Reprinted
February 27, 2008

ENGROSSED
HOUSE BILL No. 1284

DIGEST OF HB 1284 (Updated February 26, 2008 5:46 pm - DI 104)

Citations Affected: IC 27-1; IC 27-8; IC 27-13; noncode.

Synopsis: Insurance. Exempts a commissioner of insurance request for certain information from the requirement to issue an examination warrant. Permits a group life insurance policy to cover a spouse or dependent child for more than 50% of the amount provided for the insured. Revises the accident and sickness insurance form filing requirements concerning commissioner actions. Prohibits an accident and sickness insurer and a health maintenance organization from requiring a patient to travel more than 30 miles from home for dialysis treatment coverage. Requires certain reporting to the health finance commission.

Effective: Upon passage; July 1, 2008.

Fry, Ripley

(SENATE SPONSOR — PAUL)

January 15, 2008, read first time and referred to Committee on Insurance.
January 24, 2008, amended, reported — Do Pass.
January 28, 2008, read second time, ordered engrossed. Engrossed.
January 30, 2008, read third time, passed. Yeas 65, nays 26.

SENATE ACTION

February 5, 2008, read first time and referred to Committee on Insurance and Financial Institutions.
February 18, 2008, amended, reported favorably — Do Pass.
February 26, 2008, read second time, amended, ordered engrossed.

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Reprinted
February 27, 2008

Second Regular Session 115th General Assembly (2008)

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 2007 Regular Session of the General Assembly.

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ENGROSSED
HOUSE BILL No. 1284

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

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

SECTION 1. IC 27-1-3.1-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 9. (a) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the NAIC examiner's handbook. The commissioner may also employ such other guidelines or procedures as the commissioner considers appropriate. **The commissioner is not required to issue an examination warrant for a data call.**

(b) Every company or person from whom information is sought, and the officers, directors, and agents of the company or person, must provide to the examiners appointed under subsection (a) timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer

1 or other recordings relating to the property, assets, business, and affairs
2 of the company being examined. The officers, directors, employees,
3 and agents of the company or person must facilitate the examination
4 and aid in the examination so far as it is in their power to do so. The
5 refusal of any company, by its officers, directors, employees, or agents
6 within the company's control, to submit to examination or to comply
7 with any reasonable written request of the examiners, or the failure of
8 any company to make a good faith effort to require compliance with
9 such a request, is grounds for:
10 (1) suspension;
11 (2) refusal; or
12 (3) nonrenewal;
13 of any license or authority held by the company to engage in an
14 insurance or other business subject to the commissioner's jurisdiction.
15 The commissioner may proceed to suspend or revoke a license or
16 authority upon the grounds set forth in this subsection under
17 IC 27-1-3-10 or IC 27-1-3-19.
18 (c) The commissioner and the commissioner's examiners may issue
19 subpoenas, administer oaths, and examine under oath any person as to
20 any matter pertinent to an examination conducted under this chapter.
21 Upon the failure or refusal of any person to obey a subpoena, the
22 commissioner may petition a court of competent jurisdiction, and upon
23 proper showing, the court may enter any order compelling the witness
24 to appear and testify or produce documentary evidence. Failure to obey
25 the court order is punishable as contempt of court.
26 (d) When making an examination under this chapter, the
27 commissioner may retain attorneys, appraisers, independent actuaries,
28 independent certified public accountants, or other professionals and
29 specialists as examiners. The cost of retaining these examiners shall be
30 borne by the company that is the subject of the examination.
31 (e) This chapter does not limit the commissioner's authority to
32 terminate or suspend any examination in order to pursue other legal or
33 regulatory action pursuant to this title. Findings of fact and conclusions
34 made pursuant to any examination shall be prima facie evidence in any
35 legal or regulatory action.
36 SECTION 2. IC 27-1-12-40 IS AMENDED TO READ AS
37 FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 40. Except for a policy
38 that conforms to the description in section 37(2) of this chapter, a
39 group life insurance policy may be extended to insure the employees
40 or members, or any class or classes of employees or members, against
41 loss due to the death of their spouses and dependent children, subject
42 to the following:

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(1) The premium for the insurance must be paid either from funds contributed by the employer, union, association, or other person to whom the policy has been issued, from funds contributed by the covered persons, or from both sources of funds. Except as provided in subdivision (2), a policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members, or any class or classes of eligible employees or members, with respect to their spouses and dependent children.

