PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

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of the federal Patient Protection and Affordable Care Act (as defined in IC 4-1-21-1) described in IC 4-1-12-5(b) are repealed or are otherwise no longer in effect.**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(c) (expired July 1, 2007, and removed), IC 27-8-5-2.7, IC 27-8-5-19.2(c) (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(c) (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(c) (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(c) (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.)

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Representative Carbaugh