2 **Indiana, an entity must be registered as an application**
 3 **organization as follows:**

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

6 **(2) The entity's application for registration:**

7 **(A) must be signed by an individual who is an owner,**
 8 **partner, officer, director, member, or manager of the**
 9 **entity, under penalty of denial, suspension, or revocation**
 10 **of registration; and**

11 **(B) must declare that the statements made in the**
 12 **application are true, correct, and complete to the best of**
 13 **the signing individual's knowledge and belief.**

14 **(b) Before approving an application submitted under subsection**
 15 **(a), the commissioner shall:**

16 **(1) verify that the entity is in good standing with the Indiana**
 17 **secretary of state; and**

18 **(2) determine whether the entity meets the following**
 19 **requirements:**

20 **(A) The entity has paid the nonrefundable fees established**
 21 **under section 7 of this chapter.**

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

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

27 **(D) No owner, partner, officer, director, member, or**
 28 **manager of the entity has committed an act described in**
 29 **clause (C) or in section 3 of this chapter that would be**
 30 **grounds for denial, suspension, or revocation of**
 31 **certification as a navigator under this chapter.**

32 **Sec. 7. (a) The commissioner may require the production of any**
 33 **document that is reasonably necessary to verify the information**
 34 **contained in an application submitted under section 5 or 6 of this**
 35 **chapter.**

36 **(b) The commissioner shall collect from each applicant for**
 37 **certification or registration under this chapter a nonrefundable**
 38 **application fee established by the commissioner in an amount**
 39 **expected to generate revenue sufficient to cover the costs incurred**
 40 **by the commissioner in implementing this chapter.**

41 **Sec. 8. (a) A navigator who works for an application**
 42 **organization must be appointed by the application organization in**

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1 writing.

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

7 (1) submit a written report to the commissioner concerning
8 the revocation; and

9 (2) provide a copy of the report to the navigator at the
10 navigator's last known address by:

11 (A) certified mail, return receipt requested, postage
12 prepaid; or

13 (B) overnight delivery using a nationally recognized
14 carrier.

15 Sec. 9. A certified navigator who is unable to comply with the
16 certification renewal procedures under this chapter due to military
17 service or another extenuating circumstance may request from the
18 commissioner:

19 (1) a temporary waiver of:

20 (A) the renewal procedure; or

21 (B) an examination requirement; or

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

24 Sec. 10. (a) A certification or registration under this chapter
25 must contain the navigator's or application organization's name
26 and address, the date of issuance, the expiration date, and any
27 other information the commissioner considers necessary.

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

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

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

33 Sec. 11. (a) An individual who applies for certification as a
34 navigator in Indiana must complete a course of study and pass a
35 written examination as prescribed by the commissioner in
36 consultation with the secretary.

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

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

40 (2) the duties and responsibilities of a navigator;

41 (3) the insurance laws of Indiana that apply to the functions
42 of a navigator with respect to a health benefit exchange,

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1 including rules related to public health insurance programs;
2 and

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

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

7 (1) functions of a health benefit exchange;

8 (2) duties and responsibilities of a navigator;

9 (3) insurance laws of Indiana that apply to the functions of a
10 navigator with respect to a health benefit exchange, including
11 rules related to public health insurance programs; and

12 (4) the obligations of a navigator related to confidentiality of
13 information and conflicts of interest.

14 (d) The commissioner:

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

16 (A) a curriculum for a course of study for navigators; and

17 (B) policies and procedures to allow a registered
18 application organization to develop a training program
19 and a course curriculum that meets the requirements of
20 subsection (b) for use in training navigators who perform
21 the navigators' services on behalf of the registered
22 application organization; and

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

26 (A) Develop examinations and course materials.

27 (B) Administer examinations and courses of study.

28 (C) Collect nonrefundable course and examination fees.

29 (e) All training programs, course curriculums, examinations,
30 course materials, and examination fees referred to in subsection (d)
31 must be approved in advance by the commissioner in consultation
32 with the secretary.

33 Sec. 12. (a) The commissioner:

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

36 (2) may contract with one (1) or more third party
37 organizations to:

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

40 (B) administer continuing education programs; and

41 (C) collect nonrefundable continuing education program
42 fees.

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

4 (c) The commissioner may require a navigator to complete
5 specific continuing education requirements, as prescribed by the
6 commissioner in consultation with the secretary, as a prerequisite
7 to the authority to perform specific functions with respect to a
8 health benefit exchange.

