CONFERENCE COMMITTEE REPORT
DIGEST FOR EHB 1328

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

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

Effective: Upon passage; July 1, 2013.

CONFERENCE COMMITTEE REPORT

MADAM PRESIDENT:

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

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

Delete everything after the enacting clause and insert the following:

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", 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).**

SECTION 4. 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.

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 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.**

SECTION 7. IC 12-15-2-17, AS AMENDED BY P.L.196-2011, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 17. **(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) The office may apply this section only to the following Medicaid applicants or Medicaid recipients:

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

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

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

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

(A) Nursing facility services.

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

(C) Home and community based services.

(D) Home health services.

(E) Personal care services.

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

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

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

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

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

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

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

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

~~(d)~~ **(f)** In order for a trust, an escrow, a life insurance policy, or a prepaid funeral agreement to be exempt as a resource in determining an applicant's or a recipient's eligibility for Medicaid under this section,

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

(1) growth in principal;

(2) accumulation and reinvestment of dividends;

(3) accumulation and reinvestment of interest; and

(4) accumulation and reinvestment of distributions;

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

SECTION 8. 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:

(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 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 10. 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 11. 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) 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 office shall determine eligibility for a Medicaid applicant or Medicaid recipient who is aged, blind, or disabled under IC 12-15-2-3.5.

(c) 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 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 12. 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 13. 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.

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

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

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

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

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

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

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

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

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

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

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

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

(2) A pregnant woman for purposes of pregnancy related services.

(3) An individual who is otherwise eligible for medical assistance.

(c) The eligibility requirements specified in subsection (a) are subject to approval for federal financial participation by the United States Department of Health and Human Services.

SECTION 15. IC 16-28-15-2, AS ADDED BY P.L.229-2011, SECTION 162, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 2. As used in this chapter, "continuing care retirement community" means a health care facility that:

(1) provides independent living services and health facility services in a campus setting with common areas;

(2) **either:**

(A) holds continuing care agreements with at least twenty-five percent (25%) of its residents (as defined in IC 23-2-4-1); **or**

(B) has continuously maintained, for a continuing care retirement community that was registered under IC 23-2-4 before January 2, 2007, at least one (1) continuing care agreement since on or before January 1, 2007, with an individual residing in the continuing care retirement community;

(3) uses the money from the **agreement or** agreements described in subdivision (2) to provide services to the resident before the resident may be eligible for Medicaid under IC 12-15; and

(4) meets the requirements of IC 23-2-4.

SECTION 16. IC 16-28-15-7, AS ADDED BY P.L.229-2011, SECTION 162, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 7. The office shall implement the waiver approved by the United States Centers for Medicare and Medicaid Services under 42 CFR 433.68(e)(2) that provides for the following:

(1) Nonuniform quality assessment fee rates.

(2) An exemption from collection of a quality assessment fee

from the following:

(A) A continuing care retirement community as follows:

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

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

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

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

(B) A hospital based health facility.

(C) The Indiana Veterans' Home.

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

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

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

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

"Continuing care agreement" means the following:

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

(A) Meals and related services.

(B) Nursing care services.

(C) Medical services.

(D) Other health related services.

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

(A) accommodations in a living unit of a continuing care retirement community;
(B) meals and related services;
(C) nursing care services;
(D) medical services;
(E) other health related services; or
(F) any combination of these services;

for the life of the individual or for more than one (1) month, unless the agreement is canceled.

~~(2)~~ **(3)** For continuing care retirement communities registered after June 30, 2009, an agreement by a provider to furnish to an individual, for the payment of an entrance fee of at least twenty-five thousand dollars ($25,000) and periodic charges:

(A) accommodations in a living unit of a continuing care retirement community;
(B) meals and related services;
(C) nursing care services;
(D) medical services;
(E) other health related services; or
(F) any combination of these services;

for the life of the individual, unless the agreement is terminated as specified under this chapter.

"Continuing care retirement community" includes both of the following:

(1) An independent living facility.
(2) A health facility licensed under IC 16-28.

"Contracting party" means a person or persons who enter into a continuing care agreement with a provider.

"Entrance fee" means the sum of money or other property paid or transferred, or promised to be paid or transferred, to a provider in consideration for one (1) or more individuals becoming a resident of a continuing care retirement community under a continuing care agreement.

"Living unit" means a room, apartment, cottage, or other area within a continuing care retirement community set aside for the use of one (1) or more identified residents.

"Long term financing" means financing for a period in excess of one (1) year.

"Omission of a material fact" means the failure to state a material fact required to be stated in any disclosure statement or registration in order to make the disclosure statement or registration, in light of the circumstances under which they were made, not misleading.

"Person" means an individual, a corporation, a partnership, an association, a limited liability company, or other legal entity.

