



February 23, 2018

ENGROSSED HOUSE BILL No. 1301

DIGEST OF HB 1301 (Updated February 22, 2018 11:57 am - DI 97)

Citations Affected: IC 5-10; IC 5-22; IC 5-23; IC 8-2.1; IC 8-15.5; IC 8-15.7; IC 12-15; IC 27-1; IC 27-7; IC 27-8; IC 27-13; IC 27-15; IC 27-18; IC 34-30.

Synopsis: Insurance matters. Updates names of health care provider billing forms. Requires that public-private agreements must contain performance bond and payment bond requirements. Amends the financial responsibility requirement for a contract carrier that transports railroad employees. Permits the department of insurance and governor to apply for a state innovation waiver under the federal Patient Protection and Affordable Care Act. Provides for reduced limits and removal of commercial umbrella or excess liability coverage and requires notice of a reduction or removal. Repeals the law providing for a multistate surplus lines insurance compact, which has not gone into effect due to an insufficient number of states enacting the legislation. Amends the law concerning taxation of surplus lines producers on business sold to insureds whose home state is Indiana. Requires health maintenance organizations to be member insurers in the life and health insurance guaranty association. Repeals unnecessary deposit requirements of HMOs to the department of insurance for noncovered healthcare expenditures. Makes conforming amendments.

Effective: July 1, 2018.

Carbaugh, Austin, Lehman, Hamm

(SENATE SPONSOR — PERFECT)

January 11, 2018, read first time and referred to Committee on Insurance.
January 25, 2018, amended, reported — Do Pass.
January 31, 2018, read second time, amended, ordered engrossed.
February 1, 2018, engrossed. Read third time, passed. Yeas 92, nays 0.

SENATE ACTION

February 6, 2018, read first time and referred to Committee on Insurance and Financial Institutions.
February 22, 2018, amended, reported favorably — Do Pass.

EH 1301—LS 6898/DI 97



February 23, 2018

Second Regular Session of the 120th General Assembly (2018)

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 2017 Regular Session of the General Assembly.

ENGROSSED HOUSE BILL No. 1301

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

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

- 1 SECTION 1. IC 5-10-8.1-8 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. A provider shall
3 submit only the following forms for payment by an administrator:
4 (1) ~~HCFA-1500~~. **CMS-1500**.
5 (2) ~~HCFA-1450 (UB-92)~~. **CMS-1450 (UB-04)**.
6 (3) American Dental Association (ADA) claim form.
7 SECTION 2. IC 5-22-2-23, AS AMENDED BY P.L.255-2017,
8 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
9 JULY 1, 2018]: Sec. 23. (a) "Public funds" means money:
10 (1) derived from the revenue sources of the governmental body;
11 and
12 (2) deposited into the general or a special fund of the
13 governmental body.
14 (b) The term does not include either of the following:
15 (1) Money **received by paid to** a person under an authorized
16 public-private agreement under IC 5-23.
17 (2) Proceeds of bonds payable exclusively by a private entity.

EH 1301—LS 6898/DI 97



1 SECTION 3. IC 5-23-3-2 IS AMENDED TO READ AS FOLLOWS
 2 [EFFECTIVE JULY 1, 2018]: Sec. 2. BOT agreements may provide
 3 the following:

4 (1) The design, construction, operation, management,
 5 maintenance, or financing of the cost of a public facility shall be
 6 partially or entirely the responsibility of the operator.

7 (2) The governmental body shall lease the public facility and real
 8 property owned by the governmental body upon which the public
 9 facility is to be located to the operator for a predetermined period.
 10 The BOT agreement must provide for ownership of all
 11 improvements by the governmental body, unless the
 12 governmental body elects to provide for ownership of the public
 13 facility by the operator during the term of the BOT agreement. In
 14 this case, ownership reverts back to the governmental body upon
 15 the termination of the BOT agreement.

16 (3) The BOT agreement must identify which costs are to be the
 17 responsibility of the operator and which costs are to be the
 18 responsibility of the governmental body.