9 Sec. 13. An individual who fails to:

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

12 (2) pass the examination;
13 may not be rescheduled for the examination unless the individual
14 reapplies for the examination and remits all required fees and
15 forms.

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

17 (1) may not act as a navigator unless the insurance producer
18 or insurance consultant has completed the continuing
19 education requirements that apply to a navigator; and

20 (2) shall receive a designation from the commissioner as a
21 navigator upon completion of the continuing education
22 requirements;

23 under this chapter.

24 (b) The commissioner may require an insurance producer or
25 insurance consultant to complete specific continuing education
26 requirements, as prescribed by the commissioner in consultation
27 with the secretary, as a prerequisite to the authority to perform
28 specific functions with respect to a health benefit exchange.

29 SECTION 26. [EFFECTIVE JULY 1, 2013] (a) As used in this
30 SECTION, "commission" refers to the health finance commission
31 established by IC 2-5-23-3.

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

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

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

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

42 (B) Individuals who are dually eligible for the federal

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1 Medicare program (42 U.S.C. 1395 et seq.) and the
 2 Medicaid program (IC 12-15).
 3 (3) Information concerning the number of individuals
 4 participating in a program described in subdivision (2)(A) and
 5 (2)(B) who would be eligible for a tax credit under the federal
 6 Patient Protection and Affordable Care Act (P.L. 111-148).
 7 (c) This SECTION expires December 31, 2013.
 8 SECTION 27. [EFFECTIVE UPON PASSAGE] (a) As used in this
 9 SECTION, "Affordable Care Act" refers to the federal Patient
 10 Protection and Affordable Care Act (P.L. 111-148), as amended by
 11 the federal Health Care and Education Reconciliation Act of 2010
 12 (P.L. 111-152).
 13 (b) As used in this SECTION, "commission" refers to the health
 14 finance commission established by IC 2-5-23-3.
 15 (c) As used in this SECTION, "exchange" refers to an American
 16 health benefit exchange established under the Affordable Care Act.
 17 (d) Before August 1, 2013, the department of insurance, the
 18 office of the secretary of family and social services, and the state
 19 department of health shall work together to prepare a report for
 20 the commission concerning the following:
 21 (1) The establishment and implementation of an exchange in
 22 Indiana.
 23 (2) The definition of "essential health benefits" for use in
 24 Indiana under the Affordable Care Act, including ensuring
 25 that the definition results in adequate benefits.
 26 (e) This SECTION expires December 31, 2013.
 27 SECTION 28. An emergency is declared for this act.

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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

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(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**



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**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



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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."



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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**

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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.

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, 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 12-7-2-155.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 155.3. "Qualified Medicare beneficiary", for purposes of IC 12-15-2-26, has the meaning set forth in IC 12-15-2-26(b).**

SECTION 2. IC 12-7-2-155.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 155.5. "Qualifying individual",**

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for purposes of IC 12-15-2-26, has the meaning set forth in IC 12-15-2-26(c).

SECTION 3. IC 12-7-2-180.4 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 180.4. "Specified low-income Medicare beneficiary", for purposes of IC 12-15-2-26, has the meaning set forth in IC 12-15-2-26(d)."**

Page 2, line 35, delete "Beginning January 1, 2014, the" and insert **"This section applies beginning the later of the following:**

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

(2) January 1, 2014.

(b) The".

Page 3, line 15, after "(a)" delete "(b)" and insert "(c)".

Page 3, line 15, delete "(c)" and insert "(d)".

Page 3, line 15, delete "(e)," and insert "(f)".

Page 3, line 30, delete "(c)" and insert "(d)".

Page 3, line 30, delete "(e)," and insert "(f)".

Page 3, line 35, delete "(d)" and insert "(e)".

Page 3, line 36, delete "(b)" and insert "(c)".

Page 3, line 41, delete "(e)" and insert "(f)".

Page 4, between lines 18 and 19, begin a new paragraph and insert:
"SECTION 7. IC 12-15-2-26 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 26. (a) This section applies beginning the later of the following:

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

(2) January 1, 2014.

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

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

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

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

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(1) A qualified Medicare beneficiary whose:
 (A) income does not exceed one hundred fifty percent (150%) of the federal income poverty level; and
 (B) resources do not exceed the resource limits established by the office;
 is eligible for Medicare Part A and Medicare Part B premiums, coinsurance, and deductibles.

