Second Regular Session of the 122nd General Assembly (2022)

HOUSE ENROLLED ACT No. 1238

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 25-1-9-23, AS AMENDED BY P.L.202-2021, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 23. (a) This section does not apply to emergency services.

(b) As used in this section, "covered individual" means an individual who is entitled to be provided health care services at a cost established according to a network plan.

(c) As used in this section, "emergency services" means services that are:

(1) furnished by a provider qualified to furnish emergency services; and

(2) needed to evaluate or stabilize an emergency medical condition.

(d) As used in this section, "in network practitioner" means a practitioner who is required under a network plan to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

(e) As used in this section, "network plan" means a plan under which facilities and practitioners are required by contract to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

(f) As used in this section, "out of network" means that the health

care services provided by the practitioner to a covered individual are not subject to the covered individual's health carrier network plan.

(g) As used in this section, "practitioner" means the following:

(1) An individual who holds:

(A) an unlimited license, certificate, or registration;

(B) a limited or probationary license, certificate, or registration;

(C) a temporary license, certificate, registration, or permit;

(D) an intern permit; or

(E) a provisional license;

issued by the board (as defined in IC 25-0.5-11-1) regulating the profession in question.

(2) An entity that:

(A) is owned by, or employs; or

(B) performs billing for professional health care services rendered by;

an individual described in subdivision (1).

The term does not include a dentist licensed under IC 25-14, an optometrist licensed under IC 25-24, or a provider facility (as defined in IC 25-1-9.8-10).

(h) An in network practitioner who provides covered health care services to a covered individual may not charge more for the covered health care services than allowed according to the rate or amount of compensation established by the individual's network plan.

~~(i) This subsection is effective beginning January 1, 2022. Except as provided in subsection (n), a practitioner shall comply with the requirements set forth in Section 2799B-6 of the Public Health Service Act, as added by Public Law 116-260.~~

~~(j)~~ **(i)** An out of network practitioner who provides health care services at an in network facility to a covered individual may not be reimbursed more for the health care services than allowed according to the rate or amount of compensation established by the covered individual's network plan unless all of the following conditions are met:

(1) At least five (5) business days before the health care services are scheduled to be provided to the covered individual, the practitioner provides to the covered individual, on a form separate from any other form provided to the covered individual by the practitioner, a statement in conspicuous type that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of practitioner] is an out of network practitioner providing [type of care] with [name of in network facility], which is an

in network provider facility within your health carrier's plan. [Name of practitioner] will not be allowed to bill you the difference between the price charged by the practitioner and the rate your health carrier will reimburse for the services during your care at [name of in network facility] unless you give your written consent to the charge.".

(B) Sets forth the practitioner's good faith estimate of the amount that the practitioner intends to charge for the health care services provided to the covered individual.

(C) Includes a notice reading substantially as follows concerning the good faith estimate set forth under clause (B): "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate of the amount we will charge. If our actual charge for [name or description of health care services] exceeds our estimate by the greater of:

(i) one hundred dollars ($100); or

(ii) five percent (5%);

we will explain to you why the charge exceeds the estimate.".

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

~~(k)~~ **(j)** If an out of network practitioner does not meet the requirements of subsection ~~(j),~~ **(i),** the out of network practitioner shall include on any bill remitted to a covered individual a written statement in conspicuous type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

~~(l)~~ **(k)** If a covered individual's network plan remits reimbursement to the covered individual for health care services subject to the reimbursement limitation of subsection ~~(j),~~ **(i),** the network plan shall provide with the reimbursement a written statement in conspicuous type that states that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan and that is included in the reimbursement plus any required copayment, deductible, or coinsurance.

~~(m)~~ **(l)** If the charge of a practitioner for health care services provided to a covered individual exceeds the estimate provided to the covered individual under subsection ~~(j)(1)(B)~~ **(i)(1)(B)** by the greater

of:

(1) one hundred dollars ($100); or

(2) five percent (5%);

the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

~~(m)~~ **(m)** An in network practitioner is not required to provide a covered individual with the good faith estimate ~~required under subsection (i)~~ if the nonemergency health care service is scheduled to be performed by the practitioner within five (5) business days after the health care service is ordered.

