Reprinted
April 12, 2019

ENGROSSED
SENATE BILL No. 392

DIGEST OF SB 392 (Updated April 11, 2019 6:15 pm - DI 133)

Citations Affected: IC 4-1; IC 5-10; IC 12-15; IC 27-1; IC 27-4; IC 27-8; IC 27-13.

Synopsis: Health coverage. Specifies that the preexisting condition requirements of the federal Patient Protection and Affordable Care Act (ACA) as in effect on January 1, 2019, are in effect in Indiana,
(Continued next page)

Effective: July 1, 2019.

Houchin, Bassler, Walker,
Ruckelshaus, Sandlin, Bohacek, Zay,
Ford J.D., Randolph Lonnie M
(HOUSE SPONSORS — CARBAUGH, SHACKLEFORD)

January 14, 2019, read first time and referred to Committee on Insurance and Financial Institutions.
February 21, 2019, amended, reported favorably — Do Pass.
February 25, 2019, read second time, ordered engrossed. Engrossed.
February 26, 2019, read third time, passed. Yeas 41, nays 8.

HOUSE ACTION

March 5, 2019, read first time and referred to Committee on Insurance.
April 4, 2019, amended, reported — Do Pass.
April 11, 2019, read second time, amended, ordered engrossed.

regardless of the legal status of the ACA. Permits the office of the secretary of family and social services to apply for a state plan amendment requiring Medicaid reimbursement for rehabilitation option services in a school setting. Requires implementation within 1 year of approval. Prohibits preexisting condition exclusions in state employee health plans, policies of accident and sickness insurance, and health maintenance organization contracts. Permits premium rate variation based on certain factors. Specifies certain coverage and disclosures that must be provided with respect to a short term insurance plan, including renewal without underwriting, a term of not more than 364 days, and an annual limit of at least $2,000,000. Requires an insurer that makes a Medicare supplement policy available to an individual eligible for Medicare based on age to make at least one "Plan A" Medicare supplement policy available to an individual eligible for Medicare based on disability. Specifies enrollment and insurance producer compensation requirements that apply to the "Plan A" policy. Makes conforming amendments.

Reprinted
April 12, 2019

First Regular Session of the 121st General Assembly (2019)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~
Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.
Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2018 Regular and Special Session of the General Assembly.

ENGROSSED
SENATE BILL No. 392

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

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

1 SECTION 1. IC 4-1-12-1, AS ADDED BY P.L.160-2011,
2 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2019]: Sec. 1. **(a) Except as provided in subsection (b),** as
4 used in this chapter, "Patient Protection and Affordable Care Act"
5 refers to the federal Patient Protection and Affordable Care Act (P.L.
6 111-148), as amended by the federal Health Care and Education
7 Reconciliation Act of 2010 (P.L. 111-152), as amended from time to
8 time, and regulations or guidance issued under those acts.
9 **(b) As used in section 5 of this chapter, "Patient Protection and**
10 **Affordable Care Act" refers to the federal Patient Protection and**
11 **Affordable Care Act (P.L. 111-148), as amended by the federal**
12 **Health Care and Education Reconciliation Act of 2010 (P.L.**
13 **111-152), and regulations or guidance issued under those acts, all**
14 **as in effect on January 1, 2019.**
15 SECTION 2. IC 4-1-12-5 IS ADDED TO THE INDIANA CODE
16 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
17 1, 2019]: **Sec. 5. (a) As used in this section, "preexisting condition**

1 **exclusion" has the meaning set forth in 45 CFR 144.103, as in effect**
2 **on January 1, 2019.**
3 **(b) Except as provided in subsection (c), notwithstanding any**
4 **other law:**
5 **(1) 42 U.S.C. 300gg-3;**
6 **(2) 45 CFR 147.108; and**
7 **(3) all other provisions of the Patient Protection and**
8 **Affordable Care Act concerning preexisting condition**
9 **exclusions;**
10 **and the protections therein and in effect on January 1, 2019, are in**
11 **effect and must be enforced in Indiana, regardless of the legal**
12 **status of the Patient Protection and Affordable Care Act.**
13 **(c) To the extent that the provisions described in subsection (b)**
14 **conflict with IC 5-10-8.2, IC 27-8-5.1, and IC 27-13-7.1,**
15 **IC 5-10-8.2, IC 27-8-5.1, and IC 27-13-7.1 are controlling.**
16 SECTION 3. IC 5-10-8.2 IS ADDED TO THE INDIANA CODE
17 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
18 JULY 1, 2019]:
19 **Chapter 8.2. Health Related Requirements**
20 **Sec. 1. This chapter applies beginning twelve (12) months after**
21 **the date on which the provisions of the federal Patient Protection**
22 **and Affordable Care Act (as defined in IC 4-1-21-1) described in**
23 **IC 4-1-12-5(b) are repealed or are otherwise no longer in effect.**
24 **Sec. 2. As used in this chapter, "commissioner" refers to the**
25 **commissioner of insurance appointed under IC 27-1-1-2.**
26 **Sec. 3. As used in this chapter, "covered individual" means an**
27 **individual who is entitled to coverage under a state employee**
28 **health plan.**
29 **Sec. 4. As used in this chapter, "preexisting condition exclusion"**
30 **has the meaning set forth in 45 CFR 144.103, as in effect on**
31 **January 1, 2019.**
32 **Sec. 5. As used in this chapter, "state employee health plan"**
33 **refers to a:**
34 **(1) self-insurance program established under IC 5-10-8-7(b)**
35 **to provide group health coverage; or**
36 **(2) contract with a prepaid health care delivery plan that is**
37 **entered into or renewed under IC 5-10-8-7(c).**
38 **The term includes a person that administers benefits under a state**
39 **employee health plan described in subdivision (1) or (2).**
40 **Sec. 6. A state employee health plan may not impose a**
41 **preexisting condition exclusion on state employee health plan**
42 **coverage.**

1 **Sec. 7. (a) Except as provided in subsection (b), the premium**
2 **rate for coverage under a state employee health plan may vary, by**
3 **not more than five (5) to one (1), based only on the following:**
4 **(1) Whether the state employee health plan covers an**
5 **individual or a family.**
6 **(2) The rating area:**
7 **(A) established by the commissioner; and**
8 **(B) in which the state employee health plan is issued.**
9 **(3) The age of each covered individual.**
10 **(b) The premium rate for coverage under a state employee**
11 **health plan may vary based on tobacco use.**
12 **(c) The commissioner shall adopt rules under IC 4-22-2 to do the**
13 **following for use under subsection (a):**
14 **(1) Establish at least one (1) rating area in Indiana.**
15 **(2) Establish permissible age bands.**
16 **(d) With respect to family coverage, a premium rate variation**
17 **permitted under subsection (a)(3) must be applied based on the**
18 **part of the premium attributable to each family member covered**
19 **under the state employee health plan.**
20 SECTION 4. IC 12-15-1.3-21 IS ADDED TO THE INDIANA
21 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
22 [EFFECTIVE JULY 1, 2019]: **Sec. 21. (a) As used in this section,**
23 **"Medicaid rehabilitation option services" means clinical**
24 **behavioral health services provided to recipients and families of**
25 **recipients living in the community who need aid intermittently for**
26 **emotional disturbances, mental illness, and addiction as part of the**
27 **Medicaid rehabilitation option program.**
28 **(b) Before December 1, 2019, the office may apply to the United**
29 **States Department of Health and Human Services for a state plan**
30 **amendment that would require Medicaid reimbursement by:**
31 **(1) the office;**
32 **(2) a managed care organization that has contracted with the**
33 **office; or**
34 **(3) a contractor of the office;**
35 **for eligible Medicaid rehabilitation option services in a school**
36 **setting for any Medicaid recipient who qualifies for Medicaid**
37 **rehabilitation option services by meeting specific diagnosis and**
38 **level of need criteria under an assessment tool approved by the**
39 **division of mental health and addiction or who submits prior**
40 **authorization for Medicaid rehabilitation option services.**
41 **(c) If the office receives approval for the state plan amendment**
42 **applied for under this section, the office shall comply with**

IC 12-15-5-19.

SECTION 5. IC 12-15-5-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 19. (a) Not later than one (1) year from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall do the following:**

(1) Review the current services included in the Medicaid rehabilitation option services program in the school setting.

(2) Determine whether additional appropriate services, including:

(A) family engagement services; and

(B) additional comprehensive behavioral health services, including addiction services;

should be included as part of the program.

(3) Report the office's findings under this subsection to the general assembly in an electronic format under IC 5-14-6.

(b) Not later than three (3) months from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall notify each school corporation that the United States Department of Health and Human Services has approved the state plan amendment applied for under IC 12-15-1.3-21.

(c) Each school corporation shall, not later than one (1) year from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, contract with a community mental health center to provide Medicaid rehabilitation option services for:

(1) a student of the school corporation who is a Medicaid recipient; and

(2) the student's family.

SECTION 6. IC 27-1-20-36, AS ADDED BY P.L.81-2012, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 36. (a) As used in this section, "health insurance" means the kind of coverage provided under a health insurance plan.

(b) As used in this section, "health insurance plan" means any of the following:

(1) An individual policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in ~~IC 27-8-5-2.5(a).~~ **IC 27-8-5.1-2(b).**

(2) An individual contract (as defined in IC 27-13-1-21).

(c) As used in this section, "insurer" is limited to a person that enters into, issues, or delivers a health insurance plan on an individual basis in Indiana.

(d) An insurer shall, at least one hundred eighty (180) days before withdrawing from the individual health insurance market in Indiana, provide to the department written notice of the insurer's intent to withdraw.

SECTION 7. IC 27-1-37.3-5, AS ADDED BY P.L.55-2008, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) As used in this chapter, "health plan" means a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes the following:

(1) An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

(b) The term does not include the following:

(1) Accident-only, credit, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

SECTION 8. IC 27-1-37.5-5, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in ~~IC 27-8-5-2.5(a).~~ **IC 27-8-5.1-2(b).**

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The term includes a person that administers any of the following:

(1) A policy described in subsection (a)(1).

(2) A contract described in subsection (a)(2).

(3) A self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.

SECTION 9. IC 27-4-1-4, AS AMENDED BY P.L.124-2018, SECTION 64, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: 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

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

factor.
(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.
(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:
(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;
(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or
(iii) policies or contracts of any other kind or kinds of insurance whatsoever.
However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.
(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the

1 contract, or any special favor or advantage in the dividends,
2 savings, or other benefits thereon, or any valuable consideration
3 or inducement whatever not specified in the contract or policy; or
4 giving, or selling, or purchasing or offering to give, sell, or
5 purchase as inducement to such insurance or annuity or in
6 connection therewith, any stocks, bonds, or other securities of any
7 insurance company or other corporation, association, limited
8 liability company, or partnership, or any dividends, savings, or
9 profits accrued thereon, or anything of value whatsoever not
10 specified in the contract. Nothing in this subdivision and
11 subdivision (7) shall be construed as including within the
12 definition of discrimination or rebates any of the following
13 practices:
14 (A) Paying bonuses to policyholders or otherwise abating their
15 premiums in whole or in part out of surplus accumulated from
16 nonparticipating insurance, so long as any such bonuses or
17 abatement of premiums are fair and equitable to policyholders
18 and for the best interests of the company and its policyholders.
19 (B) In the case of life insurance policies issued on the
20 industrial debit plan, making allowance to policyholders who
21 have continuously for a specified period made premium
22 payments directly to an office of the insurer in an amount
23 which fairly represents the saving in collection expense.
24 (C) Readjustment of the rate of premium for a group insurance
25 policy based on the loss or expense experience thereunder, at
26 the end of the first year or of any subsequent year of insurance
27 thereunder, which may be made retroactive only for such
28 policy year.
29 (D) Paying by an insurer or insurance producer thereof duly
30 licensed as such under the laws of this state of money,
31 commission, or brokerage, or giving or allowing by an insurer
32 or such licensed insurance producer thereof anything of value,
33 for or on account of the solicitation or negotiation of policies
34 or other contracts of any kind or kinds, to a broker, an
35 insurance producer, or a solicitor duly licensed under the laws
36 of this state, but such broker, insurance producer, or solicitor
37 receiving such consideration shall not pay, give, or allow
38 credit for such consideration as received in whole or in part,
39 directly or indirectly, to the insured by way of rebate.
40 (9) Requiring, as a condition precedent to loaning money upon the
41 security of a mortgage upon real property, that the owner of the
42 property to whom the money is to be loaned negotiate any policy