(2) A specified low-income Medicare beneficiary whose:
 (A) income does not exceed one hundred seventy percent (170%) of the federal income poverty level; and
 (B) resources do not exceed the resource limits set by the office;
 is eligible for coverage of Medicare Part B premiums.

(3) A qualifying individual whose:
 (A) income does not exceed one hundred eighty-five percent (185%) of the federal income poverty level; and
 (B) resources do not exceed the resource limits set by the office;
 is eligible for coverage of Medicare Part B premiums.

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

Page 5, line 17, delete "Beginning January 1, 2014, the" and insert **"This section applies beginning the later of the following:**

- (1) The date that the office is informed that the United States Department of Health and Human Services has approved Indiana's conversion to 1634 status within the Medicaid program.
- (2) January 1, 2014.

(b) The".

Page 5, line 20, delete "(b)" and insert "(c)".

Page 8, line 38, delete "." and insert **"and the plan has been reviewed by the state budget committee."**

Page 22, between lines 36 and 37, begin a new paragraph and insert:

"(d) This title, in conformity with PPACA, applies to a health plan offered through a health benefit exchange to the same extent that this title would apply if the health plan were offered independent of a health benefit exchange."

Page 25, delete lines 25 through 36, begin a new paragraph and insert:

"Sec. 3. "Application organization" means an entity that:

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

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(2) assists individuals with application for and enrollment in a health benefit exchange or public health insurance program, including an entity that makes presumptive eligibility determinations; and

(3) performs the functions of a navigator with respect to a health benefit exchange as established by the commissioner."

Page 26, line 12, delete "a person that:" and insert "**an individual who:**".

Page 26, line 13, delete "meets the grant funding requirements of" and insert "**is described in**".

Page 26, line 14, delete "and".

Page 26, line 15, after "(2)" insert "**assists other individuals with application for and enrollment in a health benefit exchange or public health insurance program, including an individual who makes presumptive eligibility determinations; and**

(3)".

Page 26, delete lines 17 through 23, begin a new paragraph and insert:

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

Page 28, line 2, delete "Assisters" and insert "**Application Organizations**".

Page 28, line 4, delete "assister" and insert "**application organization**".

Page 28, line 6, delete "or an assister".

Page 28, line 8, delete "or an assister." and insert ".".

Page 28, line 9, delete "a navigator or an assister" and insert "**an application organization**".

Page 28, line 10, delete "a" and insert "**an application organization**".

Page 28, delete line 11.

Page 28, line 12, delete "An individual or entity that is a navigator or an assister is" and insert "**The following are**".

Page 28, line 13, delete "." and insert ":

(1) A navigator.

(2) An application organization."

Page 28, line 14, delete "A" and insert "**Neither a**".

Page 28, line 14, delete "or an assister is not" and insert "**nor an application organization is**".

Page 28, line 16, after "A" insert "**person that is a**".

Page 28, line 16, delete "assister" and insert "**application**

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organization".

Page 28, line 33, delete "or an assister certification or" and insert **"certification or an application organization".**

Page 28, line 39, delete "Shall" and insert **"If the person is a navigator, shall".**

Page 29, line 6, delete "Must" and insert **"If the person is a navigator, must".**

Page 29, line 13, delete "assister." and insert **"application organization."**

Page 29, line 15, delete "as a" and insert **"under this chapter."**

Page 29, delete line 16.

Page 29, line 17, delete "Must" and insert **"If the person is a navigator, must".**

Page 29, line 25, delete "navigator or assister is an entity," and insert **"person is an application organization,".**

Page 29, line 26, delete "and assister who is an individual".

Page 29, line 27, delete "entity" and insert **"application organization".**

Page 29, line 28, delete "or assister".

Page 29, line 30, delete "or assister".

Page 29, line 34, delete "assister;" and insert **"application organization;".**

Page 29, line 35, delete "assister;" and insert **"application organization;".**

Page 29, line 36, delete "assister" and insert **"application organization".**

Page 29, line 37, delete "or an assister's certificate or" and insert **"certification or an application organization's".**

Page 29, line 39, delete "or an assister's certificate or" and insert **"certification or an application organization's".**

Page 29, line 41, delete "or an assister's" and insert **"certification or an application organization's".**

Page 29, line 42, delete "certificate or".

Page 30, line 1, delete "assister;" and insert **"application organization;".**

Page 30, line 9, delete "assisters," and insert **"application organizations,".**

Page 30, line 13, after "navigator" insert **"certification, after which the navigator".**

Page 30, delete line 14.