(2) An insurer may exclude or limit the coverage on any spouse or dependent child as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(3) The amounts of insurance for any covered spouse or dependent child under the policy may not exceed fifty percent (50%) of the amount of insurance for which the employee or member is insured.~~

SECTION 3. IC 27-8-5-1.5, AS ADDED BY P.L.173-2007, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or a fraternal benefit society.

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

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

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

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

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

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

(f) Each person having a role in the filing process described in

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

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

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

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

(A) approve the resubmitted policy form; or

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

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

(5) If the commissioner disapproves a policy form filing under this subsection, the commissioner shall notify the filer, in writing, of the filer's right to a hearing as described in subsection (m). ~~The~~ **A disapproved** policy form **filing** may not be ~~disapproved~~ **used for a policy of accident and sickness insurance** unless ~~it contains a material error or omission. At any~~ **the disapproval is overturned in a** hearing conducted under this subsection. ~~the commissioner must prove that the policy form contains a material error or omission.~~

(6) If the commissioner does not take any action on a policy

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1 **form that is filed or resubmitted under this subsection in**
2 **accordance with any applicable period specified in subdivision**
3 **(2), (3), or (4), the policy form filing is considered to be**
4 **approved.**
5 (j) Except as provided in this subsection, the commissioner may not
6 disapprove a policy form resubmitted under subsection (i)(3) or (i)(4)
7 for a reason other than a reason specified in the original notice of
8 determination under subsection (i)(2)(B). The commissioner may
9 disapprove a resubmitted policy form for a reason other than a reason
10 specified in the original notice of determination under subsection (i)(2)
11 if:
12 (1) the filer has introduced a new provision in the resubmission;
13 (2) the filer has materially modified a substantive provision of the
14 policy form in the resubmission;
15 (3) there has been a change in requirements applying to the policy
16 form; or
17 (4) there has been reviewer error and the written disapproval fails
18 to state a specific requirement with which the policy form does
19 not comply.
20 (k) The commissioner may return a grossly inadequate filing to the
21 filer without triggering a deadline set forth in this section.
22 (l) The commissioner may disapprove a policy form if:
23 (1) the benefits provided under the policy form are not reasonable
24 in relation to the premium charged; or
25 (2) the policy form contains provisions that are unjust, unfair,
26 inequitable, misleading, or deceptive, or that encourage
27 misrepresentation of the policy.
28 (m) Upon disapproval of a filing under this section, the
29 commissioner shall provide written notice to the filer or insurer of the
30 right to a hearing within twenty (20) days of a request for a hearing.
31 (n) Unless a policy form approved under this chapter contains a
32 material error or omission, the commissioner may not:
33 (1) retroactively disapprove the policy form; or
34 (2) examine the filer of the policy form during a routine or
35 targeted market conduct examination for compliance with a policy
36 form filing requirement that was not in existence at the time the
37 policy form was filed.
38 SECTION 4. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE
39 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE
40 UPON PASSAGE]: **Sec. 10. (a) As used in this section, "dialysis**
41 **facility" means an outpatient facility in Indiana at which a dialysis**
42 **treatment provider provides dialysis treatment.**