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

1 (B) Insurance employed as a means of guaranteeing the
2 performance of goods and designed to benefit the purchasers
3 or users of such goods.
4 (C) Title insurance.
5 (D) Insurance written in connection with an indebtedness and
6 intended as a means of repaying such indebtedness in the
7 event of the death or disability of the insured.
8 (E) Insurance provided by or through motorists service clubs
9 or associations.
10 (F) Insurance that is provided to the purchaser or holder of an
11 air transportation ticket and that:
12 (i) insures against death or nonfatal injury that occurs during
13 the flight to which the ticket relates;
14 (ii) insures against personal injury or property damage that
15 occurs during travel to or from the airport in a common
16 carrier immediately before or after the flight;
17 (iii) insures against baggage loss during the flight to which
18 the ticket relates; or
19 (iv) insures against a flight cancellation to which the ticket
20 relates.
21 (14) Refusing, because of the for-profit status of a hospital or
22 medical facility, to make payments otherwise required to be made
23 under a contract or policy of insurance for charges incurred by an
24 insured in such a for-profit hospital or other for-profit medical
25 facility licensed by the state department of health.
26 (15) Refusing to insure an individual, refusing to continue to issue
27 insurance to an individual, limiting the amount, extent, or kind of
28 coverage available to an individual, or charging an individual a
29 different rate for the same coverage, solely because of that
30 individual's blindness or partial blindness, except where the
31 refusal, limitation, or rate differential is based on sound actuarial
32 principles or is related to actual or reasonably anticipated
33 experience.
34 (16) Committing or performing, with such frequency as to
35 indicate a general practice, unfair claim settlement practices (as
36 defined in section 4.5 of this chapter).
37 (17) Between policy renewal dates, unilaterally canceling an
38 individual's coverage under an individual or group health
39 insurance policy solely because of the individual's medical or
40 physical condition.
41 (18) Using a policy form or rider that would permit a cancellation
42 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)~~ **(26)** Violating IC 27-2-21 concerning use of credit information.
~~(28)~~ **(27)** Violating IC 27-4-9-3 concerning recommendations to consumers.
~~(29)~~ **(28)** 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)~~ **(29)** Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.
~~(31)~~ **(30)** Violating IC 27-2-22 concerning retained asset accounts.
~~(32)~~ **(31)** Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).
~~(33)~~ **(32)** 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.
~~(34)~~ **(33)** After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.
~~(35)~~ **(34)** Willfully violating IC 27-1-12-46 concerning a life insurance policy or certificate described in IC 27-1-12-46(a).

(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 (10 U.S.C. 992 note), 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 10. IC 27-8-5-0.1, AS ADDED BY P.L.220-2011, SECTION 435, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 0.1. The following amendments to this chapter apply as follows:
(1) The amendments made to section 1 of this chapter by P.L.257-1985 apply to insurance policies issued after December 31, 1985.
(2) The amendments made to section 21 of this chapter by P.L.98-1990 apply to a policy issued for delivery in Indiana after June 30, 1990.
(3) The addition of section 23 of this chapter by P.L.152-1990 applies to a statute or rule mandating the offering of health care coverage enacted or adopted after December 31, 1990.
(4) The amendments made to section 23 of this chapter by P.L.119-1991 apply to an insurance policy that is issued or renewed after June 30, 1991.
(5) The addition of section 2.5 of this chapter **(before its repeal)** by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1997.
(6) The addition of section 2.6 of this chapter (before its repeal) by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1995.
(7) The amendments made to sections 3 and 19 of this chapter by P.L.91-1998 apply to all accident and sickness policies in force on April 1, 1998.
(8) The amendments made to section 26 of this chapter by P.L.204-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.
(9) The amendments made to section 15.6 of this chapter by P.L.226-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.
(10) The amendments made to section 2.5 of this chapter **(before**

its repeal) by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(11) The amendments made to section 16.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(12) The amendments made to section 19 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(13) The amendments made to section 3 of this chapter by P.L.98-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after December 31, 2007.

(14) The amendments made to section 2 of this chapter by P.L.218-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

(15) The addition of section 28 of this chapter by P.L.218-2007 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

SECTION 11. IC 27-8-5-2.5 IS REPEALED [EFFECTIVE JULY 1, 2019]. ~~Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:~~

~~(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.~~

~~(2) Coverage issued as a supplement to liability insurance.~~

~~(3) Automobile medical payment insurance.~~

~~(4) A specified disease policy.~~

~~(5) A short term insurance plan that:~~

~~(A) may not be renewed; and~~

~~(B) has a duration of not more than six (6) months.~~

~~(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:~~

~~(A) hospital confinement, critical illness, or intensive care; or~~

~~(B) gaps for deductibles or copayments.~~

~~(7) Worker's compensation or similar insurance.~~

~~(8) A student health plan.~~
~~(9) A supplemental plan that always pays in addition to other coverage.~~
~~(10) An employer sponsored health benefit plan that is:~~
~~(A) provided to individuals who are eligible for Medicare; and~~
~~(B) not marketed as, or held out to be, a Medicare supplement policy.~~

~~(b) The benefits provided by:~~
~~(1) an individual policy of accident and sickness insurance; or~~
~~(2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance to an individual who is a resident of Indiana;~~
~~may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.~~

~~(c) An individual policy of accident and sickness insurance or a certificate of coverage described in subsection (b) may not define a preexisting condition, a rider, or an endorsement more restrictively than as:~~
~~(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of the plan;~~
~~(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of the plan; or~~
~~(3) a pregnancy existing on the effective date of the plan.~~

~~(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.~~

SECTION 12. IC 27-8-5-2.7 IS REPEALED [EFFECTIVE JULY 1, 2019]. ~~Sec. 2.7. (a) Notwithstanding section 2.5 of this chapter and any other law, and except as provided in subsection (b), an individual policy of accident and sickness insurance that is issued after June 30, 2005, may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:~~
~~(1) the waiver period does not exceed ten (10) years; and~~
~~(2) all the following conditions are met:~~

~~(A) The insurer provides to the applicant before issuance of the policy written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.~~

~~(B) The:~~

~~(i) offer of coverage; and~~

~~(ii) policy;~~

~~include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition.~~

~~(C) The:~~

~~(i) offer of coverage; and~~

~~(ii) policy;~~

~~do not include more than two (2) waivers per individual.~~

~~(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.~~

~~(E) The insurer agrees to:~~

~~(i) review the underwriting basis for the waiver upon request one (1) time per year; and~~

~~(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.~~

~~(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.~~

~~(G) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.~~

~~The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.~~

~~(b) An individual policy of accident and sickness insurance may not include a waiver of coverage for a:~~

~~(1) mental health condition; or~~

~~(2) developmental disability.~~

~~(c) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition~~

1 ~~or complication that is not specified as required in the:~~
2 ~~(1) written notice under subsection (a)(2)(A); and~~
3 ~~(2) offer of coverage and policy under subsection (a)(2)(B).~~
4 ~~(d) An insurer that removes a waiver under subsection (a)(2)(E)~~
5 ~~shall not consider the condition or any complication to which the~~
6 ~~waiver previously applied in making policy renewal and underwriting~~
7 ~~determinations.~~
8 ~~(e) Upon the expiration of the waiver period allowed under this~~
9 ~~section, the insurer shall:~~
10 ~~(1) remove the waiver;~~
11 ~~(2) not consider the condition or any complication to which the~~
12 ~~waiver previously applied in making policy underwriting~~
13 ~~determinations; and~~
14 ~~(3) renew the policy in accordance with 45 CFR 148.122.~~
15 SECTION 13. IC 27-8-5-15.6, AS AMENDED BY P.L.173-2007,
16 SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
17 JULY 1, 2019]: Sec. 15.6. (a) As used in this section, "coverage of
18 services for a mental illness" includes the services defined under the
19 policy of accident and sickness insurance. However, the term does not
20 include services for the treatment of substance abuse or chemical
21 dependency.
22 (b) This section applies to a policy of accident and sickness
23 insurance that:
24 (1) is issued on an individual basis or a group basis;
25 (2) is issued, entered into, or renewed after December 31, 1999;
26 and
27 (3) is issued to an employer that employs more than fifty (50)
28 full-time employees.
29 (c) This section does not apply to the following:
30 (1) A legal business entity that has obtained an exemption under
31 section 15.7 of this chapter.
32 (2) Accident only, credit, dental, vision, Medicare supplement,
33 long term care, or disability income insurance.
34 (3) Coverage issued as a supplement to liability insurance.
35 (4) Worker's compensation or similar insurance.
36 (5) Automobile medical payment insurance.
37 (6) A specified disease policy.
38 (7) A short term insurance plan that:
39 (A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
40 **(i) thirty-six (36) months; or**
41 **(ii) the maximum term permitted under federal law;**
42 (B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three**

hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).
(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(9) A supplemental plan that always pays in addition to other coverage.
(10) A student health plan.
(11) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.

SECTION 14. IC 27-8-5-16.5, AS AMENDED BY P.L.11-2011, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;
(2) the delivery state has approved the group policy; and
(3) the policy or the certificate contains provisions that are:
(A) substantially similar to the provisions required by:
(i) section 19 of this chapter;
(ii) section 21 of this chapter; and
(iii) IC 27-8-5.6; and
(B) consistent with the requirements set forth in:
(i) section 24 of this chapter;
(ii) IC 27-8-6;
(iii) IC 27-8-14;
(iv) IC 27-8-23;
(v) 760 IAC 1-38.1; and
(vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:
(1) the delivery state has a law substantially similar to section 16 of this chapter;
(2) the delivery state has approved the group policy; and
(3) the policy or the certificate contains provisions that are:
(A) substantially similar to the provisions required by:
(i) section 19 of this chapter; ~~or, if the policy or certificate is described in section 2.5(b)(2) of this chapter, section 2.5 of this chapter;~~
~~(ii) section 19.3 of this chapter if the policy or certificate contains a waiver of coverage;~~
~~(iii)~~ **(ii)** section 21 of this chapter; and
~~(iv)~~ **(iii)** IC 27-8-5.6; and
(B) consistent with the requirements set forth in:
(i) section 15.6 of this chapter;
(ii) section 24 of this chapter;
(iii) section 26 of this chapter;
(iv) IC 27-8-6;
(v) IC 27-8-14;
(vi) IC 27-8-14.1;
(vii) IC 27-8-14.5;
(viii) IC 27-8-14.7;
(ix) IC 27-8-14.8;
(x) IC 27-8-20;

1 (xi) IC 27-8-23;
2 (xii) IC 27-8-24.3;
3 (xiii) IC 27-8-26;
4 (xiv) IC 27-8-28;
5 (xv) IC 27-8-29;
6 (xvi) 760 IAC 1-38.1; and
7 (xvii) 760 IAC 1-39.
8 (e) A certificate may be issued to a resident of Indiana pursuant to
9 a group policy that is delivered or issued for delivery in a state other
10 than Indiana if the commissioner determines that the policy pursuant
11 to which the certificate is issued meets the requirements set forth in
12 section 17(a) of this chapter.
13 (f) This section does not affect any other provision of Indiana law
14 governing the terms or benefits of coverage provided to a resident of
15 Indiana under any certificate or policy of insurance.
16 SECTION 15. IC 27-8-5-19, AS AMENDED BY P.L.117-2015,
17 SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
18 JULY 1, 2019]: Sec. 19. (a) As used in this chapter, "late enrollee" has
19 the meaning set forth in 26 U.S.C. 9801(b)(3).
20 (b) A policy of group accident and sickness insurance may not be
21 issued to a group that has a legal situs in Indiana unless it contains in
22 substance:
23 (1) the provisions described in subsection (c); or
24 (2) provisions that, in the opinion of the commissioner, are:
25 (A) more favorable to the persons insured; or
26 (B) at least as favorable to the persons insured and more
27 favorable to the policyholder;
28 than the provisions set forth in subsection (c).
29 (c) The provisions referred to in subsection (b)(1) are as follows:
30 (1) A provision that the policyholder is entitled to a grace period
31 of thirty-one (31) days for the payment of any premium due
32 except the first, during which grace period the policy will
33 continue in force, unless the policyholder has given the insurer
34 written notice of discontinuance in advance of the date of
35 discontinuance and in accordance with the terms of the policy.
36 The policy may provide that the policyholder is liable to the
37 insurer for the payment of a pro rata premium for the time the
38 policy was in force during the grace period. A provision under
39 this subdivision may provide that the insurer is not obligated to
40 pay claims incurred during the grace period until the premium
41 due is received.
42 (2) A provision that the validity of the policy may not be

contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

~~(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:~~

~~(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the effective date of the person's coverage; and~~