19 (4) The operator may be authorized to retain a mutually agreed
 20 upon percentage of the revenues received in the operation and
 21 management of the public facility, or the operator may be paid an
 22 amount established by the governmental body, which shall be
 23 applied as follows:

24 (A) Capital outlay costs for the public facility and public
 25 service plus interest and principal repayment for any debt
 26 incurred.

27 (B) Costs associated with the operation, management, and
 28 maintenance of the public facility.

29 (C) Payment to the governmental body for reimbursement of
 30 the costs of maintenance, law enforcement, and other services
 31 if the services are performed by the governmental body under
 32 the BOT agreement.

33 (D) An agreed upon return on investment to the operator.

34 (5) The operator may pay the governmental body either a lease
 35 payment or a percentage of gross revenue per month for the
 36 operator's operation and use of the public facility.

37 (6) The BOT agreement ~~may~~ **must**:

38 (A) require a performance bond **in an amount equal to at**
 39 **least twenty-five percent (25%) of the cost to design and**
 40 **construct the public facility;** and

41 (B) provide for the payment of contractors and subcontractors
 42 under IC 4-13.6-7, IC 5-16-5, or IC 36-1-12, whichever is



1 applicable.

2 SECTION 4. IC 8-2.1-22-46, AS AMENDED BY P.L.1-2006,
 3 SECTION 152, IS AMENDED TO READ AS FOLLOWS
 4 [EFFECTIVE JULY 1, 2018]: Sec. 46. (a) Notwithstanding any other
 5 provision of this chapter, common and contract carriers and other
 6 carriers engaged in the transportation of passengers or household goods
 7 for hire, over regular or irregular routes, whether operating pursuant to
 8 a certificate or permit or as an exempt carrier under section 2.1(5) of
 9 this chapter, shall file with the department proof of financial
 10 responsibility in the form of surety bonds or policies of insurance or
 11 shall qualify as a self-insured. The minimum level of financial
 12 responsibility required shall be **as follows:**

13 **(1) Except as provided in subdivision (2), the minimum level**
 14 **established under 49 U.S.C. 13906(a)(1).**

15 **(2) For contract carriers that transport railroad employees,**
 16 **at least five million dollars (\$5,000,000).**

17 (b) A person who violates this section commits a Class C infraction.
 18 However, the offense is a Class A misdemeanor if the person has a
 19 prior unrelated judgment for violating this section.

20 (c) In addition to any other penalty imposed upon a person for a
 21 conviction of a Class A misdemeanor under subsection (b), the law
 22 enforcement agency may impound the vehicles owned by the person.
 23 Unless the vehicle is impounded or forfeited under a law other than this
 24 section, the vehicle shall be released to the carrier when the carrier
 25 complies with this section.

26 SECTION 5. IC 8-15.5-5-2, AS AMENDED BY P.L.91-2014,
 27 SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 28 JULY 1, 2018]: Sec. 2. A public-private agreement entered into under
 29 this article must provide for the following:

30 (1) The original term of the public-private agreement, which may
 31 not exceed seventy-five (75) years.

32 (2) Provisions for a:

33 (A) lease, franchise, or license of the project and the real
 34 property owned by the authority upon which the project is
 35 located or is to be located; or

36 (B) management agreement or other contract to operate the
 37 project and the real property owned by the authority upon
 38 which the project is located or is to be located;

39 for a predetermined period. The public-private agreement must
 40 provide for ownership of all improvements and real property by
 41 the authority in the name of the state or by a governmental entity,
 42 or both.