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1 **(b) As used in this section, “contracted dialysis facility" means**
2 **a dialysis facility that has entered into an agreement with a**
3 **particular insurer under section 3 of this chapter.**
4 **(c) Notwithstanding section 1 of this chapter, as used in this**
5 **section, "insured" refers only to an insured who requires dialysis**
6 **treatment.**
7 **(d) As used in this section, "insurer" includes the following:**
8 **(1) An administrator licensed under IC 27-1-25.**
9 **(2) An agent of an insurer.**
10 **(e) As used in this section, “non-contracted dialysis facility"**
11 **means a dialysis facility that has not entered into an agreement**
12 **with a particular insurer under section 3 of this chapter.**
13 **(f) An insurer shall not require an insured, as a condition of**
14 **coverage, to travel more than thirty (30) miles from the insured's**
15 **home to obtain dialysis treatment, regardless of whether the**
16 **insured chooses to receive dialysis treatment at a contracted**
17 **dialysis facility or a non-contracted dialysis facility.**
18 SECTION 5. IC 27-13-1-11.5 IS ADDED TO THE INDIANA
19 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
20 [EFFECTIVE UPON PASSAGE]: **Sec. 11.5. "Dialysis facility"**
21 **means an outpatient facility in Indiana at which a dialysis**
22 **treatment provider provides dialysis treatment.**
23 SECTION 6. IC 27-13-15-5 IS ADDED TO THE INDIANA CODE
24 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE
25 UPON PASSAGE]: **Sec. 5. (a) Notwithstanding IC 27-13-1-12, as**
26 **used in this section, "enrollee" refers only to an enrollee who**
27 **requires dialysis treatment.**
28 **(b) As used in this section, "health maintenance organization"**
29 **includes the following:**
30 **(1) A limited service health maintenance organization.**
31 **(2) An agent of a health maintenance organization or a limited**
32 **service health maintenance organization.**
33 **(c) A health maintenance organization shall not require an**
34 **enrollee, as a condition of coverage, to travel more than thirty (30)**
35 **miles from the enrollee's home to obtain dialysis treatment,**
36 **regardless of whether the enrollee chooses to receive dialysis**
37 **treatment at a dialysis facility that is a participating provider or a**
38 **dialysis facility that is not a participating provider.**
39 SECTION 7. [EFFECTIVE JULY 1, 2008] **(a) As used in this**
40 **SECTION, "commission" refers to the health finance commission**
41 **established by IC 2-5-23-3.**
42 **(b) As used in this SECTION, "taxpayer" means an individual**

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1 **or entity that has state tax liability.**
2 **(c) Not later than September 1 of each year, the department of**
3 **state revenue shall submit a written report in an electronic format**
4 **under IC 5-14-6 to the commission with the following information,**
5 **if possible, concerning the health benefit tax credit provided under**
6 **IC 6-3.1-31:**
7 **(1) The number of taxpayers that have taken:**
8 **(A) the first year credit; and**
9 **(B) the second year credit;**
10 **in the previous taxable year.**
11 **(2) The amount of each credit taken.**
12 **(3) The amount of any carryover credit.**
13 **(4) Any other information the department of state revenue**
14 **determines is relevant.**
15 **(d) This SECTION expires December 31, 2010.**
16 SECTION 8. [EFFECTIVE JULY 1, 2008] **(a) As used in this**
17 **SECTION, "commission" refers to the health finance commission**
18 **established by IC 2-5-23-3.**
19 **(b) As used in this SECTION, "program" refers to the Indiana**
20 **check-up plan established by IC 12-15-44-3.**
21 **(c) Not later than September 1 of each year, the office of the**
22 **secretary of family and social services shall report the following**
23 **information concerning the program to the commission:**
24 **(1) An update on the implementation of the program.**
25 **(2) The number of individuals who have applied for the**
26 **program.**
27 **(3) The number of individuals participating in the program.**
28 **(4) The federal income level of individuals participating in the**
29 **program.**
30 **(5) Any other information the office of the secretary**
31 **determines is relevant.**
32 **(d) This SECTION expires December 31, 2010.**
33 SECTION 9. **An emergency is declared for this act.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1284, 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 27-1-3.1-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 9. (a) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the NAIC examiner's handbook. The commissioner may also employ such other guidelines or procedures as the commissioner considers appropriate. **The commissioner is not required to issue an examination warrant for a data call.**