~~(o)~~ **(n)** The department of insurance shall adopt emergency rules under IC 4-22-2-37.1 to specify the requirements of the notifications set forth in subsections ~~(k)~~ **(j)** and ~~(l).~~ **(k).**

(o) A practitioner may satisfy the requirements of this section by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.

SECTION 2. IC 25-1-9.8-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 20. A practitioner may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 3. IC 27-1-12.5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 3. (a) The minimum values as specified in sections 4, 5, 6, 7, and 9 of this chapter of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(b) With respect to any annuity contract, the minimum nonforfeiture amounts at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at an annual rate of interest determined under subsections (d) and (e) of the net considerations as set forth in subsection (c) paid prior to such time, decreased by the sum of the following:

(1) Any prior withdrawals from or partial surrenders of the annuity contract accumulated at an annual rate of interest determined under subsections (d) and (e).

(2) The amount of any indebtedness to the company on the annuity contract, including interest due and accrued.

(3) An annual contract charge of fifty dollars ($50), accumulated at the annual rate of interest determined under subsections (d) and

(e).

(c) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the annuity contract during that contract year.

(d) Except as provided in subsection (e), the interest rate used in determining minimum nonforfeiture amounts is an annual rate of interest determined under either of the following methods:

(1) The five-year constant maturity treasury rate, rounded to the nearest five-hundredths of one percent (0.05%), as reported by the Federal Reserve as of a date specified in the annuity contract. Reduce this amount by one hundred twenty-five (125) basis points.

(2) An average of the five-year constant maturity treasury rate as reported by the Federal Reserve, rounded to the nearest five-hundredths of one percent (0.05%), over a specified period as set forth in the annuity contract. Reduce this amount by one hundred twenty-five (125) basis points.

The date under subdivision (1) or the average period used under subdivision (2) may not be longer than fifteen (15) months before the annuity contract issue date or the redetermination date as determined under subsection (f).

(e) If the rate of interest determined under subsection (d) is:

(1) less than one percent (1%), the interest rate used in determining minimum nonforfeiture amounts is **fifteen one-hundredths of** one percent ~~(1%),~~ **(0.15%);** or

(2) greater than three percent (3%), the interest rate used in determining minimum nonforfeiture amounts is three percent (3%).

(f) The interest rate determined under subsections (d) and (e) applies for an initial period and may be redetermined for subsequent periods. The redetermination date, basis, and period, if any, must be specified in the annuity contract. The basis is:

(1) the date; or

(2) an average calculated over a specified period;

that produces the value of the five-year constant maturity treasury rate reported by the Federal Reserve to be used at each redetermination date.

(g) During the period or term that an annuity contract provides substantive participation in an equity index benefit, the contract may increase the basis point reduction described in subsection (d) by not more than an additional one hundred (100) basis points to reflect the

value of the equity index benefit. The present value at the annuity contract issue date, and at each redetermination date after the annuity contract issue date, of the additional reduction may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. If the demonstration is not acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

(h) The commissioner may adopt rules under IC 4-22-2 to provide for further adjustments to the calculation of minimum nonforfeiture amounts for:

(1) annuity contracts that provide participation in an equity index benefit; and

(2) other annuity contracts for which the commissioner determines adjustments are justified.

SECTION 4. IC 27-1-15.7-2, AS AMENDED BY P.L.196-2021, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 2. (a) Except as provided in subsection (b), to renew a license issued under IC 27-1-15.6, a resident insurance producer must complete at least twenty-four (24) hours of credit in continuing education courses, not more than four (4) hours of which may be in courses concerning one (1) or a combination of the following:

(1) Sales promotion.

(2) Sales technique.

(3) Motivation.

(4) Psychology.

(5) Time management.