~~(B) may not apply to a loss incurred or disability beginning~~

~~after the earlier of:~~
~~(i) the end of a continuous period of twelve (12) months beginning on or after the effective date of the person's coverage; or~~
~~(ii) the end of a continuous period of eighteen (18) months beginning on the effective date of the person's coverage if the person is a late enrollee.~~
~~This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.~~
~~(6)~~ **(5)** A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:
(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and
(B) may not apply to a loss incurred or disability beginning after the earlier of the following:
(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.
(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.
This subdivision applies only to group policies of accident and sickness insurance described in ~~section 2.5(a)(1) through~~ **IC 27-8-5.1-2(b)(1) through (8).** ~~2.5(a)(8) of this chapter.~~
~~(7)~~ **(6)** If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:
(A) premiums;
(B) benefits; or
(C) both premiums and benefits;
to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.
~~(8)~~ **(7)** A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or

paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

~~(9)~~ **(8)** A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

~~(10)~~ **(9)** A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

~~(11)~~ **(10)** A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the

1 claimant) no later than one (1) year from the time proof is
2 otherwise required under the policy.
3 ~~(12)~~ **(11)** A provision that:
4 (A) all benefits payable under the policy (other than benefits
5 for loss of time) will be paid:
6 (i) not more than forty-five (45) days after the insurer's (as
7 defined in IC 27-8-5.7-3) receipt of written proof of loss if
8 the claim is filed by the policyholder; or
9 (ii) in accordance with IC 27-8-5.7 if the claim is filed by
10 the provider (as defined in IC 27-8-5.7-4); and
11 (B) subject to due proof of loss, all accrued benefits under the
12 policy for loss of time will be paid not less frequently than
13 monthly during the continuance of the period for which the
14 insurer is liable, and any balance remaining unpaid at the
15 termination of the period for which the insurer is liable will be
16 paid as soon as possible after receipt of the proof of loss.
17 ~~(13)~~ **(12)** A provision that benefits for loss of life of the person
18 insured are payable to the beneficiary designated by the person
19 insured. However, if the policy contains conditions pertaining to
20 family status, the beneficiary may be the family member specified
21 by the policy terms. In either case, payment of benefits for loss of
22 life is subject to the provisions of the policy if no designated or
23 specified beneficiary is living at the death of the person insured.
24 All other benefits of the policy are payable to the person insured.
25 The policy may also provide that if any benefit is payable to the
26 estate of a person or to a person who is a minor or otherwise not
27 competent to give a valid release, the insurer may pay the benefit,
28 up to an amount of five thousand dollars ($5,000), to any relative
29 by blood or connection by marriage of the person who is deemed
30 by the insurer to be equitably entitled to the benefit.
31 ~~(14)~~ **(13)** A provision that the insurer, at the insurer's expense, has
32 the right and must be allowed the opportunity to:
33 (A) examine the person of the individual for whom a claim is
34 made under the policy when and as often as the insurer
35 reasonably requires during the pendency of the claim; and
36 (B) conduct an autopsy in case of death if it is not prohibited
37 by law.
38 ~~(15)~~ **(14)** A provision that no action at law or in equity may be
39 brought to recover on the policy less than sixty (60) days after
40 proof of loss is filed in accordance with the requirements of the
41 policy and that no action may be brought at all more than three (3)
42 years after the expiration of the time within which proof of loss is

required by the policy.

~~(16)~~ **(15)** In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

~~(17)~~ **(16)** If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of a mental, intellectual, or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a child who has a mental, intellectual, or physical disability who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

~~(18)~~ **(17)** A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), **as in effect on January 1, 2019.**

(d) Subsection ~~(c)(5), (c)(8),~~ **(c)(7)** and ~~(c)(13)~~ **(c)(12)** do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the

approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection ~~(c)(8);~~ **(c)(7);** and

(2) request the certificate in paper form.

SECTION 16. IC 27-8-5-19.3 IS REPEALED [EFFECTIVE JULY 1, 2019]. ~~Sec. 19.3. (a) This section applies to an association or a discretionary group policy of accident and sickness insurance:~~

~~(1) under which a certificate of coverage is issued after June 30, 2005, to an individual member of the association or discretionary group;~~

~~(2) under which a member of the association or discretionary group is individually underwritten; and~~

~~(3) that is not employer based.~~

~~(b) Notwithstanding sections 19 and 19.2 of this chapter and any other law, and except as provided in subsection (c), a policy described in subsection (a) may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:~~

~~(1) the waiver period does not exceed ten (10) years; and~~

~~(2) all of the following conditions are met:~~

~~(A) The insurer provides to the applicant before issuance of the certificate written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.~~

~~(B) The:~~

~~(i) offer of coverage; and~~

~~(ii) certificate of coverage;~~

~~include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition.~~

~~(C) The:~~

~~(i) offer of coverage; and~~

~~(ii) certificate of coverage;~~

~~do not include more than two (2) waivers per individual.~~

~~(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.~~

~~(E) The insurer agrees to:~~

1 (i) review the underwriting basis for the waiver upon request
2 one (1) time per year; and
3 (ii) remove the waiver if the insurer determines that
4 evidence of insurability is satisfactory.
5 (F) The insurer discloses to the applicant that the applicant
6 may decline the offer of coverage, and that any individual to
7 whom the waiver would have applied may apply for a policy
8 issued by the Indiana comprehensive health insurance
9 association under IC 27-8-10.
10 (G) An insurance benefit card issued by the insurer to the
11 applicant includes a telephone number for verification of
12 coverage waived.
13 (c) The insurer shall require an applicant to initial the written notice
14 provided under subsection (b)(2)(A) and the waiver included in the
15 offer of coverage and in the certificate of coverage under subsection
16 (b)(2)(B) to acknowledge acceptance of the waiver of coverage.
17 (d) An offer of coverage under a policy that includes a waiver under
18 this section does not preclude eligibility for an Indiana comprehensive
19 health insurance association policy under IC 27-8-10-5.1.
20 (e) A policy described in subsection (a) may not include a waiver of
21 coverage for a:
22 (1) mental health condition; or
23 (2) developmental disability.
24 (f) An insurer may not, on the basis of a waiver contained in a policy
25 as provided in this section, deny coverage for any condition or
26 complication that is not specified as required in the:
27 (1) written notice under subsection (b)(2)(A); and
28 (2) offer of coverage and certificate of coverage under subsection
29 (b)(2)(B).
30 (g) An insurer that removes a waiver under subsection (b)(2)(E)
31 shall not consider the condition or any complication to which the
32 waiver previously applied in making policy renewal and underwriting
33 determinations.
34 (h) Upon the expiration of the waiver period allowed under this
35 section, the insurer shall:
36 (1) remove the waiver;
37 (2) not consider the condition or any complication to which the
38 waiver previously applied in making policy underwriting
39 determinations; and
40 (3) renew the policy in accordance with 45 CFR 148.122.
41 SECTION 17. IC 27-8-5-27, AS AMENDED BY P.L.173-2007,
42 SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2019]: Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(7) Worker's compensation or similar insurance.

(8) A student health plan.

(9) A supplemental plan that always pays in addition to other coverage.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.

(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(d) As used in this section, "individual with a disability" means an individual:

(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and

(2) who:

(A) has a record of; or

1 (B) is regarded as;
2 having an impairment described in subdivision (1).
3 (e) A policy of accident and sickness insurance must include
4 coverage for anesthesia and hospital charges for dental care for an
5 insured if the mental or physical condition of the insured requires
6 dental treatment to be rendered in a hospital or an ambulatory
7 outpatient surgical center. The Indications for General Anesthesia, as
8 published in the reference manual of the American Academy of
9 Pediatric Dentistry, are the utilization standards for determining
10 whether performing dental procedures necessary to treat the insured's
11 condition under general anesthesia constitutes appropriate treatment.
12 (f) An insurer that issues a policy of accident and sickness insurance
13 may:
14 (1) require prior authorization for hospitalization or treatment in
15 an ambulatory outpatient surgical center for dental care
16 procedures in the same manner that prior authorization is required
17 for hospitalization or treatment of other covered medical
18 conditions; and
19 (2) restrict coverage to include only procedures performed by a
20 licensed dentist who has privileges at the hospital or ambulatory
21 outpatient surgical center.
22 (g) This section does not apply to treatment rendered for temporal
23 mandibular joint disorders (TMJ).
24 SECTION 18. IC 27-8-5.1 IS ADDED TO THE INDIANA CODE
25 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
26 JULY 1, 2019]:
27 **Chapter 5.1. Health Related Requirements**
28 **Sec. 1. As used in this chapter, "covered individual" means an**
29 **individual who is entitled to coverage under a policy of accident**
30 **and sickness insurance.**
31 **Sec. 2. (a) As used in this chapter, "policy of accident and**
32 **sickness insurance" has the meaning set forth in IC 27-8-5-1.**
33 **(b) The term "policy of accident and sickness insurance" does**
34 **not include the following:**
35 **(1) Accident only, credit, dental, vision, Medicare supplement,**
36 **long term care, or disability income insurance.**
37 **(2) Coverage issued as a supplement to liability insurance.**
38 **(3) Automobile medical payment insurance.**
39 **(4) A specified disease policy.**
40 **(5) A short term insurance plan that:**
41 **(A) may be renewed for the greater of:**
42 **(i) thirty-six (36) months; or**

1 **(ii) the maximum term permitted under federal law;**
2 **(B) has a term of not more than three hundred sixty-four**
3 **(364) days; and**
4 **(C) has an annual limit of at least two million dollars**
5 **($2,000,000).**
6 **(6) A policy that provides indemnity benefits not based on any**
7 **expense incurred requirement, including a plan that provides**
8 **coverage for:**
9 **(A) hospital confinement, critical illness, or intensive care;**
10 **or**
11 **(B) gaps for deductibles or copayments.**
12 **(7) Worker's compensation or similar insurance.**
13 **(8) A student health plan.**
14 **(9) A supplemental plan that always pays in addition to other**
15 **coverage.**
16 **(10) An employer sponsored health benefit plan that is:**
17 **(A) provided to individuals who are eligible for Medicare;**
18 **and**
19 **(B) not marketed as, or held out to be, a Medicare**
20 **supplement policy.**
21 **Sec. 3. As used in this chapter, "preexisting condition exclusion"**
22 **has the meaning set forth in 45 CFR 144.103, as in effect on**
23 **January 1, 2019.**
24 **Sec. 4. As used in this chapter, "small group" has the meaning**
25 **set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.**
26 **Sec. 5. (a) This section applies beginning twelve (12) months**
27 **after the date on which the provisions of the federal Patient**
28 **Protection and Affordable Care Act (as defined in IC 4-1-21-1)**
29 **described in IC 4-1-12-5(b) are repealed or are otherwise no longer**
30 **in effect.**
31 **(b) An insurer that issues a policy of accident and sickness**
32 **insurance in Indiana may not impose a preexisting condition**
33 **exclusion on the policy or coverage under the policy.**
34 **Sec. 6. (a) This section applies:**
35 **(1) beginning twelve (12) months after the date on which the**
36 **provisions of the federal Patient Protection and Affordable**
37 **Care Act (as defined in IC 4-1-21-1) described in**
38 **IC 4-1-12-5(b) are repealed or are otherwise no longer in**
39 **effect; and**
40 **(2) to the following:**
41 **(A) An individual policy of accident and sickness**
42 **insurance.**

1 **(B) A small group policy of accident and sickness**
2 **insurance.**
3 **(b) Except as provided in subsection (c), an insurer may vary, by**
4 **not more than five (5) to one (1), the premium rate for coverage**
5 **under an individual or small group policy of accident and sickness**
6 **insurance based only on the following:**
7 **(1) Whether the policy covers an individual or a family.**
8 **(2) The rating area:**
9 **(A) established by the commissioner; and**
10 **(B) in which the policy is issued.**
11 **(3) The age of each covered individual.**
12 **(c) An insurer may vary the premium rate for coverage under**
13 **an individual or small group policy of accident and sickness**
14 **insurance based on tobacco use.**
15 **(d) The commissioner shall adopt rules under IC 4-22-2 to do**
16 **the following for use under subsection (b):**
17 **(1) Establish at least one (1) rating area in Indiana.**
18 **(2) Establish permissible age bands.**
19 **(e) With respect to family coverage, a premium rate variation**
20 **permitted under subsection (b)(3) must be applied based on the**
21 **part of the premium attributable to each family member covered**
22 **under the policy.**
23 SECTION 19. IC 27-8-5.6-1, AS AMENDED BY P.L.86-2018,
24 SECTION 207, IS AMENDED TO READ AS FOLLOWS
25 [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, the
26 term "accident and sickness insurance" means any policy or contract
27 covering one (1) or more of the kinds of insurance described in classes
28 1(b) or 2(a) of IC 27-1-5-1, as governed by IC 27-8-5.
29 (b) The term does not include the following:
30 (1) Accident only, credit, dental, vision, Medicare supplement,
31 long term care, or disability income insurance.
32 (2) Coverage issued as a supplement to liability insurance.
33 (3) Worker's compensation or similar insurance.
34 (4) Automobile medical payment insurance.
35 (5) A specified disease policy.
36 (6) A short term insurance plan that:
37 (A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
38 **(i) thirty-six (36) months; or**
39 **(ii) the maximum term permitted under federal law;**
40 (B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three**
41 **hundred sixty-four (364) days; and**
42 **(C) has an annual limit of at least two million dollars**

($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 20. IC 27-8-5.8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

SECTION 21. IC 27-8-5.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 5.9. Short Term Insurance Plan