(b) Every company or person from whom information is sought, and the officers, directors, and agents of the company or person, must provide to the examiners appointed under subsection (a) timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents within the company's control, to submit to examination or to comply with any reasonable written request of the examiners, or the failure of any company to make a good faith effort to require compliance with such a request, is grounds for:

(1) suspension;
(2) refusal; or
(3) nonrenewal;

of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. The commissioner may proceed to suspend or revoke a license or authority upon the grounds set forth in this subsection under IC 27-1-3-10 or IC 27-1-3-19.

(c) The commissioner and the commissioner's examiners may issue

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subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to an examination conducted under this chapter. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter any order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(d) When making an examination under this chapter, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of retaining these examiners shall be borne by the company that is the subject of the examination.

(e) This chapter does not limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to this title. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.".

Page 1, line 3, delete "subsection (b)," and insert "**subsections (b) and (c),**".

Page 1, after line 17, begin a new paragraph and insert:

"**(c) An insurer shall not issue the following on a group basis:**

(1) A personal policy that insures loss of or damage to:

(A) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(B) personal property:

(i) in which the named insured has an insurable interest; and

(ii) that is used within a residential dwelling for personal, family, or household purposes.

(2) A personal policy that provides any type of insurance described in IC 27-1-5-1, Class 2(f).

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

SECTION 3. IC 27-1-12-40 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 40. Except for a policy that conforms to the description in section 37(2) of this chapter, a group life insurance policy may be extended to insure the employees or members, or any class or classes of employees or members, against loss due to the death of their spouses and dependent children, subject to the following:

(1) The premium for the insurance must be paid either from funds

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contributed by the employer, union, association, or other person to whom the policy has been issued, from funds contributed by the covered persons, or from both sources of funds. Except as provided in subdivision (2), a policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members, or any class or classes of eligible employees or members, with respect to their spouses and dependent children.

(2) An insurer may exclude or limit the coverage on any spouse or dependent child as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(3) The amounts of insurance for any covered spouse or dependent child under the policy may not exceed fifty percent (50%) of the amount of insurance for which the employee or member is insured.~~

SECTION 4. IC 27-8-5-1.5, AS ADDED BY P.L.173-2007, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or a fraternal benefit society.

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

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

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

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

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

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

(f) Each person having a role in the filing process described in subsection (i) shall act in good faith and with due diligence in the

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performance of the person's duties.

(g) A policy form may not be issued or delivered in Indiana unless the policy form has been filed with and approved by the commissioner.

(h) The commissioner shall do the following:

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

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

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

(i) The filing process is as follows:

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

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

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

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

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

(A) approve the filing; or

(B) provide written notice of a determination:

(i) that deficiencies exist in the filing; or

(ii) that the commissioner disapproves the filing.

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

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

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

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

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revised.

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

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

(A) approve the resubmitted policy form; or

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

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

(5) If the commissioner disapproves a policy form filing under this subsection, the commissioner shall notify the filer, in writing, of the filer's right to a hearing as described in subsection (m). ~~The~~ **A disapproved** policy form **filing** may not be ~~disapproved~~ **used for a policy of accident and sickness insurance** unless ~~it contains a material error or omission. At any~~ **the disapproval is overturned in a** hearing conducted under this subsection. ~~the commissioner must prove that the policy form contains a material error or omission.~~

(6) If the commissioner does not take any action on a policy form that is filed or resubmitted under this subsection in

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accordance with any applicable period specified in subdivision (2), (3), or (4), the policy form filing is considered to be approved.