If the insurance producer has a qualification described in IC 27-1-15.6-7(a)(1), IC 27-1-15.6-7(a)(2), or IC 27-1-15.6-7(a)(5), for a license renewal that occurs after June 30, 2014, at least three (3) of the hours of credit required by this subsection must be related to ethical practices in the marketing and sale of life, health, or annuity insurance products. An attorney in good standing who is admitted to the practice of law in Indiana and holds a license issued under IC 27-1-15.6 may complete all or any number of hours of continuing education required by this subsection by completing an equivalent number of hours in continuing legal education courses that are related to the business of insurance.

(b) Except as provided in subsection (c), to renew a license issued under IC 27-1-15.6, a limited lines producer with a title qualification under IC 27-1-15.6-7(a)(8) must complete at least seven (7) hours of

credit in continuing education courses related to the business of title insurance, ~~with at least one (1) hour of instruction~~ in a structured setting or comparable self-study, in ~~each~~ **any** of the following **or any combination of the following:**

(1) Ethical practices in the marketing and selling of title insurance, **including provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act set forth in 12 U.S.C. 2608.**

(2) Title insurance underwriting.

(3) Escrow ~~issues.~~ **matters.**

(4) ~~Principles of the federal Real Estate Settlement Procedures Act (12 U.S.C. 2608).~~ **Matters concerning regulation by the department.**

(5) Any other topic related to the marketing and selling of title insurance.

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

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

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

(2) A limited line credit insurance producer.

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

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

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

(d) Except as provided in section 2.2 of this chapter, to satisfy the requirements of subsection (a) or (b), a licensee may use only those credit hours earned in continuing education courses completed by the licensee:

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

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

(e) If an insurance producer receives qualification for a license in

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

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

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

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

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

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

(1) a continuing education statement that:

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

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

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

(2) any other information required by the commissioner.

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

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

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

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

(2) is held in a classroom setting; and

(3) concerns ethics;

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

SECTION 5. IC 27-1-30.4 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]:

Chapter 30.4. Group Property and Casualty Insurance for Permitted Groups

Sec. 1. As used in this chapter, "permitted group" means a group of ten (10) or more commercial, business, or not-for-profit entities that have a preexisting relationship to one another

through:

(1) a common trade;

(2) an association;

(3) an affiliation; or

(4) another organizational relationship that is separate and distinct from any group insurance arrangement of the group.

Sec. 2. As used in this chapter, "property and casualty insurance" means one (1) or more of the types of insurance described in IC 27-1-5-1, Class 2 and Class 3.

Sec. 3. As used in this chapter, "property and casualty insurance company" means a company authorized to make one (1) or more types of property or casualty insurance.

Sec. 4. (a) An insurer authorized under IC 27-1-3-20 to transact business as a property and casualty insurance company may provide property and casualty insurance to a permitted group on a group basis.

(b) A policy may not be issued or renewed to provide group coverage under this chapter to a group that includes fewer than ten (10) commercial, business, or not-for-profit entities as part of the group.

Sec. 5. The commissioner may adopt rules under IC 4-22-2 to implement and administer this chapter.

SECTION 6. IC 27-1-44.5-2, AS AMENDED BY P.L.195-2021, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. As used in this chapter, "health payer" includes the following:

(1) Medicare.

(2) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that has contracted with Medicaid to provide services to a Medicaid recipient.

(3) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:

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

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

(C) Automobile medical payment insurance.

(D) A specified disease policy.

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

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

(ii) gaps for deductibles or copayments.

(F) Worker's compensation or similar insurance.

(G) A student health plan.

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

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

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

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

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).

(6) An administrator (as defined in IC 27-1-25-1).

(7) A multiple employer welfare arrangement (as defined in IC 27-1-34-1).

~~(7)~~ **(8)** Any other person identified by the commissioner for participation in the data base described in this chapter.

SECTION 7. IC 27-1-45-7, AS AMENDED BY P.L.202-2021, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 7. (a) This section is effective beginning January 1, 2022.