1 **Sec. 1. As used in this chapter, "covered individual" means an**
2 **individual entitled to coverage under a short term insurance plan.**
3 **Sec. 2. As used in this chapter, "PPACA" has the meaning set**
4 **forth in IC 27-19-2-14.**
5 **Sec. 3. As used in this chapter, "short term insurance plan"**
6 **means a policy of accident and sickness insurance (as defined in**
7 **IC 27-8-5-1) that:**
8 **(1) may be renewed for the greater of:**
9 **(A) thirty-six (36) months; or**
10 **(B) the maximum term permitted under federal law;**
11 **(2) has a term of not more than three hundred sixty-four (364)**
12 **days; and**
13 **(3) has an annual limit of at least two million dollars**
14 **($2,000,000).**
15 **Sec. 4. (a) An insurer may require an applicant for coverage**
16 **under a short term insurance plan to specify, before issuance of the**
17 **short term insurance plan, the number of renewals the applicant**
18 **elects.**
19 **(b) After issuance of a short term insurance plan, the insurer**
20 **may not require underwriting of the short term insurance plan**
21 **until:**
22 **(1) all renewal periods elected under subsection (a) have**
23 **ended; and**
24 **(2) the covered individual renews the short term insurance**
25 **plan beyond the periods described in subdivision (1).**
26 **Sec. 5. A short term insurance plan must include coverage for**
27 **the following:**
28 **(1) Ambulatory patient services.**
29 **(2) Hospitalization.**
30 **(3) Emergency services.**
31 **(4) Laboratory services.**
32 **Sec. 6. (a) This section applies to an insurer that issues a short**
33 **term insurance plan and undertakes a preferred provider plan**
34 **under IC 27-8-11 to render health care services to covered**
35 **individuals under the short term insurance plan.**
36 **(b) An insurer described in subsection (a) shall ensure that the**
37 **preferred provider plan meets the following requirements:**
38 **(1) The preferred provider plan includes essential community**
39 **providers in accordance with PPACA.**
40 **(2) The preferred provider plan is sufficient in number and**
41 **types of providers (other than mental health and substance**
42 **abuse treatment providers) to assure covered individuals'**

1 **access to all health care services without unreasonable delay.**
2 **(3) The preferred provider plan is consistent with the network**
3 **adequacy requirements that:**
4 **(A) apply to qualified health plan issuers under 45 CFR**
5 **156.230(a) and 45 CFR 156.230(b); and**
6 **(B) are consistent with subdivisions (1) and (2).**
7 **Sec. 7. (a) An insurer that issues a short term insurance plan**
8 **shall disclose to an applicant, in bold, 10 point type, the following:**
9 **(1) That the short term insurance plan does not include**
10 **coverage for the ten (10) essential health benefits required**
11 **under PPACA.**
12 **(2) That the short term insurance plan does not provide the**
13 **coverage that is required under PPACA.**
14 **(3) That enrollment in health coverage that provides the**
15 **coverage that is required under PPACA may be done during**
16 **the next PPACA open enrollment period.**
17 **(4) The dates of the next PPACA open enrollment period**
18 **during which the applicant may enroll in coverage described**
19 **in subdivision (3).**
20 **(b) An insurer shall obtain the signature of an applicant to**
21 **whom the disclosures required by subsection (a) are made.**
22 **Sec. 8. An insurer shall not, as a condition of enrollment or**
23 **continued enrollment in a short term insurance plan, require an**
24 **individual to pay a premium or contribution greater than the**
25 **premium or contribution for a similarly situated individual**
26 **enrolled in the short term insurance plan on the basis of a health**
27 **status related factor in relation to the individual or a dependent of**
28 **the individual.**
29 **Sec. 9. This chapter does not prevent an insurer from**
30 **establishing a premium discount, a rebate, or out-of-pocket**
31 **payment modifications in return for adherence to programs of**
32 **health promotion and disease prevention.**
33 SECTION 22. IC 27-8-6-6, AS ADDED BY P.L.133-2011,
34 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
35 JULY 1, 2019]: Sec. 6. (a) As used in this section, "policy of accident
36 and sickness insurance" has the meaning set forth in IC 27-8-5-1.
37 However, the term does not include the following:
38 (1) Accident only, credit, dental, vision, Medicare supplement,
39 long term care, or disability income insurance.
40 (2) Coverage issued as a supplement to liability insurance.
41 (3) Automobile medical payment insurance.
42 (4) A specified disease policy.

(5) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(7) A supplemental plan that always pays in addition to other coverage.

(b) A policy of accident and sickness insurance that provides coverage for physical medicine and rehabilitative services shall provide the coverage for physical medicine and rehabilitative services that are:
(1) rendered by an athletic trainer who is licensed under IC 25-5.1; and
(2) within the athletic trainer's scope of practice.

(c) This section does not require a policy of accident and sickness insurance to provide coverage for physical medicine or rehabilitative services generally.

SECTION 23. IC 27-8-10-5.1, AS AMENDED BY P.L.208-2018, SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for any of the coverage described in subdivisions (1) and (2). A person other than a federally eligible individual may not apply for an association policy unless the person has applied for:
(1) Medicaid; and
(2) coverage under the:
(A) preexisting condition insurance plan program established by the Secretary of Health and Human Services under Section 1101 of Title I of the federal Patient Protection and Affordable Care Act (P.L. 111-148); and
(B) healthy Indiana plan under IC 12-15-44.2;
not more than sixty (60) days before applying for the association policy.

(b) Except as provided in subsection (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has

or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. ~~However, an offer of coverage described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed), IC 27-8-5-2.7, IC 27-8-5-19.2(e) (expired July 1, 2007, and repealed), or IC 27-8-5-19.3 does not affect an individual's eligibility for an association policy under this subsection.~~ Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(c) Except as provided in subsection (a), a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(d) Coverage under an association policy terminates as follows:

(1) On the first date on which an insured is no longer a resident of Indiana.

(2) On the date on which an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(e) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of a mental, intellectual, or physical disability; and

(2) chiefly dependent upon the person in whose name the contract

1 is issued for support and maintenance.
2 However, proof of such incapacity and dependency must be furnished
3 to the carrier within one hundred twenty (120) days of the child's
4 attainment of the limiting age, and subsequently as may be required by
5 the carrier, but not more frequently than annually after the two (2) year
6 period following the child's attainment of the limiting age.
7 (f) An association policy that provides coverage for a family
8 member of the person in whose name the contract is issued must, as to
9 the family member's coverage, also provide that the health insurance
10 benefits applicable for children are payable with respect to a newly
11 born child of the person in whose name the contract is issued from the
12 moment of birth. The coverage for newly born children must consist of
13 coverage of injury or illness, including the necessary care and treatment
14 of medically diagnosed congenital defects and birth abnormalities. If
15 payment of a specific premium is required to provide coverage for the
16 child, the contract may require that notification of the birth of a child
17 and payment of the required premium must be furnished to the carrier
18 within thirty-one (31) days after the date of birth in order to have the
19 coverage continued beyond the thirty-one (31) day period.
20 (g) Except as provided in subsection (h), an association policy may
21 contain provisions under which coverage is excluded during a period
22 of three (3) months following the effective date of coverage as to a
23 given covered individual for preexisting conditions, as long as medical
24 advice or treatment was recommended or received within a period of
25 three (3) months before the effective date of coverage. This subsection
26 may not be construed to prohibit preexisting condition provisions in an
27 insurance policy that are more favorable to the insured.
28 (h) If a person applies for an association policy within six (6)
29 months after termination of the person's coverage under a health
30 insurance arrangement and the person meets the eligibility
31 requirements of subsection (c), then an association policy may not
32 contain provisions under which:
33 (1) coverage as to a given individual is delayed to a date after the
34 effective date or excluded from the policy; or
35 (2) coverage as to a given condition is denied;
36 on the basis of a preexisting health condition. This subsection may not
37 be construed to prohibit preexisting condition provisions in an
38 insurance policy that are more favorable to the insured.
39 (i) For purposes of this section, coverage under a health insurance
40 arrangement includes, but is not limited to, coverage pursuant to the
41 Consolidated Omnibus Budget Reconciliation Act of 1985.
42 SECTION 24. IC 27-8-13-9 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9. (a) A Medicare supplement policy, contract, or certificate in force in Indiana may not contain benefits that duplicate benefits provided by Medicare. However, a change in Medicare coverage that becomes effective after a Medicare supplement policy, contract, or certificate is in force in Indiana and that causes a duplication of benefits does not void the policy, contract, or certificate.

(b) The commissioner shall adopt rules under IC 4-22-2 to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with Indiana law. No requirement of IC 27 relating to minimum required policy benefits other than the minimum standards contained in this chapter apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

(1) terms of renewability;
(2) initial and subsequent conditions of eligibility;
(3) nonduplication of coverage;
(4) probationary periods;
(5) benefit limitations, exceptions, and reductions;
(6) elimination periods;
(7) requirements for replacement;
(8) recurrent conditions; and
(9) definitions of terms.

(c) The commissioner may adopt rules under IC 4-22-2 that specify prohibited policy provisions not specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to a person insured or proposed to be insured under a Medicare supplement policy or certificate.

(d) Notwithstanding any other law, a Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six (6) months after the effective date of the policy because the loss involves a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(e) After June 30, 2020, an issuer that makes a Medicare supplement policy or certificate available to a person who is at least sixty-five (65) years of age and eligible for Medicare benefits as described in 42 U.S.C. 1395c(1) shall make at least one (1) Medicare supplement policy or certificate that meets the requirements of section 9.5 of this chapter available to an

1 **individual who is eligible for and enrolled in Medicare by reason**
2 **of disability as described in 42 U.S.C. 1395c(2).**
3 SECTION 25. IC 27-8-13-9.5 IS ADDED TO THE INDIANA
4 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
5 [EFFECTIVE JULY 1, 2019]: **Sec. 9.5. (a) This section applies:**
6 **(1) after June 30, 2020; and**
7 **(2) to a Medicare supplement policy or certificate made**
8 **available under section 9(e) of this chapter to an individual**
9 **who is eligible for and enrolled in Medicare by reason of**
10 **disability as described in 42 U.S.C. 1395c(2).**
11 **(b) A Medicare supplement policy or certificate described in**
12 **subsection (a) must meet the following requirements:**
13 **(1) Except as provided in this section, meet all requirements**
14 **of this chapter that apply to a Medicare supplement policy or**
15 **certificate made available to a person who is at least sixty-five**
16 **(65) years of age and eligible for Medicare as described in 42**
17 **U.S.C. 1395c(1).**
18 **(2) Be standardized as Plan A by the federal Centers for**
19 **Medicare and Medicaid Services.**
20 **(c) An individual may enroll in a Medicare supplement policy or**
21 **certificate under this section as follows:**
22 **(1) At any time the individual is authorized or required to**
23 **enroll under federal law.**
24 **(2) On:**
25 **(A) July 1, 2020; or**
26 **(B) six (6) months after enrolling in Medicare Part B;**
27 **whichever is later.**
28 **(3) Within six (6) months after receiving notice that the**
29 **individual has been retroactively enrolled in Medicare Part B**
30 **due to a retroactive eligibility decision under 42 U.S.C. 1395.**
31 **(4) Within six (6) months after experiencing a qualifying event**
32 **under 42 U.S.C. 1395.**
33 **(d) Notwithstanding any other law, an issuer or another entity**
34 **may provide to an insurance producer or another agent of the**
35 **issuer or other entity a commission or other compensation of not**
36 **more than two percent (2%) of the premium for the sale of a**
37 **Medicare supplement policy or certificate described in subsection**
38 **(a).**
39 SECTION 26. IC 27-8-13.4-1, AS ADDED BY P.L.124-2014,
40 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
41 JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and
42 sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, Class 1(b) and Class 2(a); and
(2) is issued on a group or individual basis.

(b) As used in this chapter, "accident and sickness insurance policy" does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 27. IC 27-8-13.5-4, AS ADDED BY P.L.126-2013, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Automobile medical payment insurance.
(4) A specified disease policy.
(5) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(7) Worker's compensation or similar insurance.
(8) A student health plan.
(9) A supplemental plan that always pays in addition to other coverage.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 28. IC 27-8-14-1, AS AMENDED BY P.L.173-2007, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) The term does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any

expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 29. IC 27-8-14.1-1, AS AMENDED BY P.L.173-2007, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) As used in this chapter, "accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 30. IC 27-8-14.2-1, AS AMENDED BY P.L.173-2007, SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) The term does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 31. IC 27-8-14.5-1, AS AMENDED BY P.L.173-2007, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "health insurance plan" means any:
(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or
(3) health maintenance organization subscriber contract;
provided to an insured.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 32. IC 27-8-14.7-1, AS AMENDED BY P.L.173-2007, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 33. IC 27-8-14.8-1, AS AMENDED BY P.L.173-2007, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 34. IC 27-8-15-9, AS AMENDED BY P.L.11-2011, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9. (a) Except as provided in section 28 of this chapter, as used in this chapter, "health insurance plan" or "plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to the employees of a small employer.