Page 30, run in lines 13 through 15.

Page 30, between lines 16 and 17, begin a new line block indented

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and insert:

"(4) Define a reasonable period for the duration of application organization registration, after which the application organization must pay a renewal fee and reapply for registration.

(5) Develop a policy, procedure, and form for use by an application organization to attest to the commissioner that a navigator who provides the navigator's services on behalf of the application organization meets the requirements of section 3 of this chapter."

Page 30, line 17, delete "or an assister".

Page 30, line 19, delete "or an assister".

Page 30, line 38, delete "a navigator or assister" and insert "**an application organization**".

Page 30, line 39, delete "a navigator or an assister" and insert "**an application organization**".

Page 30, line 40, delete "a navigator or an".

Page 30, line 41, delete "assister" and insert "**an application organization**".

Page 31, line 16, delete "individual".

Page 31, line 17, delete "or assister".

Page 31, line 24, delete "." and insert "**or in section 3 of this chapter that would be grounds for denial, suspension, or revocation of certification as a navigator under this chapter.**".

Page 31, line 34, delete "An individual navigator or assister" and insert "**A navigator**".

Page 31, line 35, delete "entity that is a navigator or an assister" and insert "**application organization**".

Page 31, line 36, delete "entity" and insert "**application organization**".

Page 31, line 37, delete "entity," and insert "**application organization,**".

Page 31, line 38, delete "an individual" and insert "**a**".

Page 31, line 39, delete "or assister".

Page 31, line 39, delete "entity," and insert "**application organization,**".

Page 31, line 40, delete "entity" and insert "**application organization**".

Page 32, line 2, delete "individual" and insert "**navigator**".

Page 32, line 3, delete "individual's" and insert "**navigator's**".

Page 32, line 8, delete "individual navigator or assister" and insert "**navigator**".

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Page 32, line 17, delete "navigator or an assister".

Page 32, line 18, after "registration" insert "**under this chapter**".

Page 32, line 18, delete "assister's" and insert "**application organization's**".

Page 32, line 21, delete "assister" and insert "**application organization**".

Page 32, line 27, delete "or an assister".

Page 32, line 33, delete "or an assister;" and insert ";".

Page 32, delete line 34.

Page 32, line 36, delete "or an assister".

Page 32, line 38, delete "." and insert "; **and**

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

Page 32, line 42, delete "or assister; and" and insert ";".

Page 33, line 2, delete "or an assister".

Page 33, line 4, delete "." and insert "; **and**

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

Page 33, line 6, after "develop" insert ":

(A)".

Page 33, line 7, delete "and assisters;" and insert "; **and**

(B) policies and procedures to allow a registered application organization to develop a training program and a course curriculum that meets the requirements of subsection (b) for use in training navigators who perform the navigators' services on behalf of the registered application organization;".

Page 33, line 9, delete "a" and insert "**one (1) or more**".

Page 33, line 9, delete "organization to:" and insert "**organizations to do any of the following with respect to the course of study described in subdivision (1)(A):**".

Page 33, delete lines 10 through 13, begin a new line double block indented and insert:

"(A) Develop examinations and course materials.

(B) Administer examinations and courses of study.

(C) Collect nonrefundable course and examination fees.".

Page 33, line 14, after "All" insert "**training programs, course curriculums,**".

Page 33, line 15, delete "(d)(2)" and insert "**(d)**".

Page 33, line 19, delete "and assisters;" and insert ";".

Page 33, line 20, delete "a" and insert "**one (1) or more**".

Page 33, line 20, delete "organization" and insert "**organizations**".

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Page 33, line 29, delete "or an assister".
Page 33, line 42, delete "or an assister".
Page 34, line 2, after "navigator" insert "; and".
Page 34, delete line 3.
Page 34, line 5, delete "or an assister".
Page 35, line 10, delete "chapter" and insert "SECTION".
Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 551 as printed February 15, 2013.)

KENLEY, Chairperson

Committee Vote: Yeas 12, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 551 be amended to read as follows:

Page 30, between lines 16 and 17, begin a new line double block indented and insert:

"(G) PPACA or a federal regulation adopted under PPACA."

Page 31, between lines 21 and 22, begin a new line block indented and insert:

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

(Reference is to SB 551 as printed February 22, 2013.)

MILLER PATRICIA

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