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

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

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

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

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

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

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

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

SECTION 5. IC 27-8-5-2, AS AMENDED BY P.L.218-2007, SECTION 45, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are

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expressed in the policy.
(2) The time at which the insurance takes effect and terminates is expressed in the policy.
(3) The policy purports to insure only one (1) person, except that a policy must insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children who are less than twenty-four (24) years of age, and any other person dependent upon the policyholder.
(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).
(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.
(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.
(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.
(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a

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dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

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

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a child who has mental retardation or a mental or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

(d) An insurer shall, for purposes of coverage of a child who is less than twenty-four (24) years of age and not dependent on the policyholder as described in subsection (a)(3), do all of the following:

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(1) Provide to each policyholder at the time of application, amendment, or renewal of a policy of accident and sickness insurance written notice that:

(A) is provided in a document that is separate from any other document provided to the policyholder; and

(B) clearly explains:

(i) that a child who is less than twenty-four (24) years of age and not dependent on the policyholder will be covered upon the request of the policyholder; and

(ii) the manner and form in which the policyholder must request the coverage.

(2) Allow at least thirty (30) days after a policyholder receives the notice required by subdivision (1) for the policyholder to make a request for the coverage.

(3) Immediately provide the coverage to the individual for whom a request for coverage is made, without any limitation or exclusion of coverage related to a preexisting condition.

SECTION 6. IC 27-8-5-28, AS ADDED BY P.L.218-2007, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 28. **(a)** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-four (24) years of age.

(b) An insurer shall, for purposes of coverage of a child under subsection (a), do all of the following:

(1) Provide to each policyholder or certificate holder at the time of application, amendment, or renewal of a policy of accident and sickness insurance written notice that:

(A) is provided in a document that is separate from any other document provided to the policyholder or certificate holder; and

(B) clearly explains:

(i) that a child who is less than twenty-four (24) years of age will be covered upon the request of the policyholder or certificate holder; and

(ii) the manner and form in which the policyholder or certificate holder must request the coverage.

(2) Allow at least thirty (30) days after a policyholder or certificate holder receives the notice required by subdivision (1) for the policyholder or certificate holder to make a request for the coverage.

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(3) Immediately provide the coverage to the child for whom a request for coverage is made, without any:
(A) limitation or exclusion of coverage related to a preexisting condition; or
(B) requirement that the child:
(i) wait for an open enrollment period; or
(ii) be otherwise treated as a late enrollee (as defined in 26 U.S.C. 9801(b)(3)).

SECTION 7. IC 27-13-7-3, AS AMENDED BY P.L.218-2007, SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:
(1) The name and address of the health maintenance organization.
(2) Eligibility requirements.
(3) Benefits and services within the service area.
(4) Emergency care benefits and services.
(5) Any out-of-area benefits and services.
(6) Copayments, deductibles, and other out-of-pocket costs.
(7) Limitations and exclusions.
(8) Enrollee termination provisions.
(9) Any enrollee reinstatement provisions.
(10) Claims procedures.
(11) Enrollee grievance procedures.
(12) Continuation of coverage provisions.
(13) Conversion provisions.
(14) Extension of benefit provisions.
(15) Coordination of benefit provisions.
(16) Any subrogation provisions.
(17) A description of the service area.
(18) The entire contract provisions.
(19) The term of the coverage provided by the contract.
(20) Any right of cancellation of the group or individual contract holder.
(21) Right of renewal provisions.
(22) Provisions regarding reinstatement of a group or an individual contract holder.
(23) Grace period provisions.
(24) A provision on conformity with state law.
(25) A provision or provisions that comply with the:
(A) guaranteed renewability; and
(B) group portability;
requirements of the federal Health Insurance Portability and

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Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the date the child becomes twenty-four (24) years of age.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

(c) A health maintenance organization shall, for purposes of coverage of a child as described in subsection (a)(26), do all of the following:

(1) Provide to each subscriber at the time of application, amendment, or renewal of an individual contract or a group contract written notice that:

(A) is provided in a document that is separate from any other document provided to the subscriber; and

(B) clearly explains:

(i) that a child who is less than twenty-four (24) years of age will be covered upon the request of the subscriber; and

(ii) the manner and form in which the subscriber must request the coverage.