~~(b) Except as provided in subsection (c), a:~~

~~(1) facility; and~~

~~(2) practitioner;~~

~~shall comply with the requirements of Section 2799B-6 of the Public Health Service Act, as added by Public Law 116-260.~~

~~(c)~~ **(b)** A facility or a practitioner is not required to provide the good faith estimate ~~required in subsection (b)~~ if the health care service to be provided to the covered individual is scheduled to be performed within five (5) business days after the health care service is ordered.

SECTION 8. IC 27-1-45-8, AS AMENDED BY P.L.202-2021, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 8. (a) An out of network practitioner who provides health care services at an in network facility to a covered individual may not be reimbursed more for the health care services than allowed according to the rate or amount of compensation established by the covered individual's network plan as described in subsection (b) unless all of the following conditions are met:

(1) At least five (5) business days before the health care service is scheduled to be provided to the covered individual, the facility or practitioner provides to the covered individual, on a form

separate from any other form provided to the covered individual by the facility or practitioner, a statement in conspicuous type that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of facility or practitioner] is an out of network practitioner providing [type of care], with [name of in network facility], which is an in network provider facility within your health carrier's plan. [Name of facility or practitioner] will not be allowed to bill you the difference between the price charged for the services and the rate your health carrier will reimburse for the services during your care at [name of in network facility] unless you give your written consent to the charge.".

(B) Sets forth the facility's or practitioner's good faith estimate of the established fee for the health care services provided to the covered individual.

(C) Includes a notice reading substantially as follows concerning the good faith estimate set forth under clause (B): "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate of the amount we will charge. If the actual charge for [name or description of health care services] exceeds our estimate by the greater of:

(i) one hundred dollars ($100); or

(ii) five percent (5%);

we will explain to you why the charge exceeds the estimate.".

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

(b) If an out of network practitioner does not meet the requirements of subsection (a), the out of network practitioner shall include on any bill remitted to a covered individual a written statement in conspicuous type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

(c) If a covered individual's network plan remits reimbursement to the covered individual for health care services that did not meet the requirements of subsection (a), the network plan shall provide with the reimbursement a written statement in conspicuous type that states that the covered individual is not responsible for more than the rate or

amount of compensation established by the covered individual's network plan and that is included in the reimbursement plus any required copayment, deductible, or coinsurance.

(d) If the charge of a facility or practitioner for health care services provided to a covered individual exceeds the estimate provided to the covered individual under subsection (a)(1)(B) by an amount greater than:

(1) one hundred dollars ($100); or

(2) five percent (5%);

the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

(e) The department shall adopt emergency rules under IC 4-22-2-37.1 to specify the requirements of the notifications set forth in:

(1) subsections (b) and (c); and

(2) **IC 25-1-9-23(j) and** IC 25-1-9-23(k). ~~and IC 25-1-9-23(l).~~

SECTION 9. IC 27-1-45-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 10. A facility or a practitioner may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 10. IC 27-1-46-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: **Sec. 18. A provider facility may satisfy the requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.**

SECTION 11. IC 27-5.1-2-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 6. A farm mutual insurance company with an annual direct written premium of more than ~~ten million dollars ($10,000,000)~~ **fifteen million dollars ($15,000,000)** may not function as a farm mutual insurance company and shall be regulated as a domestic mutual insurance company described in IC 27-1-6-15.

SECTION 12. IC 27-8-14.8-3, AS AMENDED BY P.L.36-2020, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 3. **(a) As used in this section, "follow-up colonoscopy" means a colonoscopy that is performed as a follow-up to a colorectal cancer screening test, other than a colonoscopy, that is assigned a grade of "A" or "B" by the United States Preventive Services Task Force and for which the result was**

positive.

~~(a)~~ **(b)** Except as provided in subsection ~~(d),~~ **(e),** an insurer shall provide coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic insured in any accident and sickness insurance policy that the insurer issues in Indiana or issues for delivery in Indiana. **Except as provided in subsection (f), covered services must include:**

(1) a colorectal cancer screening test assigned either an "A" or "B" grade by the United States Preventive Services Task Force; and

(2) a follow-up colonoscopy.