(b) The term does not include the following:

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides

1 coverage for:
2 (A) hospital confinement, critical illness, or intensive care; or
3 (B) gaps for deductibles or copayments.
4 (8) A supplemental plan that always pays in addition to other
5 coverage.
6 (9) A student health plan.
7 (10) An employer sponsored health benefit plan that is:
8 (A) provided to individuals who are eligible for Medicare; and
9 (B) not marketed as, or held out to be, a Medicare supplement
10 policy.
11 SECTION 35. IC 27-8-15-27, AS AMENDED BY P.L.160-2011,
12 SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
13 JULY 1, 2019]: Sec. 27. (a) This section shall be applied in conformity
14 with the requirements of the federal Patient Protection and Affordable
15 Care Act (P.L. 111-148), as amended by the federal Health Care and
16 Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on
17 September 23, 2010, **IC 27-8-5.1, and IC 27-13-7.1.**
18 (b) A health insurance plan provided by a small employer insurer to
19 a small employer must comply with the following:
20 (1) The benefits provided by a plan to an eligible employee
21 enrolled in the plan may not be excluded, limited, or denied for
22 more than nine (9) months after the effective date of the coverage
23 because of a preexisting condition of the eligible employee, the
24 eligible employee's spouse, or the eligible employee's dependent.
25 (2) The plan may not define a preexisting condition, rider, or
26 endorsement more restrictively than as a condition for which
27 medical advice, diagnosis, care, or treatment was recommended
28 or received during the six (6) months immediately preceding the
29 effective date of enrollment in the plan.
30 SECTION 36. IC 27-8-15-29, AS AMENDED BY P.L.160-2011,
31 SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
32 JULY 1, 2019]: Sec. 29. (a) This section shall be applied in conformity
33 with the requirements of the federal Patient Protection and Affordable
34 Care Act (P.L. 111-148), as amended by the federal Health Care and
35 Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on
36 September 23, 2010, **IC 27-8-5.1, and IC 27-13-7.1.**
37 (b) A plan may exclude coverage for a late enrollee or the late
38 enrollee's covered spouse or dependent for not more than fifteen (15)
39 months.
40 (c) If a late enrollee or the late enrollee's covered spouse or
41 dependent has a preexisting condition, a plan may exclude coverage for
42 the preexisting condition for not more than fifteen (15) months.

(d) If a period of exclusion from coverage under subsection (b) and a preexisting condition exclusion under subsection (c) are applicable to the late enrollee, the combined period of exclusion may not exceed fifteen (15) months from the date that the eligible employee enrolls for coverage under the health insurance plan.

SECTION 37. IC 27-8-24.1-1, AS AMENDED BY P.L.173-2007, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 38. IC 27-8-24.2-3, AS ADDED BY P.L.109-2008, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 3. (a) As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

1 (b) The term does not include the following:
2 (1) Accident only, credit, dental, vision, Medicare, Medicare
3 supplement, long term care, or disability income insurance.
4 (2) Coverage issued as a supplement to liability insurance.
5 (3) Automobile medical payment insurance.
6 (4) A specified disease policy.
7 (5) A limited benefit health insurance policy.
8 (6) A short term insurance plan that:
9 (A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
10 **(i) thirty-six (36) months; or**
11 **(ii) the maximum term permitted under federal law;**
12 (B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three**
13 **hundred sixty-four (364) days; and**
14 **(C) has an annual limit of at least two million dollars**
15 **($2,000,000).**
16 (7) A policy that provides a stipulated daily, weekly, or monthly
17 payment to an insured during hospital confinement, without
18 regard to the actual expense of the confinement.
19 (8) Worker's compensation or similar insurance.
20 (9) A student health insurance policy.
21 SECTION 39. IC 27-8-27-4 IS AMENDED TO READ AS
22 FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. (a) For purposes of
23 this chapter, "health insurance plan" means any:
24 (1) hospital or medical expense incurred policy or certificate;
25 (2) hospital or medical service plan contract; or
26 (3) health maintenance organization subscriber contract;
27 provided to an insured.
28 (b) The term does not include the following:
29 (1) Accident-only, credit, dental, Medicare supplement, long term
30 care, or disability income insurance.
31 (2) Coverage issued as a supplement to liability insurance.
32 (3) Worker's compensation or similar insurance.
33 (4) Automobile medical payment insurance.
34 (5) A specified disease policy issued as an individual policy.
35 (6) A limited benefit health insurance plan issued as an individual
36 policy.
37 (7) A short term insurance plan that:
38 (A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
39 **(i) thirty-six (36) months; or**
40 **(ii) the maximum term permitted under federal law;**
41 (B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three**
42 **hundred sixty-four (364) days; and**

1 **(C) has an annual limit of at least two million dollars**
2 **($2,000,000).**
3 (8) A policy that provides a stipulated daily, weekly, or monthly
4 payment to an insured during hospital confinement, without
5 regard to the actual expense of the confinement.
6 SECTION 40. IC 27-8-28-1 IS AMENDED TO READ AS
7 FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this
8 chapter, "accident and sickness insurance policy" means an insurance
9 policy that provides one (1) or more of the kinds of insurance described
10 in Class 1(b) and 2(a) of IC 27-1-5-1.
11 (b) The term does not include the following:
12 (1) Accident only, credit, dental, vision, Medicare supplement,
13 long term care, or disability income insurance.
14 (2) Coverage issued as a supplement to liability insurance.
15 (3) Automobile medical payment insurance.
16 (4) A specified disease policy issued as an individual policy.
17 (5) A limited benefit health insurance policy issued as an
18 individual policy.
19 (6) A short term insurance plan that:
20 (A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
21 **(i) thirty-six (36) months; or**
22 **(ii) the maximum term permitted under federal law;**
23 (B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three**
24 **hundred sixty-four (364) days; and**
25 **(C) has an annual limit of at least two million dollars**
26 **($2,000,000).**
27 (7) A policy that provides a stipulated daily, weekly, or monthly
28 payment to an insured during hospital confinement without regard
29 to the actual expense of the confinement.
30 (8) Worker's compensation or similar insurance.
31 SECTION 41. IC 27-8-29-6, AS AMENDED BY P.L.3-2008,
32 SECTION 215, IS AMENDED TO READ AS FOLLOWS
33 [EFFECTIVE JULY 1, 2019]: Sec. 6. As used in this chapter, "external
34 grievance" means the independent review under this chapter of a
35 ~~(1)~~ grievance filed under IC 27-8-28. ~~or~~
36 ~~(2) denial of coverage based on a waiver described in~~
37 ~~IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or~~
38 ~~IC 27-8-5-19.2 (expired July 1, 2007, and repealed).~~
39 SECTION 42. IC 27-8-29-12, AS AMENDED BY P.L.160-2011,
40 SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
41 JULY 1, 2019]: Sec. 12. An insurer shall establish and maintain an
42 external grievance procedure for the resolution of external grievances

regarding the following:

(1) The following determinations made by the insurer or an agent of the insurer regarding a service proposed by the treating health care provider:

(A) An adverse determination of appropriateness.

(B) An adverse determination of medical necessity.

(C) A determination that a proposed service is experimental or investigational.

~~(D) A denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).~~

(2) The insurer's decision to rescind an accident and sickness insurance policy.

SECTION 43. IC 27-8-29-13, AS AMENDED BY P.L.160-2011, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual, or a covered individual's representative, to file a written request with the insurer for an external grievance review of the insurer's

~~(A)~~ appeal resolution under IC 27-8-28-17 ~~or~~

~~(B) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed);~~

not more than one hundred twenty (120) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the

1 department under section 19 of this chapter; and
2 (2) rotate the choice of an independent review organization
3 among all certified independent review organizations before
4 repeating a selection.
5 (c) The independent review organization chosen under subsection
6 (b) shall assign a medical review professional who is board certified in
7 the applicable specialty for resolution of an external grievance.
8 (d) The independent review organization and the medical review
9 professional conducting the external review under this chapter may not
10 have a material professional, familial, financial, or other affiliation with
11 any of the following:
12 (1) The insurer.
13 (2) Any officer, director, or management employee of the insurer.
14 (3) The health care provider or the health care provider's medical
15 group that is proposing the service.
16 (4) The facility at which the service would be provided.
17 (5) The development or manufacture of the principal drug, device,
18 procedure, or other therapy that is proposed for use by the treating
19 health care provider.
20 (6) The covered individual requesting the external grievance
21 review.
22 However, the medical review professional may have an affiliation
23 under which the medical review professional provides health care
24 services to covered individuals of the insurer and may have an
25 affiliation that is limited to staff privileges at the health facility, if the
26 affiliation is disclosed to the covered individual and the insurer before
27 commencing the review and neither the covered individual nor the
28 insurer objects.
29 (e) A covered individual shall not pay any of the costs associated
30 with the services of an independent review organization under this
31 chapter. All costs must be paid by the insurer.
32 SECTION 44. IC 27-8-29-15, AS AMENDED BY P.L.72-2016,
33 SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
34 JULY 1, 2019]: Sec. 15. (a) An independent review organization shall:
35 (1) for an expedited external grievance filed under section
36 13(a)(2)(A) of this chapter, within seventy-two (72) hours after
37 the external grievance is filed; or
38 (2) for a standard external grievance filed under section
39 13(a)(2)(B) of this chapter, within fifteen (15) business days after
40 the external grievance is filed;
41 make a determination to uphold or reverse the insurer's appeal
42 resolution under IC 27-8-28-17 based on information gathered from the

covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the covered individual's accident and sickness insurance policy.

~~(c) In an external grievance described in section 12(1)(D) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).~~

~~(d)~~ **(c)** The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours after the external grievance is filed; and

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

SECTION 45. IC 27-8-29-15.5, AS ADDED BY P.L.173-2007, SECTION 42, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 15.5. Upon the request of a covered individual who is notified under section ~~15(d)~~ **15(c)** of this chapter that the independent review organization has made a determination, the independent review organization shall provide to the covered individual all information reasonably necessary to enable the covered individual to understand the:

(1) effect of the determination on the covered individual; and

(2) manner in which the insurer may be expected to respond to the determination.

SECTION 46. IC 27-13-7.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 7.1. Health Related Requirements

Sec. 1. This chapter applies:

1 **(1) beginning twelve (12) months after the date on which the**
2 **provisions of the federal Patient Protection and Affordable**
3 **Care Act (as defined in IC 4-1-21-1) described in**
4 **IC 4-1-12-5(b) are repealed or are otherwise no longer in**
5 **effect; and**
6 **(2) to an individual contract, or a group contract, that**
7 **provides coverage for basic health care services.**
8 **Sec. 2. As used in this chapter, "preexisting condition exclusion"**
9 **has the meaning set forth in 45 CFR 144.103, as in effect on**
10 **January 1, 2019.**
11 **Sec. 3. As used in this chapter, "small group" has the meaning**
12 **set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.**
13 **Sec. 4. A health maintenance organization that issues an**
14 **individual contract or a group contract in Indiana may not impose**
15 **a preexisting condition exclusion on the individual contract or**
16 **group contract or coverage under the individual contract or group**
17 **contract.**
18 **Sec. 5. (a) This section applies to any of the following:**
19 **(1) An individual contract.**
20 **(2) A small group contract.**
21 **(b) Except as provided in subsection (c), a health maintenance**
22 **organization may vary, by not more than five (5) to one (1), the**
23 **premium rate for coverage under an individual contract, or a small**
24 **group contract, based only on the following:**
25 **(1) Whether the individual contract or small group contract**
26 **covers an individual or a family.**
27 **(2) The rating area:**
28 **(A) established by the commissioner; and**
29 **(B) in which the individual contract or small group**
30 **contract is issued.**
31 **(3) The age of each enrollee.**
32 **(c) A health maintenance organization may vary the premium**
33 **rate for coverage under an individual contract or a small group**
34 **contract based on tobacco use.**
35 **(d) The commissioner shall adopt rules under IC 4-22-2 to do**
36 **the following for use under subsection (b):**
37 **(1) Establish at least one (1) rating area in Indiana.**
38 **(2) Establish permissible age bands.**
39 **(e) With respect to family coverage, a premium rate variation**
40 **permitted under subsection (b)(3) must be applied based on the**
41 **part of the premium attributable to each family member covered**
42 **under the individual contract or small group contract.**

COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred Senate Bill No. 392, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, line 21, delete "An" and insert "**After June 30, 2020, an**".

Page 2, line 21, after "policy" insert "**or certificate**".

Page 2, line 22, after "is" insert "**at least sixty-five (65) years of age and**".

Page 2, line 24, after "policy" insert "**or certificate that meets the requirements of section 9.5 of this chapter**".

Page 2, line 24, after "for" insert "**and enrolled in**".

Page 2, line 24, after "Medicare" insert "**by reason of disability**".