"Provider" means a person that agrees to provide care under a continuing care agreement.

"Refurbishment fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in refurbishing a previously occupied living unit specifically designated for occupancy by that individual.

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

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

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

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

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

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

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

(A) enters into;

(B) extends; or

(C) solicits;

a continuing care agreement; or

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 19. 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 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 order to facilitate public understanding and comparison and to eliminate provisions contained in those policies or contracts which may be misleading or confusing in connection either with the purchase of those coverages or with the settlement of claims and to provide for full disclosure in the sale of those coverages.

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

(b) The commissioner may not:

(1) disclose; or

(2) subject to subpoena;

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

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

(1) the National Association of Insurance Commissioners; or

(2) an insurance department of another state;

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

(d) The commissioner may share confidential information with:

(1) the National Association of Insurance Commissioners; or

(2) an insurance department of another state;

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

(e) The commissioner may share confidential information

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), with the health benefit exchange if the health benefit exchange:

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

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

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

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

(1) Ethical practices in the marketing and selling of title insurance.

(2) Title insurance underwriting.

(3) Escrow issues.

(4) Principles of the federal Real Estate Settlement Procedures Act (12 U.S.C. 2608).

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

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

(1) A limited lines producer who is licensed without examination under IC 27-1-15.6-18(1).

(2) A limited line credit insurance producer.

(3) A nonresident limited lines producer with a title qualification:

(A) whose home state requires continuing education for a title qualification; and

(B) who has met the continuing education requirements described in clause (A).

(d) To satisfy the requirements of subsection (a) or (b), a licensee may use only those credit hours earned in continuing education courses completed by the licensee:

(1) after the effective date of the licensee's last renewal of a license under this chapter; or

(2) if the licensee is renewing a license for the first time, after the date on which the licensee was issued the license under this chapter.

(e) If an insurance producer receives qualification for a license in more than one (1) line of authority under IC 27-1-15.6, the insurance producer may not be required to complete a total of more than twenty-four (24) hours of credit in continuing education courses to renew the license.

(f) Except as provided in subsection (g), a licensee may receive credit only for completing **the following** continuing education courses:

(1) Continuing education courses that have been approved by the commissioner under section 4 of this chapter.

(2) Continuing education courses that are required for the licensee under IC 27-19-4-14.

(g) A licensee who teaches a course approved by the commissioner under section 4 of this chapter shall receive continuing education credit for teaching the course.

(h) When a licensee renews a license issued under this chapter, the licensee must submit:

(1) a continuing education statement that:

(A) is in a format authorized by the commissioner;

(B) is signed by the licensee under oath; and

(C) lists the continuing education courses completed by the licensee to satisfy the continuing education requirements of this section; and

(2) any other information required by the commissioner.

(i) A continuing education statement submitted under subsection (h) may be reviewed and audited by the department.

(j) A licensee shall retain a copy of the original certificate of completion received by the licensee for completion of a continuing education course.

(k) A licensee who completes a continuing education course that:

(1) is approved by the commissioner under section 4 of this chapter;

(2) is held in a classroom setting; and

(3) concerns ethics;

shall receive continuing education credit not to exceed four (4) hours in a renewal period.

SECTION 22. IC 27-4-1-4, AS AMENDED BY P.L.67-2011, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 4. (a) The following are hereby defined as unfair

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Making or permitting any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

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

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as 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 carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the state department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).
(27) Violating IC 27-2-21 concerning use of credit information.
(28) Violating IC 27-4-9-3 concerning recommendations to consumers.
(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:
(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or
(B) defined in rules adopted under subsection (b).
(30) Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.
(31) Violating IC 27-2-22 concerning retained asset accounts.
(32) Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).
(33) Violating a requirement of 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), that is enforceable by the state.

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act (P.L.109-290), adopt rules under IC 4-22-2 to:
(1) define; and
(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;
dishonest or predatory insurance practices.

SECTION 23. IC 27-8-5-1, AS AMENDED BY P.L.160-2011, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy, until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with and reviewed by the commissioner under section 1.5 of this

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

(c) This chapter shall be applied in conformity with the requirements of 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), as in effect on September 23, 2010.

(d) A policy of accident and sickness insurance that is issued or delivered through 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), is subject to the requirements of this chapter. The commissioner may adopt rules under IC 4-22-2 to implement this subsection, including rules concerning:

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

(2) open enrollment.

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

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

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

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

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

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

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

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

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

(h) The commissioner shall do the following:

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

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

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

(i) The filing process is as follows:

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

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

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

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

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

(A) approve the filing; or

(B) provide written notice of a determination:

(i) that deficiencies exist in the filing; or

(ii) that the commissioner disapproves the filing.