~~(b)~~ **(c)** For an insured who is:

(1) at least forty-five (45) years of age; or

(2) less than forty-five (45) years of age and at high risk for colorectal cancer;

the coverage required under this section must meet the requirements set forth in subsection ~~(c),~~ **(d),** except as provided in subsection ~~(e).~~ **(f).**

~~(c)~~ **(d)** An insured may not be required to pay an additional annual deductible or coinsurance for the colorectal cancer examination and laboratory testing benefit required by this section that is greater than an annual deductible or coinsurance established for similar benefits under the accident and sickness insurance policy under which the insured is covered. If the accident and sickness insurance policy does not cover a similar benefit, a deductible or coinsurance for the colorectal cancer examination and laboratory testing benefit may not be set at a level that materially diminishes the value of the colorectal cancer examination and laboratory testing benefit.

~~(d)~~ **(e)** In the case of an accident and sickness insurance policy that is not employer based, the insurer shall offer to provide the coverage described in this section.

~~(e)~~ **(f)** ~~The requirements imposed under this section do not apply to a high deductible health plan, as defined by Section 223 of the Internal Revenue Code. High deductible health plans described in this subsection may not excuse a deductible requirement with respect to colorectal cancer screening in a manner inconsistent with Section 223(c)(2)(C) of the Internal Revenue Code.~~ **The requirements imposed under subsection (b)(2) do not apply to grandfathered health plans as defined in 45 CFR 147.140.**

SECTION 13. IC 27-13-7-17, AS AMENDED BY P.L.36-2020, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2022]: Sec. 17. (a) As used in this section, "colorectal cancer testing" means examinations and laboratory tests for cancer for any

nonsymptomatic enrollee.

(b) As used in this section, "follow-up colonoscopy" means a colonoscopy that is performed as a follow-up to a colorectal cancer screening test, other than a colonoscopy, that is assigned a grade of "A" or "B" by the United States Preventive Services Task Force and for which the result was positive.

~~(b)~~ **(c)** Except as provided in subsection ~~(c),~~ **(f),** a health maintenance organization issued a certificate of authority in Indiana shall provide colorectal cancer testing, **including:**

(1) a colorectal cancer screening test assigned either an "A" or "B" grade by the United States Preventive Services Task Force; and

(2) a follow-up colonoscopy;

as a covered service under every group contract that provides coverage for basic health care services.

~~(c)~~ **(d)** For an enrollee who is:

(1) at least forty-five (45) years of age; or

(2) less than forty-five (45) years of age and at high risk for colorectal cancer;

the colorectal cancer testing required under this section must meet the requirements set forth in subsection ~~(d),~~ **(e),** except as provided in subsection ~~(f).~~ **(g).**

~~(d)~~ **(e)** An enrollee may not be required to pay a copayment for the colorectal cancer testing benefit required by this section that is greater than a copayment established for similar benefits under the group contract under which the enrollee is entitled to services. If the group contract does not cover a similar covered service, the copayment for the colorectal cancer testing benefit may not be set at a level that materially diminishes the value of the colorectal cancer testing benefit.

~~(e)~~ **(f)** In the case of coverage that is not employer based, the health maintenance organization is required only to offer to provide colorectal cancer testing as a covered service under a proposed group contract providing coverage for basic health care services.

~~(f)~~ **(g)** ~~The requirements imposed under this section do not apply to a high deductible health plan, as defined by Section 223 of the Internal Revenue Code. High deductible health plans described in this subsection may not excuse a deductible requirement with respect to colorectal cancer screening in a manner inconsistent with Section 223(c)(2)(C) of the Internal Revenue Code.~~ **The requirements imposed under subsection (c)(2) do not apply to grandfathered health plans as defined in 45 CFR 147.140.**

SECTION 14. **An emergency is declared for this act**.

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____