- 1 (3) Monitoring of the operator's maintenance practices by the
 2 authority and the taking of actions by the authority that it
 3 considers appropriate to ensure that the project is properly
 4 maintained.
 5 (4) The basis upon which user fees that may be collected by the
 6 operator, as determined under this article, are established.
 7 (5) Compliance with applicable state and federal laws and local
 8 ordinances.
 9 (6) Grounds for termination of the public-private agreement by
 10 the authority or the operator.
 11 (7) The date of termination of the operator's authority and duties
 12 under this article.
 13 (8) Procedures for amendment of the agreement.
 14 (9) Provisions requiring the completion of all environmental
 15 analyses of the project required by state and federal law in the
 16 manner and at the times required by the appropriate state and
 17 federal agencies.
 18 (10) An expedited method for resolving disputes between or
 19 among the authority, the parties to the public-private agreement,
 20 and units of local government that contain any part of the project,
 21 as required by IC 8-15.5-10-8.
 22 **(11) For a public-private agreement entered into after June**
 23 **30, 2018, bond requirements as follows:**
 24 **(A) A performance bond in an amount equal to at least**
 25 **twenty-five percent (25%) of the cost to design and**
 26 **construct the project.**
 27 **(B) A payment bond conditioned on payment for labor and**
 28 **material furnished for use in construction of the project.**
 29 SECTION 6. IC 8-15.7-5-1.5, AS ADDED BY P.L.85-2010,
 30 SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 31 JULY 1, 2018]: Sec. 1.5. In addition to the other requirements of this
 32 article, a public-private agreement entered into under this article must
 33 include the following:
 34 (1) A requirement for the completion of all environmental
 35 analyses of the project required by state and federal law in the
 36 manner and at the times required by the appropriate state and
 37 federal agencies.
 38 (2) A requirement for ownership by the department in the name
 39 of the state of Indiana of:
 40 (A) all the real property on which the project is located; and
 41 (B) all of the improvements on that real property.
 42 (3) An expedited method for resolving disputes between or among



1 the department, the parties to the public-private agreement, and
 2 affected jurisdictions, as required by IC 8-15.7-12-2.

3 **(4) For a public-private agreement entered into after June 30,**
 4 **2018, bond requirements as follows:**

5 **(A) A performance bond in an amount equal to at least**
 6 **twenty-five percent (25%) of the cost to design and**
 7 **construct the project.**

8 **(B) A payment bond conditioned on payment for labor and**
 9 **material furnished for use in construction of the project.**

10 SECTION 7. IC 12-15-12-13 IS AMENDED TO READ AS
 11 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 13. (a) The office and
 12 an entity with which the office contracts for the payment of claims shall
 13 accept claims submitted on any of the following forms by an individual
 14 or organization that is a contractor or subcontractor of the office:

- 15 (1) ~~HCFA-1500~~; **CMS-1500**.
 16 (2) ~~HCFA-1450 (UB-92)~~; **CMS-1450 (UB-04)**.
 17 (3) American Dental Association (ADA) claim form.
 18 (4) Pharmacy and compound drug form.

19 (b) The office and an entity with which the office contracts for the
 20 payment of claims:

- 21 (1) may designate as acceptable claim forms other than a form
 22 listed in subsection (a); and
 23 (2) may not mandate the use of a crossover claim form.

24 SECTION 8. IC 27-1-3-35 IS ADDED TO THE INDIANA CODE
 25 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 26 1, 2018]: **Sec. 35. (a) The governor and the commissioner may**
 27 **apply to the United States Secretary of Health and Human Services**
 28 **for a waiver for state innovation under Section 1332 of the federal**
 29 **Patient Protection and Affordable Care Act (42 U.S.C. 18052).**

30 **(b) If the waiver applied for under subsection (a) is granted, the**
 31 **governor and the commissioner may implement a state plan of**
 32 **innovation that meets the waiver requirements established under**
 33 **federal law and as approved by the United States Secretary of**
 34 **Health and Human Services.**

35 SECTION 9. IC 27-1-15.6-2, AS AMENDED BY P.L.146-2015,
 36 SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 37 JULY 1, 2018]: Sec. 2. **Except as otherwise provided in this section,**
 38 the following definitions apply throughout this chapter, IC 27-1-15.7,
 39 and IC 27-1-15.8:

- 40 (1) "Bureau" refers to the child support bureau established by
 41 IC 31-25-3-1.
 42 (2) "Business entity" means a corporation, an association, a