(2) Allow at least thirty (30) days after a subscriber receives the notice required by subdivision (1) for the subscriber to make a request for the coverage.

(3) Immediately provide the coverage to the child for whom a request for coverage is made, without any:

(A) limitation or exclusion of coverage related to a preexisting condition; or

(B) requirement that the child:

(i) wait for an open enrollment period; or

(ii) be otherwise treated as a late enrollee (as defined in 26 U.S.C. 9801(b)(3)).".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1284 as introduced.)

FRY, Chair

Committee Vote: yeas 9, nays 0.

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COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred House Bill No. 1284, 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, delete lines 36 through 42.

Page 3, delete lines 1 through 24.

Page 7, delete lines 27 through 42.

Delete pages 8 through 12.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1284 as printed January 25, 2008.)

PAUL, Chairperson

Committee Vote: Yeas 9, Nays 0.

SENATE MOTION

Madam President: I move that Engrossed House Bill 1284 be amended to read as follows:

Page 6, after line 37, begin a new paragraph and insert:

"SECTION 4. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 10. (a) As used in this section, "dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.**

(b) As used in this section, "contracted dialysis facility" means a dialysis facility that has entered into an agreement with a particular insurer under section 3 of this chapter.

(c) Notwithstanding section 1 of this chapter, as used in this section, "insured" refers only to an insured who requires dialysis treatment.

(d) As used in this section, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.

(2) An agent of an insurer.

(e) As used in this section, "non-contracted dialysis facility" means a dialysis facility that has not entered into an agreement with a particular insurer under section 3 of this chapter.

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(f) An insurer shall not require an insured, as a condition of coverage, to travel more than thirty (30) miles from the insured's home to obtain dialysis treatment, regardless of whether the insured chooses to receive dialysis treatment at a contracted dialysis facility or a non-contracted dialysis facility.

SECTION 5. IC 27-13-1-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11.5. "Dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.**

SECTION 6. IC 27-13-15-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. (a) Notwithstanding IC 27-13-1-12, as used in this section, "enrollee" refers only to an enrollee who requires dialysis treatment.**

(b) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) An agent of a health maintenance organization or a limited service health maintenance organization.

(c) A health maintenance organization shall not require an enrollee, as a condition of coverage, to travel more than thirty (30) miles from the enrollee's home to obtain dialysis treatment, regardless of whether the enrollee chooses to receive dialysis treatment at a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

SECTION 7. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1284 as printed February 19, 2008.)

BECKER

SENATE MOTION

Madam President: I move that Engrossed House Bill 1284 be amended to read as follows:

Delete the title and insert the following:

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

Page 6, after line 37, begin a new paragraph and insert:

"SECTION 3. [EFFECTIVE JULY 1, 2008] **(a) As used in this**

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SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.

(b) As used in this SECTION, "taxpayer" means an individual or entity that has state tax liability.

(c) Not later than September 1 of each year, the department of state revenue shall submit a written report in an electronic format under IC 5-14-6 to the commission with the following information, if possible, concerning the health benefit tax credit provided under IC 6-3.1-31:

(1) The number of taxpayers that have taken:

(A) the first year credit; and

(B) the second year credit;

in the previous taxable year.

(2) The amount of each credit taken.

(3) The amount of any carryover credit.

(4) Any other information the department of state revenue determines is relevant.

(d) This SECTION expires December 31, 2010.

SECTION 4. [EFFECTIVE JULY 1, 2008] **(a) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.**

(b) As used in this SECTION, "program" refers to the Indiana check-up plan established by IC 12-15-44-3.

(c) Not later than September 1 of each year, the office of the secretary of family and social services shall report the following information concerning the program to the commission:

(1) An update on the implementation of the program.

(2) The number of individuals who have applied for the program.

(3) The number of individuals participating in the program.

(4) The federal income level of individuals participating in the program.

(5) Any other information the office of the secretary determines is relevant.

(d) This SECTION expires December 31, 2010.".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1284 as printed February 19, 2008.)

DILLON

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