Page 2, after line 25, begin a new paragraph and insert:

"SECTION 2. IC 27-8-13-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.5. (a) This section applies:**

(1) after June 30, 2020; and

(2) to a Medicare supplement policy or certificate made available under section 9(e) of this chapter to an individual who is eligible for and enrolled in Medicare by reason of disability as described in 42 U.S.C. 1395c(2).

(b) A Medicare supplement policy or certificate described in subsection (a) must meet the following requirements:

(1) Except as provided in this section, meet all requirements of this chapter that apply to a Medicare supplement policy or certificate made available to a person who is at least sixty-five (65) years of age and eligible for Medicare as described in 42 U.S.C. 1395c(1).

(2) Be standardized as Plan A by the federal Centers for Medicare and Medicaid Services.

(c) An individual may enroll in a Medicare supplement policy or certificate under this section as follows:

(1) At any time the individual is authorized or required to enroll under federal law.

(2) On:

(A) July 1, 2020; or

(B) six (6) months after enrolling in Medicare Part B;

whichever is later.

(3) Within six (6) months after receiving notice that the individual has been retroactively enrolled in Medicare Part B

due to a retroactive eligibility decision under 42 U.S.C. 1395.
(4) Within six (6) months after experiencing a qualifying event under 42 U.S.C. 1395.

(d) Notwithstanding any other law, an issuer or another entity may provide to an insurance producer or another agent of the issuer or other entity a commission or other compensation of not more than two percent (2%) of the premium for the sale of a Medicare supplement policy or certificate described in subsection (a).".

and when so amended that said bill do pass.

(Reference is to SB 392 as introduced.)

BASSLER, Chairperson

Committee Vote: Yeas 8, Nays 1.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred Senate Bill 392, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

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

"SECTION 1. IC 4-1-12-1, AS ADDED BY P.L.160-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. **(a) Except as provided in subsection (b),** as used in this chapter, "Patient Protection and Affordable Care Act" 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), as amended from time to time, and regulations or guidance issued under those acts.

(b) As used in section 5 of this chapter, "Patient Protection and Affordable Care Act" 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), and regulations or guidance issued under those acts, all as in effect on January 1, 2019.

SECTION 2. IC 4-1-12-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

1, 2019]: **Sec. 5. (a) As used in this section, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.**

(b) Notwithstanding any other law:

(1) 42 U.S.C. 300gg-3;

(2) 45 CFR 147.108; and

(3) all other provisions of the Patient Protection and Affordable Care Act concerning preexisting condition exclusions;

and the protections therein and in effect on January 1, 2019, are in effect and must be enforced in Indiana, regardless of the legal status of the Patient Protection and Affordable Care Act.

SECTION 3. IC 5-10-8.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 8.2. Health Status Related Requirements

Sec. 1. As used in this chapter, "commissioner" refers to the commissioner of insurance appointed under IC 27-1-1-2.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a state employee health plan.

Sec. 3. As used in this chapter, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

Sec. 4. As used in this chapter, "state employee health plan" refers to a:

(1) self-insurance program established under IC 5-10-8-7(b) to provide group health coverage; or

(2) contract with a prepaid health care delivery plan that is entered into or renewed under IC 5-10-8-7(c).

The term includes a person that administers benefits under a state employee health plan described in subdivision (1) or (2).

Sec. 5. A state employee health plan may not impose a preexisting condition exclusion on state employee health plan coverage.

Sec. 6. (a) Except as provided in subsection (b), the premium rate for coverage under a state employee health plan may vary, by not more than five (5) to one (1), based only on the following:

(1) Whether the state employee health plan covers an individual or a family.

(2) The rating area:

(A) established by the commissioner; and

(B) in which the state employee health plan is issued.

(3) The age of each covered individual.

(b) The premium rate for coverage under a state employee health plan may vary based on tobacco use.

(c) The commissioner shall adopt rules under IC 4-22-2 to do the following for use under subsection (a):

(1) Establish at least one (1) rating area in Indiana.

(2) Establish permissible age bands.

(d) With respect to family coverage, a premium rate variation permitted under subsection (a)(3) must be applied based on the part of the premium attributable to each family member covered under the state employee health plan.

SECTION 4. IC 27-1-37.3-5, AS ADDED BY P.L.55-2008, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) As used in this chapter, "health plan" means a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes the following:

(1) An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

(b) The term does not include the following:

(1) Accident-only, credit, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

SECTION 5. IC 27-8-5-2.5 IS REPEALED [EFFECTIVE JULY 1, 2019]. ~~Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:~~

~~(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.~~

~~(2) Coverage issued as a supplement to liability insurance.~~

~~(3) Automobile medical payment insurance.~~

~~(4) A specified disease policy.~~

~~(5) A short term insurance plan that:~~

~~(A) may not be renewed; and~~

~~(B) has a duration of not more than six (6) months.~~

~~(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:~~

~~(A) hospital confinement, critical illness, or intensive care; or~~

~~(B) gaps for deductibles or copayments.~~

~~(7) Worker's compensation or similar insurance.~~

~~(8) A student health plan.~~

~~(9) A supplemental plan that always pays in addition to other coverage.~~

~~(10) An employer sponsored health benefit plan that is:~~

~~(A) provided to individuals who are eligible for Medicare; and~~

~~(B) not marketed as, or held out to be, a Medicare supplement policy.~~

~~(b) The benefits provided by:~~

~~(1) an individual policy of accident and sickness insurance; or~~

~~(2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance to an individual who is a resident of Indiana;~~

~~may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.~~

~~(c) An individual policy of accident and sickness insurance or a certificate of coverage described in subsection (b) may not define a preexisting condition, a rider, or an endorsement more restrictively than as:~~

~~(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of the plan;~~

~~(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12)~~

~~months immediately preceding the effective date of the plan; or~~
~~(3) a pregnancy existing on the effective date of the plan.~~

~~(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.~~

SECTION 6. IC 27-8-5-15.6, AS AMENDED BY P.L.173-2007, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a policy of accident and sickness insurance that:
(1) is issued on an individual basis or a group basis;
(2) is issued, entered into, or renewed after December 31, 1999; and
(3) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to the following:
(1) A legal business entity that has obtained an exemption under section 15.7 of this chapter.
(2) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(3) Coverage issued as a supplement to liability insurance.
(4) Worker's compensation or similar insurance.
(5) Automobile medical payment insurance.
(6) A specified disease policy.
(7) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides

coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.

SECTION 7. IC 27-8-5-19, AS AMENDED BY P.L.117-2015, SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due

except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

~~(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the~~

~~person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:~~

~~(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the effective date of the person's coverage; and~~

~~(B) may not apply to a loss incurred or disability beginning after the earlier of:~~

~~(i) the end of a continuous period of twelve (12) months beginning on or after the effective date of the person's coverage; or~~

~~(ii) the end of a continuous period of eighteen (18) months beginning on the effective date of the person's coverage if the person is a late enrollee.~~

~~This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.~~

~~(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:~~

~~(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and~~

~~(B) may not apply to a loss incurred or disability beginning after the earlier of the following:~~

~~(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.~~

~~(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.~~

~~This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.~~

~~(7)~~ **(5)** If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

~~(8)~~ **(6)** A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

~~(9)~~ **(7)** A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

~~(10)~~ **(8)** A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

~~(11)~~ **(9)** A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the

continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;
(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and
(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

~~(12)~~ **(10)** A provision that:
(A) all benefits payable under the policy (other than benefits for loss of time) will be paid:
(i) not more than forty-five (45) days after the insurer's (as defined in IC 27-8-5.7-3) receipt of written proof of loss if the claim is filed by the policyholder; or
(ii) in accordance with IC 27-8-5.7 if the claim is filed by the provider (as defined in IC 27-8-5.7-4); and
(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

~~(13)~~ **(11)** A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

~~(14)~~ **(12)** A provision that the insurer, at the insurer's expense, has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and
(B) conduct an autopsy in case of death if it is not prohibited by law.

~~(15)~~ **(13)** A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

~~(16)~~ **(14)** In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

~~(17)~~ **(15)** If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:
(A) incapable of self-sustaining employment because of a mental, intellectual, or physical disability; and
(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a child who has a mental, intellectual, or physical disability who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

~~(18)~~ **(16)** A provision that complies with the group portability and guaranteed renewability provisions of the federal Health

Insurance Portability and Accountability Act of 1996 (P.L.104-191), **as in effect on January 1, 2019.**

(d) Subsection ~~(c)(5), (c)(8),~~ **(c)(6)** and ~~(c)(13)~~ **(c)(11)** do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection ~~(c)(8);~~ **(c)(6);** and

(2) request the certificate in paper form.

SECTION 8. IC 27-8-5-27, AS AMENDED BY P.L.173-2007, SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.
(7) Worker's compensation or similar insurance.
(8) A student health plan.
(9) A supplemental plan that always pays in addition to other coverage.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.

(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(d) As used in this section, "individual with a disability" means an individual:
(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and
(2) who:
(A) has a record of; or
(B) is regarded as;
having an impairment described in subdivision (1).

(e) A policy of accident and sickness insurance must include coverage for anesthesia and hospital charges for dental care for an insured if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.

(f) An insurer that issues a policy of accident and sickness insurance may:
(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and
(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.

(g) This section does not apply to treatment rendered for temporal

mandibular joint disorders (TMJ).

SECTION 9. IC 27-8-5.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 5.1. Health Status Related Requirements

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

Sec. 2. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 3. As used in this chapter, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

Sec. 4. As used in this chapter, "small group" has the meaning set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.

Sec. 5. An insurer that issues a policy of accident and sickness insurance in Indiana may not impose a preexisting condition exclusion on the policy or coverage under the policy.

Sec. 6. (a) This section applies to any of the following:

(1) An individual policy of accident and sickness insurance.

(2) A small group policy of accident and sickness insurance.

(b) Except as provided in subsection (c), an insurer may vary, by not more than five (5) to one (1), the premium rate for coverage under an individual or small group policy of accident and sickness insurance based only on the following:

(1) Whether the policy covers an individual or a family.

(2) The rating area:

(A) established by the commissioner; and

(B) in which the policy is issued.

(3) The age of each covered individual.

(c) An insurer may vary the premium rate for coverage under an individual or small group policy of accident and sickness insurance based on tobacco use.

(d) The commissioner shall adopt rules under IC 4-22-2 to do the following for use under subsection (b):

(1) Establish at least one (1) rating area in Indiana.

(2) Establish permissible age bands.

(e) With respect to family coverage, a premium rate variation permitted under subsection (b)(3) must be applied based on the part of the premium attributable to each family member covered under the policy.

SECTION 10. IC 27-8-5.6-1, AS AMENDED BY P.L.86-2018,

SECTION 207, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, the term "accident and sickness insurance" means any policy or contract covering one (1) or more of the kinds of insurance described in classes 1(b) or 2(a) of IC 27-1-5-1, as governed by IC 27-8-5.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 11. IC 27-8-5.8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Automobile medical payment insurance.

(4) A specified disease policy.
(5) A limited benefit health insurance policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
(8) Worker's compensation or similar insurance.
(9) A student health insurance policy.

SECTION 12. IC 27-8-5.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 5.9. Short Term Insurance Plan

Sec. 1. As used in this chapter, "covered individual" means an individual entitled to coverage under a short term insurance plan.

Sec. 2. As used in this chapter, "PPACA" has the meaning set forth in IC 27-19-2-14.

Sec. 3. As used in this chapter, "short term insurance plan" means a policy of accident and sickness insurance (as defined in IC 27-8-5-1) that:
(1) may be renewed for the greater of:
(A) thirty-six (36) months; or
(B) the maximum term permitted under federal law;
(2) has a term of not more than three hundred sixty-four (364) days; and
(3) has an annual limit of at least two million dollars ($2,000,000).

Sec. 4. An insurer shall not require underwriting of an existing insured upon renewal of a short term insurance plan.

Sec. 5. A short term insurance plan shall include coverage for the following, as provided under PPACA:
(1) Ambulatory patient services.
(2) Hospitalization.
(3) Emergency services.
(4) Laboratory services.

Sec. 6. (a) An insurer that issues a short term insurance plan

shall disclose to an applicant, in bold, 10 point type, the following:

(1) That the short term insurance plan does not include coverage for the essential health benefits required under PPACA, other than the essential health benefits specified in section 5 of this chapter.

(2) That the short term insurance plan does not provide the coverage that is required under PPACA.

(3) That enrollment in health coverage that provides the coverage that is required under PPACA may be done during the next PPACA open enrollment period.

(4) The dates of the next PPACA open enrollment period during which the applicant may enroll in coverage described in subdivision (3).

(b) An insurer shall obtain the signature of an applicant to whom the disclosures required by subsection (a) are made.

Sec. 7. An insurer shall not, as a condition of enrollment or continued enrollment in a short term insurance plan, require an individual to pay a premium or contribution greater than the premium or contribution for a similarly situated individual enrolled in the short term insurance plan on the basis of a health status related factor in relation to the individual or a dependent of the individual.

Sec. 8. This chapter does not prevent an insurer from establishing a premium discount, a rebate, or out-of-pocket payment modifications in return for adherence to programs of health promotion and disease prevention.