- 1 partnership, a limited liability company, a limited liability
 2 partnership, or another legal entity.
- 3 (3) "Commissioner" means the insurance commissioner appointed
 4 under IC 27-1-1-2.
- 5 (4) "Consultant" means a person who:
 6 (A) holds himself or herself out to the public as being engaged
 7 in the business of offering; or
 8 (B) for a fee, offers;
 9 any advice, counsel, opinion, or service with respect to the
 10 benefits, advantages, or disadvantages promised under any policy
 11 of insurance that could be issued in Indiana.
- 12 (5) "Delinquent" means the condition of being at least:
 13 (A) two thousand dollars (\$2,000); or
 14 (B) three (3) months;
 15 past due in the payment of court ordered child support.
- 16 (6) "Designated home state license" means a license issued by the
 17 commissioner to an insurance producer who:
 18 (A) maintains the insurance producer's principal place of
 19 residence or principal place of business in a state that does not
 20 license insurance producers for the line of authority for which
 21 the insurance producer seeks licensure in Indiana; and
 22 (B) is permitted by the commissioner to designate Indiana as
 23 the insurance producer's nonresident home state.
- 24 (7) "FINRA" refers to the independent Financial Industry
 25 Regulatory Authority.
- 26 (8) "Home state" means the District of Columbia or any state or
 27 territory of the United States in which an insurance producer:
 28 (A) maintains the insurance producer's principal place of
 29 residence or principal place of business; and
 30 (B) is licensed to act as an insurance producer.
- 31 **This subdivision does not apply to IC 27-1-15.8.**
- 32 (9) "Insurance producer" means a person required to be licensed
 33 under the laws of Indiana to sell, solicit, or negotiate insurance.
- 34 (10) "License" means a document issued by the commissioner
 35 authorizing a person to act as an insurance producer for the lines
 36 of authority specified in the document. The license itself does not
 37 create any authority, actual, apparent, or inherent, in the holder to
 38 represent or commit an insurance carrier.
- 39 (11) "Limited line credit insurance" includes the following:
 40 (A) Credit life insurance.
 41 (B) Credit disability insurance.
 42 (C) Credit property insurance.



- 1 (D) Credit unemployment insurance.
 2 (E) Involuntary unemployment insurance.
 3 (F) Mortgage life insurance.
 4 (G) Mortgage guaranty insurance.
 5 (H) Mortgage disability insurance.
 6 (I) Guaranteed automobile protection (gap) insurance.
 7 (J) Any other form of insurance:
 8 (i) that is offered in connection with an extension of credit
 9 and is limited to partially or wholly extinguishing that credit
 10 obligation; and
 11 (ii) that the insurance commissioner determines should be
 12 designated a form of limited line credit insurance.
 13 (12) "Limited line credit insurance producer" means a person who
 14 sells, solicits, or negotiates one (1) or more forms of limited line
 15 credit insurance coverage to individuals through a master,
 16 corporate, group, or individual policy.
 17 (13) "Limited lines insurance" means any of the following:
 18 (A) The lines of insurance defined in section 18 of this
 19 chapter.
 20 (B) Any line of insurance the recognition of which is
 21 considered necessary by the commissioner for the purpose of
 22 complying with section 8(e) of this chapter.
 23 (C) For purposes of section 8(e) of this chapter, any form of
 24 insurance with respect to which authority is granted by a home
 25 state that restricts the authority granted by a limited lines
 26 producer's license to less than total authority in the associated
 27 major lines described in section 7(a)(1) through 7(a)(6) of this
 28 chapter.
 29 (14) "Limited lines producer" means a person authorized by the
 30 commissioner to sell, solicit, or negotiate limited lines insurance.
 31 (15) "Limited lines travel insurance producer" means a person
 32 designated by an insurer to sell, solicit, or negotiate a travel
 33 insurance policy. The term includes the following:
 34 (A) A managing general underwriter.
 35 (B) A managing general agent.
 36 (C) A limited lines producer.
 37 (16) "Negotiate" means the act of conferring directly with or
 38 offering advice directly to a purchaser or prospective purchaser of
 39 a particular contract of insurance concerning any of the
 40 substantive benefits, terms, or conditions of the contract, provided
 41 that the person engaged in that act either sells insurance or
 42 obtains insurance from insurers for purchasers.