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

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

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

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

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

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

(A) approve the resubmitted policy form; or

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

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

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

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

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

(1) the filer has introduced a new provision in the resubmission;

(2) the filer has materially modified a substantive provision of the policy form in the resubmission;

(3) there has been a change in requirements applying to the policy form; or

(4) there has been reviewer error and the written disapproval fails to state a specific requirement with which the policy form does not comply.

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

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

(1) the benefits provided under the policy form are not reasonable in relation to the premium charged; or

(2) the policy form contains provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.

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

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

(1) retroactively disapprove the policy form; or

(2) examine the filer of the policy form during a routine or targeted market conduct examination for compliance with a policy form filing requirement that was not in existence at the time the policy form was filed.

SECTION 25. IC 27-8-5-29 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 29. (a) The definitions in IC 27-19-2 apply throughout this section.**

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

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

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

(c) An insurer that offers a multistate health plan under Section 1334 of PPACA through a health benefit exchange shall file, for review and approval, the form of the policy, classification of risks, and premium rates that apply to the multistate health plan with the commissioner within five (5) business days of the date on which the same filing is made with the federal government.

(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 independently of a health benefit exchange.

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

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

(2) December 31, 2013.

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

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

(2) March 1, 2014.

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

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

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

(2) March 30, 2014.

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

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

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

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

(i) assessments; and

(ii) cessation of the liability;

of members of the association.

(C) Resolution of any net asset deficiency.

(D) Cessation of all liability of the association.

(E) Final dissolution of the association.

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

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

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

(2) complies with subsection (e).

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

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

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

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

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

SECTION 27. 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 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. (a) Subject to subsections (b) and (c), "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; or

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

(b) In the commissioner's discretion, the term does not include an entity that does one (1) or more of the following:

(1) Provides assistance with application for and enrollment in Medicaid to individuals who, based on preliminary information obtained by the entity, may be eligible for Medicaid without respect to the individuals' income or assets.

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

(c) The term does not include an entity that makes presumptive eligibility determinations concerning individuals' eligibility for enrollment in a public health insurance program.

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. "Medicaid" refers to the federal Medicaid program (42 U.S.C. 1396 et seq.).

Sec. 12. (a) Subject to subsections (b), (c), and (d), "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 enrollment in a health benefit exchange or public health insurance program; or

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

(b) In the commissioner's discretion, the term does not include an individual who does one (1) or more of the following:

(1) Provides assistance with application for and enrollment in Medicaid to other individuals who, based on preliminary

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

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

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

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

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

Sec. 14. "PPACA" refers to 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).

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

(b) The term includes the following:

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

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

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

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

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

Chapter 3. Health Benefit Exchange Authority

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

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

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

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

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

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

services in Indiana.

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

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

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

(1) 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.

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

(A) that concerns the disclosure and receiving of data necessary to implement this section 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 4. Health Benefit Exchange Navigators and Application Organizations

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

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

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

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

(1) A navigator.

(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 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 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);

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 fee established under section 7 of this chapter.

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

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

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

(2) The entity's application for registration:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) overnight delivery using a nationally recognized carrier.

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

(1) a temporary waiver of:

(A) the renewal procedure; or

(B) an examination requirement; or

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

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

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

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

(2) by any means acceptable to the commissioner.

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

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

(1) the functions of a health benefit exchange;

(2) the duties and responsibilities of a navigator;

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

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

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

knowledge of the individual concerning the applicable:

(1) functions of a health benefit exchange;

(2) duties and responsibilities of a navigator;

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

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

(d) The commissioner:

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

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

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

(A) Develop examinations and course materials.

(B) Administer examinations and courses of study.

(C) Collect nonrefundable course and examination fees.

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

Sec. 12. (a) The commissioner:

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

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

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

(B) administer continuing education programs; and

(C) collect nonrefundable continuing education program fees.

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

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

Sec. 13. An individual who fails to:

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

(2) pass the examination;

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

forms.

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

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

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

under this chapter.

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

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

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

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

(1) primary care case management;

(2) care coordination; and

(3) chronic care management models;

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

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

(1) primary care management;

(2) care coordination; and

(3) integrated delivery of health and social support services.

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

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

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

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

(A) beneficiary choice of network and nonnetwork providers;

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

(C) provider network and rate setting processes; and

(D) coordination of care for dually eligible enrollees.

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

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

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

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

(d) This SECTION expires December 31, 2013.

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

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

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

(A) The hours of operation for the clinic.

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

(C) How the health care clinic is funded.

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

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

Conference Committee Report
on
Engrossed House Bill 1328

Signed by:

Representative Brown T Chairperson	Senator Miller Patricia
Representative Goodin	Senator Miller Pete
House Conferees	**Senate Conferees**