SECTION 13. IC 27-8-6-6, AS ADDED BY P.L.133-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 6. (a) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. However, the term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(7) A supplemental plan that always pays in addition to other coverage.

(b) A policy of accident and sickness insurance that provides coverage for physical medicine and rehabilitative services shall provide the coverage for physical medicine and rehabilitative services that are:

(1) rendered by an athletic trainer who is licensed under IC 25-5.1; and

(2) within the athletic trainer's scope of practice.

(c) This section does not require a policy of accident and sickness insurance to provide coverage for physical medicine or rehabilitative services generally.".

Page 3, after line 22, begin a new paragraph and insert:

"SECTION 16. IC 27-8-13.4-1, AS ADDED BY P.L.124-2014, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, Class 1(b) and Class 2(a); and

(2) is issued on a group or individual basis.

(b) As used in this chapter, "accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 17. IC 27-8-13.5-4, AS ADDED BY P.L.126-2013, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(7) Worker's compensation or similar insurance.

(8) A student health plan.

(9) A supplemental plan that always pays in addition to other coverage.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 18. IC 27-8-14-1, AS AMENDED BY P.L.173-2007, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 19. IC 27-8-14.1-1, AS AMENDED BY P.L.173-2007, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) As used in this chapter, "accident and sickness insurance policy"

does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 20. IC 27-8-14.2-1, AS AMENDED BY P.L.173-2007, SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 21. IC 27-8-14.5-1, AS AMENDED BY P.L.173-2007, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to an insured.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any

expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 22. IC 27-8-14.7-1, AS AMENDED BY P.L.173-2007, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 23. IC 27-8-14.8-1, AS AMENDED BY P.L.173-2007, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 24. IC 27-8-15-9, AS AMENDED BY P.L.11-2011, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9. (a) Except as provided in section 28 of this

chapter, as used in this chapter, "health insurance plan" or "plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to the employees of a small employer.

(b) The term does not include the following:

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 25. IC 27-8-15-27, AS AMENDED BY P.L.160-2011, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 27. (a) This section 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, **IC 27-8-5.1, and IC 27-13-7.1.**

(b) A health insurance plan provided by a small employer insurer to a small employer must comply with the following:

(1) The benefits provided by a plan to an eligible employee enrolled in the plan may not be excluded, limited, or denied for more than nine (9) months after the effective date of the coverage because of a preexisting condition of the eligible employee, the eligible employee's spouse, or the eligible employee's dependent.
(2) The plan may not define a preexisting condition, rider, or endorsement more restrictively than as a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the effective date of enrollment in the plan.

SECTION 26. IC 27-8-15-29, AS AMENDED BY P.L.160-2011, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 29. (a) This section 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, **IC 27-8-5.1, and IC 27-13-7.1.**

(b) A plan may exclude coverage for a late enrollee or the late enrollee's covered spouse or dependent for not more than fifteen (15) months.

(c) If a late enrollee or the late enrollee's covered spouse or dependent has a preexisting condition, a plan may exclude coverage for the preexisting condition for not more than fifteen (15) months.

(d) If a period of exclusion from coverage under subsection (b) and a preexisting condition exclusion under subsection (c) are applicable to the late enrollee, the combined period of exclusion may not exceed fifteen (15) months from the date that the eligible employee enrolls for coverage under the health insurance plan.

SECTION 27. IC 27-8-24.1-1, AS AMENDED BY P.L.173-2007, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis.

(b) The term does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 28. IC 27-8-24.2-3, AS ADDED BY P.L.109-2008, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 3. (a) As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

(b) The term does not include the following:
(1) Accident only, credit, dental, vision, Medicare, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Automobile medical payment insurance.
(4) A specified disease policy.
(5) A limited benefit health insurance policy.
(6) A short term insurance plan that:
(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**
(C) has an annual limit of at least two million dollars ($2,000,000).
(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

SECTION 29. IC 27-8-27-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. (a) For purposes of this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to an insured.

(b) The term does not include the following:

(1) Accident-only, credit, dental, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A limited benefit health insurance plan issued as an individual policy.

(7) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

SECTION 30. IC 27-8-28-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the kinds of insurance described in Class 1(b) and 2(a) of IC 27-1-5-1.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may ~~not~~ be renewed ~~and~~ **for the greater of:**

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a ~~duration~~ **term** of not more than ~~six (6) months;~~ **three hundred sixty-four (364) days; and**

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

SECTION 31. IC 27-13-7.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 7.1. Health Status Related Requirements

Sec. 1. As used in this chapter, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

Sec. 2. As used in this chapter, "small group" has the meaning set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.

Sec. 3. A health maintenance organization that issues an individual contract or a group contract in Indiana may not impose a preexisting condition exclusion on the individual contract or group contract or coverage under the individual contract or group contract.

Sec. 4. (a) This section applies to any of the following:

(1) An individual contract.

(2) A small group contract.

(b) Except as provided in subsection (c), a health maintenance organization may vary, by not more than five (5) to one (1), the premium rate for coverage under an individual contract, or a small group contract, based only on the following:

(1) Whether the individual contract or small group contract covers an individual or a family.

(2) The rating area:

(A) established by the commissioner; and

(B) in which the individual contract or small group contract is issued.

(3) The age of each enrollee.

(c) A health maintenance organization may vary the premium rate for coverage under an individual contract or a small group contract based on tobacco use.

(d) The commissioner shall adopt rules under IC 4-22-2 to do the following for use under subsection (b):

(1) Establish at least one (1) rating area in Indiana.

(2) Establish permissible age bands.

(e) With respect to family coverage, a premium rate variation permitted under subsection (b)(3) must be applied based on the part of the premium attributable to each family member covered under the individual contract or small group contract.

SECTION 32. [EFFECTIVE JULY 1, 2019] **(a) The legislative services agency shall prepare legislation for introduction during the 2020 session of the general assembly to conform the Indiana Code to amendments made by this act.**

(b) To the extent that a provision of this act is inconsistent with another provision of the Indiana Code, the provision of this act prevails.

(c) This SECTION expires July 1, 2020.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 392 as printed February 22, 2019.)

CARBAUGH

Committee Vote: yeas 11, nays 0.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 392 be amended to read as follows:

Page 2, line 3, delete "Notwithstanding" and insert "**Except as provided in subsection (c), notwithstanding**".

Page 2, between lines 11 and 12, begin a new paragraph and insert:

"**(c) To the extent that the provisions described in subsection (b) conflict with IC 5-10-8.2, IC 27-8-5.1, and IC 27-13-7.1, IC 5-10-8.2, IC 27-8-5.1, and IC 27-13-7.1 are controlling.**

Page 2, line 15, delete "Status".

Page 2, line 16, after "1." insert "**This chapter applies beginning twelve (12) months after the date on which the provisions of the federal Patient Protection and Affordable Care Act (as defined in IC 4-1-21-1) described in IC 4-1-12-5(b) are repealed or are**

otherwise no longer in effect.

Sec. 2.".

Page 2, line 18, delete "2." and insert "**3.**".

Page 2, line 21, delete "3." and insert "**4.**".

Page 2, line 24, delete "4." and insert "**5.**".

Page 2, line 32, delete "5." and insert "**6.**".

Page 2, line 35, delete "6." and insert "**7.**".

Page 3, between lines 11 and 12, begin a new paragraph and insert:

"SECTION 4. IC 27-1-20-36, AS ADDED BY P.L.81-2012, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 36. (a) As used in this section, "health insurance" means the kind of coverage provided under a health insurance plan.

(b) As used in this section, "health insurance plan" means any of the following:

(1) An individual policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in ~~IC 27-8-5-2.5(a).~~ **IC 27-8-5.1-2(b).**

(2) An individual contract (as defined in IC 27-13-1-21).

(c) As used in this section, "insurer" is limited to a person that enters into, issues, or delivers a health insurance plan on an individual basis in Indiana.

(d) An insurer shall, at least one hundred eighty (180) days before withdrawing from the individual health insurance market in Indiana, provide to the department written notice of the insurer's intent to withdraw.".

Page 3, between lines 41 and 42, begin a new paragraph and insert:

"SECTION 6. IC 27-1-37.5-5, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in ~~IC 27-8-5-2.5(a).~~ **IC 27-8-5.1-2(b).**

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The term includes a person that administers any of the following:

(1) A policy described in subsection (a)(1).

(2) A contract described in subsection (a)(2).

(3) A self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.

SECTION 7. IC 27-4-1-4, AS AMENDED BY P.L.124-2018,

SECTION 64, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: 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)~~ **(26)** Violating IC 27-2-21 concerning use of credit information.

~~(28)~~ **(27)** Violating IC 27-4-9-3 concerning recommendations to consumers.

~~(29)~~ **(28)** 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)~~ **(29)** Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.

~~(31)~~ **(30)** Violating IC 27-2-22 concerning retained asset accounts.

~~(32)~~ **(31)** Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).

~~(33)~~ **(32)** 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.

~~(34)~~ **(33)** After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.

~~(35)~~ **(34)** Willfully violating IC 27-1-12-46 concerning a life insurance policy or certificate described in IC 27-1-12-46(a).

(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 (10 U.S.C. 992 note), 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 8. IC 27-8-5-0.1, AS ADDED BY P.L.220-2011, SECTION 435, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The amendments made to section 1 of this chapter by P.L.257-1985 apply to insurance policies issued after December 31, 1985.
(2) The amendments made to section 21 of this chapter by P.L.98-1990 apply to a policy issued for delivery in Indiana after June 30, 1990.
(3) The addition of section 23 of this chapter by P.L.152-1990 applies to a statute or rule mandating the offering of health care coverage enacted or adopted after December 31, 1990.
(4) The amendments made to section 23 of this chapter by P.L.119-1991 apply to an insurance policy that is issued or renewed after June 30, 1991.
(5) The addition of section 2.5 of this chapter **(before its repeal)** by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1997.
(6) The addition of section 2.6 of this chapter (before its repeal) by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1995.
(7) The amendments made to sections 3 and 19 of this chapter by P.L.91-1998 apply to all accident and sickness policies in force on April 1, 1998.
(8) The amendments made to section 26 of this chapter by P.L.204-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.
(9) The amendments made to section 15.6 of this chapter by P.L.226-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.
(10) The amendments made to section 2.5 of this chapter **(before its repeal)** by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.
(11) The amendments made to section 16.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.
(12) The amendments made to section 19 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and

sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(13) The amendments made to section 3 of this chapter by P.L.98-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after December 31, 2007.

(14) The amendments made to section 2 of this chapter by P.L.218-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

(15) The addition of section 28 of this chapter by P.L.218-2007 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.".

Page 5, between lines 8 and 9, begin a new paragraph and insert:

"SECTION 10. IC 27-8-5-2.7 IS REPEALED [EFFECTIVE JULY 1, 2019]. ~~Sec. 2.7. (a) Notwithstanding section 2.5 of this chapter and any other law, and except as provided in subsection (b), an individual policy of accident and sickness insurance that is issued after June 30, 2005, may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:~~

~~(1) the waiver period does not exceed ten (10) years; and~~

~~(2) all the following conditions are met:~~

~~(A) The insurer provides to the applicant before issuance of the policy written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.~~

~~(B) The:~~

~~(i) offer of coverage; and~~

~~(ii) policy;~~

~~include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition.~~

~~(C) The:~~

~~(i) offer of coverage; and~~

~~(ii) policy;~~

~~do not include more than two (2) waivers per individual.~~

~~(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.~~

~~(E) The insurer agrees to:~~

~~(i) review the underwriting basis for the waiver upon request one (1) time per year; and~~

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(b) An individual policy of accident and sickness insurance may not include a waiver of coverage for a:

(1) mental health condition; or

(2) developmental disability.

(c) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition or complication that is not specified as required in the:

(1) written notice under subsection (a)(2)(A); and

(2) offer of coverage and policy under subsection (a)(2)(B).

(d) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(e) Upon the expiration of the waiver period allowed under this section, the insurer shall:

(1) remove the waiver;

(2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) renew the policy in accordance with 45 CFR 148.122.".