- 1 (17) "Person" means an individual or a business entity.
 2 (18) "Sell" means to exchange a contract of insurance by any
 3 means, for money or its equivalent, on behalf of a company.
 4 (19) "Solicit" means attempting to sell insurance or asking or
 5 urging a person to apply for a particular kind of insurance from a
 6 particular company.
 7 (20) "Surplus lines producer" means a person who sells, solicits,
 8 negotiates, or procures from an insurance company not licensed
 9 to transact business in Indiana an insurance policy that cannot be
 10 procured from insurers licensed to do business in Indiana.
 11 (21) "Terminate" means:
 12 (A) the cancellation of the relationship between an insurance
 13 producer and the insurer; or
 14 (B) the termination of a producer's authority to transact
 15 insurance.
 16 (22) "Travel insurance" means insurance coverage for personal
 17 risks incident to planned travel, including the following:
 18 (A) Interruption or cancellation of a trip or an event.
 19 (B) Loss of baggage or personal effects.
 20 (C) Damage to accommodations or rental vehicles.
 21 (D) Sickness, accident, disability, or death that occurs during
 22 travel.
 23 The term does not include a major medical plan that provides
 24 comprehensive medical insurance for a traveler on a trip that lasts
 25 at least six (6) months, including a traveler who is an individual
 26 who works overseas as an ~~expatriot~~ **expatriate** or is deployed as
 27 a member of the military.
 28 (23) "Travel retailer" means a business entity that offers and
 29 delivers travel insurance on behalf of and under the direction of
 30 a limited lines travel insurance producer.
 31 (24) "Uniform business entity application" means the current
 32 version of the national association of insurance commissioners
 33 uniform business entity application for resident and nonresident
 34 business entities.
 35 (25) "Uniform application" means the current version of the
 36 national association of insurance commissioners uniform
 37 application for resident and nonresident producer licensing.
 38 SECTION 10. IC 27-1-15.8-1 IS AMENDED TO READ AS
 39 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. **(a) Except as**
 40 **provided in this section**, the definitions in IC 27-1-15.6-2 apply
 41 throughout this chapter.
 42 **(b) As used in this chapter, "affiliate" means, with respect to an**



1 insured, an entity that controls, is controlled by, or is under
2 common control with the insured.

3 (c) As used in this chapter, "affiliated group" means a group of
4 affiliates.

5 (d) As used in this chapter, "control" means:

6 (1) ownership or power to vote at least twenty-five percent
7 (25%) of any class of voting securities; or

8 (2) power to determine the election of a majority of the
9 directors or trustees;

10 of an entity.

11 (e) As used in this chapter, "home state" means the following:

12 (1) With respect to an insured:

13 (A) the state in which the insured maintains:

14 (i) the insured's principal place of business; or

15 (ii) if the insured is an individual, the insured's principal
16 residence; or

17 (B) if one hundred percent (100%) of the insured risk is
18 located outside the state described in clause (A), the state
19 to which the greatest percentage of the insured's taxable
20 premium for the insurance contract is allocated.

21 (2) With respect to an affiliated group, if more than one (1)
22 insured from the affiliated group is a named insured on a
23 single nonadmitted insurance policy or contract, the home
24 state determined under subdivision (1) of the member of the
25 affiliated group that has the largest percentage of premium
26 attributed to the member under the nonadmitted insurance
27 policy or contract.

28 (f) As used in this chapter, "nonadmitted insurance policy or
29 contract" means an insurance policy or contract that is issued by
30 an insurer that is not authorized to transact the business of
31 insurance under the law of the home state.

32 (g) As used in this chapter, "principal place of business" means,
33 with respect to determining the home state of an insured, the state
34 where the:

35 (1) insured maintains the insured's headquarters; and

36 (2) insured's officers direct, control, and coordinate the
37 business activities of the insured.

38 SECTION 11. IC 27-1-15.8-4, AS AMENDED BY P.L.173-2007,
39 SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
40 JULY 1, 2018]: Sec. 4. (a) In addition to all other charges, fees, and
41 taxes that may be imposed by law, a surplus lines producer licensed
42 under this chapter shall, on or before February 1 and August 1 of each



1 year, collect from the insured and remit to the department for the use
 2 and benefit of the state of Indiana an amount equal to two and one-half
 3 percent (2 1/2%) of all gross premiums upon all policies and contracts
 4 procured:

- 5 (1) by the surplus lines producer;
- 6 (2) under the provisions of this section;
- 7 **(3) for insureds whose home state is Indiana; and**
- 8 **(4) during the preceding six (6) twelve (12) month period ending**
 9 **December 31. and June 30, respectively.**

10 The declarations page of a policy referred to in this subsection must
 11 itemize the amounts of all charges for taxes, fees, and premiums.

12 (b) A licensed surplus lines producer shall execute and file with the
 13 department of insurance on or before the twentieth day of each month
 14 an affidavit that specifies all transactions, policies, and contracts
 15 procured during the preceding calendar month, including:

- 16 (1) the description and location of the insured property or risk and
 17 the name of the insured;
- 18 (2) the gross premiums charged in the policy or contract;
- 19 (3) the name and home office address of the insurer whose policy
 20 or contract is issued, and the kind of insurance effected; and
- 21 (4) a statement that:
 - 22 (A) the licensee, after diligent effort, was unable to procure
 23 from any insurer authorized to transact the particular class of
 24 insurance business in Indiana the full amount of insurance
 25 required to protect the insured; and
 - 26 (B) the insurance placed under this chapter is not placed for
 27 the purpose of procuring it at a premium rate lower than would
 28 be accepted by an insurer authorized and licensed to transact
 29 insurance business in Indiana.

30 (c) A licensed surplus lines producer shall file with the department,
 31 not later than March 31 of each year, the financial statement, dated as
 32 of December 31 of the preceding year, of each unauthorized insurer
 33 from whom the surplus lines producer has procured a policy or
 34 contract. The insurance commissioner may, in the commissioner's
 35 discretion, after reviewing the financial statement of the unauthorized
 36 insurer, order the surplus lines producer to cancel an unauthorized
 37 insurer's policies and contracts if the commissioner is of the opinion
 38 that the financial statement or condition of the unauthorized insurer
 39 does not warrant continuance of the risk.

40 (d) A licensed surplus lines producer shall keep a separate account
 41 of all business transacted under this section. The account may be
 42 inspected at any time by the commissioner or the commissioner's



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deputy or examiner.

(e) An insurer that issues a policy or contract to insure a risk under this section is considered to have appointed the commissioner as the insurer's attorney upon whom process may be served in Indiana in any suit, action, or proceeding based upon or arising out of the policy or contract.

(f) The commissioner may revoke or refuse to renew a surplus lines producer's license for failure to comply with this section.

(g) A surplus lines producer licensed under this chapter may accept and place policies or contracts authorized under this section for an insurance producer duly licensed in Indiana, and may compensate the insurance producer even though the insurance producer is not licensed under this chapter.

(h) If a surplus lines producer does not remit an amount due to the department within the time prescribed in subsection (a), the commissioner shall assess the surplus lines producer a penalty of ten percent (10%) of the amount due. The commissioner shall assess a further penalty of an additional one percent (1%) of the amount due for each month or portion of a month that any amount due remains unpaid after the first month. Penalties assessed under this subsection are payable by the surplus lines producer and are not collectible from an insured.

SECTION 12. IC 27-7-5-2, AS AMENDED BY P.L.148-2013, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. (a) Except as provided in subsections (d), (f), and (h), the insurer shall make available, in each automobile liability or motor vehicle liability policy of insurance which is delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state, insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person and for injury to or destruction of property to others arising from the ownership, maintenance, or use of a motor vehicle, or in a supplement to such a policy, the following types of coverage:

(1) in limits for bodily injury or death and for injury to or destruction of property not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death, and for the protection of persons insured under the policy who are legally



1 entitled to recover damages from owners or operators of
 2 uninsured motor vehicles for injury to or destruction of property
 3 resulting therefrom; or

4 (2) in limits for bodily injury or death not less than those set forth
 5 in IC 9-25-4-5 under policy provisions approved by the
 6 commissioner of insurance, for the protection of persons insured
 7 under the policy provisions who are legally entitled to recover
 8 damages from owners or operators of uninsured or underinsured
 9 motor vehicles because of bodily injury, sickness or disease,
 10 including death resulting therefrom.