Page 6, between lines 25 and 26, begin a new paragraph and insert:

"SECTION 12. IC 27-8-5-16.5, AS AMENDED BY P.L.11-2011, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;
(2) the delivery state has approved the group policy; and
(3) the policy or the certificate contains provisions that are:
(A) substantially similar to the provisions required by:
(i) section 19 of this chapter;
(ii) section 21 of this chapter; and
(iii) IC 27-8-5.6; and
(B) consistent with the requirements set forth in:
(i) section 24 of this chapter;
(ii) IC 27-8-6;
(iii) IC 27-8-14;
(iv) IC 27-8-23;
(v) 760 IAC 1-38.1; and
(vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;
(2) the delivery state has approved the group policy; and
(3) the policy or the certificate contains provisions that are:
(A) substantially similar to the provisions required by:
(i) section 19 of this chapter; ~~or, if the policy or certificate is described in section 2.5(b)(2) of this chapter, section 2.5 of this chapter;~~
~~(ii) section 19.3 of this chapter if the policy or certificate contains a waiver of coverage;~~
~~(iii)~~ **(ii)** section 21 of this chapter; and
~~(iv)~~ **(iii)** IC 27-8-5.6; and
(B) consistent with the requirements set forth in:
(i) section 15.6 of this chapter;
(ii) section 24 of this chapter;
(iii) section 26 of this chapter;
(iv) IC 27-8-6;

(v) IC 27-8-14;
(vi) IC 27-8-14.1;
(vii) IC 27-8-14.5;
(viii) IC 27-8-14.7;
(ix) IC 27-8-14.8;
(x) IC 27-8-20;
(xi) IC 27-8-23;
(xii) IC 27-8-24.3;
(xiii) IC 27-8-26;
(xiv) IC 27-8-28;
(xv) IC 27-8-29;
(xvi) 760 IAC 1-38.1; and
(xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.

(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance.".

Page 8, reset in roman lines 21 through 40.

Page 8, line 21, strike "(6)" and insert "**(5)**".

Page 8, line 40, strike "section 2.5(a)(1) through" and insert "**IC 27-8-5.1-2(b)(1) through (8).**".

Page 8, line 42, delete "(5)" and insert "**(6)**".

Page 9, line 8, delete "(6)" and insert "**(7)**".

Page 9, line 18, delete "(7)" and insert "**(8)**".

Page 9, line 25, delete "(8)" and insert "**(9)**".

Page 9, line 37, delete "(9)" and insert "**(10)**".

Page 10, line 12, delete "(10)" and insert "**(11)**".

Page 10, line 26, delete "(11)" and insert "**(12)**".

Page 10, line 40, delete "(12)" and insert "**(13)**".

Page 11, line 5, delete "(13)" and insert "**(14)**".

Page 11, line 11, delete "(14)" and insert "**(15)**".

Page 11, line 16, delete "(15)" and insert "**(16)**".

Page 11, line 40, delete "(16)" and insert "**(17)**".

Page 12, line 2, delete "(c)(6)" and insert "**(c)(7)**".

Page 12, line 2, delete "(c)(11)" and insert "**(c)(12)**".

Page 12, line 16, delete "(c)(6);" and insert "**(c)(7);**".

Page 12, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 14. IC 27-8-5-19.3 IS REPEALED [EFFECTIVE JULY

1, 2019]. ~~Sec. 19.3. (a) This section applies to an association or a discretionary group policy of accident and sickness insurance:~~

~~(1) under which a certificate of coverage is issued after June 30, 2005, to an individual member of the association or discretionary group;~~

~~(2) under which a member of the association or discretionary group is individually underwritten; and~~

~~(3) that is not employer based.~~

~~(b) Notwithstanding sections 19 and 19.2 of this chapter and any other law, and except as provided in subsection (c), a policy described in subsection (a) may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:~~

~~(1) the waiver period does not exceed ten (10) years; and~~

~~(2) all of the following conditions are met:~~

~~(A) The insurer provides to the applicant before issuance of the certificate written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.~~

~~(B) The:~~

~~(i) offer of coverage; and~~

~~(ii) certificate of coverage;~~

~~include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition.~~

~~(C) The:~~

~~(i) offer of coverage; and~~

~~(ii) certificate of coverage;~~

~~do not include more than two (2) waivers per individual.~~

~~(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.~~

~~(E) The insurer agrees to:~~

~~(i) review the underwriting basis for the waiver upon request one (1) time per year; and~~

~~(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.~~

~~(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and that any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.~~

~~(G) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.~~

~~(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage and in the certificate of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage.~~

~~(d) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.~~

~~(e) A policy described in subsection (a) may not include a waiver of coverage for a:~~

~~(1) mental health condition; or~~

~~(2) developmental disability.~~

~~(f) An insurer may not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition or complication that is not specified as required in the:~~

~~(1) written notice under subsection (b)(2)(A); and~~

~~(2) offer of coverage and certificate of coverage under subsection (b)(2)(B).~~

~~(g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.~~

~~(h) Upon the expiration of the waiver period allowed under this section, the insurer shall:~~

~~(1) remove the waiver;~~

~~(2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and~~

~~(3) renew the policy in accordance with 45 CFR 148.122.~~".

Page 14, line 4, delete "Status".

Page 14, line 8, after "2." insert "**(a)**".

Page 14, between lines 9 and 10, begin a new paragraph and insert:

"**(b) The term "policy of accident and sickness insurance" does not include the following:**

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may be renewed for the greater of:
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a term of not more than three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).
(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(7) Worker's compensation or similar insurance.
(8) A student health plan.
(9) A supplemental plan that always pays in addition to other coverage.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.".

Page 14, line 15, after "5." insert "**(a) This section applies beginning twelve (12) months after the date on which the provisions of the federal Patient Protection and Affordable Care Act (as defined in IC 4-1-21-1) described in IC 4-1-12-5(b) are repealed or are otherwise no longer in effect.**
(b)".

Page 14, delete lines 18 through 20, begin a new paragraph and insert:

"**Sec. 6. (a) This section applies:**
(1) beginning twelve (12) months after the date on which the provisions of the federal Patient Protection and Affordable Care Act (as defined in IC 4-1-21-1) described in IC 4-1-12-5(b) are repealed or are otherwise no longer in effect; and
(2) to the following:
(A) An individual policy of accident and sickness insurance.
(B) A small group policy of accident and sickness insurance.".

Page 16, delete lines 33 through 34, begin a new paragraph and

insert:

"**Sec. 4. (a) An insurer may require an applicant for coverage under a short term insurance plan to specify, before issuance of the short term insurance plan, the number of renewals the applicant elects.**

(b) After issuance of a short term insurance plan, the insurer may not require underwriting of the short term insurance plan until:

(1) all renewal periods elected under subsection (a) have ended; and

(2) the covered individual renews the short term insurance plan beyond the periods described in subdivision (1).

Page 16, line 35, delete "shall" and insert "**must**".

Page 16, line 36, delete "following, as provided under PPACA:" and insert "**following:**".

Page 16, line 41, after "6." insert "**(a) This section applies to an insurer that issues a short term insurance plan and undertakes a preferred provider plan under IC 27-8-11 to render health care services to covered individuals under the short term insurance plan.**

(b) An insurer described in subsection (a) shall ensure that the preferred provider plan meets the following requirements:

(1) The preferred provider plan includes essential community providers in accordance with PPACA.

(2) The preferred provider plan is sufficient in number and types of providers (other than mental health and substance abuse treatment providers) to assure covered individuals' access to all health care services without unreasonable delay.

(3) The preferred provider plan is consistent with the network adequacy requirements that:

(A) apply to qualified health plan issuers under 45 CFR 156.230(a) and 45 CFR 156.230(b); and

(B) are consistent with subdivisions (1) and (2).

Sec. 7.".

Page 17, line 2, after "the" insert "**ten (10)**".

Page 17, line 3, delete "PPACA, other than the essential health benefits specified in" and insert "**PPACA.**".

Page 17, delete line 4.

Page 17, line 15, delete "7." and insert "**8.**".

Page 17, line 22, delete "8." and insert "**9.**".

Page 18, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 18. IC 27-8-10-5.1, AS AMENDED BY P.L.208-2018,

SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for any of the coverage described in subdivisions (1) and (2). A person other than a federally eligible individual may not apply for an association policy unless the person has applied for:

(1) Medicaid; and

(2) coverage under the:

(A) preexisting condition insurance plan program established by the Secretary of Health and Human Services under Section 1101 of Title I of the federal Patient Protection and Affordable Care Act (P.L. 111-148); and

(B) healthy Indiana plan under IC 12-15-44.2;

not more than sixty (60) days before applying for the association policy.

(b) Except as provided in subsection (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. ~~However, an offer of coverage described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed), IC 27-8-5-2.7, IC 27-8-5-19.2(e) (expired July 1, 2007, and repealed), or IC 27-8-5-19.3 does not affect an individual's eligibility for an association policy under this subsection.~~ Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(c) Except as provided in subsection (a), a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(d) Coverage under an association policy terminates as follows:

(1) On the first date on which an insured is no longer a resident of Indiana.

(2) On the date on which an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(e) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of a mental, intellectual, or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(f) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(g) Except as provided in subsection (h), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection

may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (c), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(i) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.".

Page 31, between lines 6 and 7, begin a new paragraph and insert:

"SECTION 39. IC 27-8-29-6, AS AMENDED BY P.L.3-2008, SECTION 215, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a

~~(1)~~ grievance filed under IC 27-8-28. ~~or~~

~~(2) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).~~

SECTION 40. IC 27-8-29-12, AS AMENDED BY P.L.160-2011, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding the following:

(1) The following determinations made by the insurer or an agent of the insurer regarding a service proposed by the treating health care provider:

(A) An adverse determination of appropriateness.

(B) An adverse determination of medical necessity.

(C) A determination that a proposed service is experimental or investigational.

~~(D) A denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).~~

(2) The insurer's decision to rescind an accident and sickness insurance policy.

SECTION 41. IC 27-8-29-13, AS AMENDED BY P.L.160-2011, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual, or a covered individual's representative, to file a written request with the insurer for an external grievance review of the insurer's

~~(A)~~ appeal resolution under IC 27-8-28-17 ~~or~~

~~(B) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed);~~

not more than one hundred twenty (120) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

SECTION 42. IC 27-8-29-15, AS AMENDED BY P.L.72-2016, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 15. (a) An independent review organization shall:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours after the external grievance is filed; or

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the external grievance is filed;

make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the covered individual's accident and sickness insurance policy.

~~(c) In an external grievance described in section 12(1)(D) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or~~

~~treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).~~

~~(d)~~ **(c)** The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours after the external grievance is filed; and

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

SECTION 43. IC 27-8-29-15.5, AS ADDED BY P.L.173-2007, SECTION 42, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 15.5. Upon the request of a covered individual who is notified under section ~~15(d)~~ **15(c)** of this chapter that the independent review organization has made a determination, the independent review organization shall provide to the covered individual all information reasonably necessary to enable the covered individual to understand the:

(1) effect of the determination on the covered individual; and

(2) manner in which the insurer may be expected to respond to the determination.".

Page 31, line 10, delete "Status".

Page 31, line 11, after "1." insert "**This chapter applies:**

(1) beginning twelve (12) months after the date on which the provisions of the federal Patient Protection and Affordable Care Act (as defined in IC 4-1-21-1) described in IC 4-1-12-5(b) are repealed or are otherwise no longer in effect; and

(2) to an individual contract, or a group contract, that provides coverage for basic health care services.

Sec. 2.".

Page 31, line 14, delete "2." and insert "**3.**".

Page 31, line 16, delete "3." and insert "**4.**".
Page 31, line 21, delete "4." and insert "**5.**".
Page 32, delete lines 4 through 11.
Renumber all SECTIONS consecutively.

(Reference is to ESB 392 as printed April 5, 2019.)

CARBAUGH

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 392 be amended to read as follows:

Page 3, between lines 11 and 12, begin a new paragraph and insert:

"SECTION 4. IC 12-15-1.3-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 21. (a) As used in this section, "Medicaid rehabilitation option services" means clinical behavioral health services provided to recipients and families of recipients living in the community who need aid intermittently for emotional disturbances, mental illness, and addiction as part of the Medicaid rehabilitation option program.**

(b) Before December 1, 2019, the office may apply to the United States Department of Health and Human Services for a state plan amendment that would require Medicaid reimbursement by:

(1) the office;

(2) a managed care organization that has contracted with the office; or

(3) a contractor of the office;

for eligible Medicaid rehabilitation option services in a school setting for any Medicaid recipient who qualifies for Medicaid rehabilitation option services by meeting specific diagnosis and level of need criteria under an assessment tool approved by the division of mental health and addiction or who submits prior authorization for Medicaid rehabilitation option services.

(c) If the office receives approval for the state plan amendment applied for under this section, the office shall comply with IC 12-15-5-19.

SECTION 5. IC 12-15-5-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 19. (a) Not later than one (1) year from the date the**

office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall do the following:

(1) Review the current services included in the Medicaid rehabilitation option services program in the school setting.

(2) Determine whether additional appropriate services, including:

(A) family engagement services; and

(B) additional comprehensive behavioral health services, including addiction services;

should be included as part of the program.

(3) Report the office's findings under this subsection to the general assembly in an electronic format under IC 5-14-6.

(b) Not later than three (3) months from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall notify each school corporation that the United States Department of Health and Human Services has approved the state plan amendment applied for under IC 12-15-1.3-21.

(c) Each school corporation shall, not later than one (1) year from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, contract with a community mental health center to provide Medicaid rehabilitation option services for:

(1) a student of the school corporation who is a Medicaid recipient; and

(2) the student's family.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 392 as printed April 5, 2019.)

CLERE