11 The uninsured and underinsured motorist coverages must be provided
 12 by insurers for either a single premium or for separate premiums, in
 13 limits at least equal to the limits of liability specified in the bodily
 14 injury liability provisions of an insured's policy, unless such coverages
 15 have been rejected in writing by the insured. However, underinsured
 16 motorist coverage must be made available in limits of not less than fifty
 17 thousand dollars (\$50,000). At the insurer's option, the bodily injury
 18 liability provisions of the insured's policy may be required to be equal
 19 to the insured's underinsured motorist coverage. Insurers may not sell
 20 or provide underinsured motorist coverage in an amount less than fifty
 21 thousand dollars (\$50,000). Insurers must make underinsured motorist
 22 coverage available to all existing policyholders on the date of the first
 23 renewal of existing policies that occurs on or after January 1, 1995, and
 24 on any policies newly issued or delivered on or after January 1, 1995.
 25 Uninsured motorist coverage or underinsured motorist coverage may
 26 be offered by an insurer in an amount exceeding the limits of liability
 27 specified in the bodily injury and property damage liability provisions
 28 of the insured's policy.

29 (b) A named insured of an automobile or motor vehicle liability
 30 policy has the right, in writing, to:

31 (1) reject both the uninsured motorist coverage and the
 32 underinsured motorist coverage provided for in this section; or

33 (2) reject either the uninsured motorist coverage alone or the
 34 underinsured motorist coverage alone, if the insurer provides the
 35 coverage not rejected separately from the coverage rejected.

36 A rejection of coverage under this subsection by a named insured is a
 37 rejection on behalf of all other named insureds, all other insureds, and
 38 all other persons entitled to coverage under the policy. No insured may
 39 have uninsured motorist property damage liability insurance coverage
 40 under this section unless the insured also has uninsured motorist bodily
 41 injury liability insurance coverage under this section. Following
 42 rejection of either or both uninsured motorist coverage or underinsured



1 motorist coverage, unless later requested in writing, the insurer need
 2 not offer uninsured motorist coverage or underinsured motorist
 3 coverage in or supplemental to a renewal or replacement policy issued
 4 to the same insured by the same insurer or a subsidiary or an affiliate
 5 of the originally issuing insurer. Renewals of policies issued or
 6 delivered in this state which have undergone interim policy
 7 endorsement or amendment do not constitute newly issued or delivered
 8 policies for which the insurer is required to provide the coverages
 9 described in this section.

10 (c) A rejection under subsection (b) must specify:

11 (1) that the named insured is rejecting:

12 (A) the uninsured motorist coverage;

13 (B) the underinsured motorist coverage; or

14 (C) both the uninsured motorist coverage and the underinsured
 15 motorist coverage;

16 that would otherwise be provided under the policy; and

17 (2) the date on which the rejection is effective.

18 (d) ~~An insurer is not required to make available~~ **The following**
 19 **apply to** the coverage described in subsection (a) in **connection with**
 20 a commercial umbrella or excess liability policy, including a
 21 commercial umbrella or excess liability policy that is issued or
 22 delivered to a motor carrier (as defined in IC 8-2.1-17-10) that is in
 23 compliance with the minimum levels of financial responsibility set
 24 forth in 49 CFR Part 387:

25 **(1) An insurer is not required to make available in a**
 26 **commercial umbrella or excess liability policy the coverage**
 27 **described in subsection (a).**

28 **(2) An insurer that, through a rider or an endorsement,**
 29 **reduces or removes from a commercial umbrella or excess**
 30 **liability policy the coverage described in subsection (a) shall:**

31 **(A) through the United States mail; or**

32 **(B) by electronic means;**

33 **provide to the named insured written notice of the reduction**
 34 **or removal.**

35 **(3) An insurer that makes available in a commercial umbrella**
 36 **or excess liability policy the coverage described in subsection**
 37 **(a):**

38 **(A) may make available the coverage in limits determined**
 39 **by the insurer; and**

40 **(B) is not required to make available the coverage in limits**
 41 **equal to the limits specified in the commercial umbrella or**
 42 **excess liability policy.**



1 (e) A rejection under subsection (b) of uninsured motorist coverage
 2 of insurance is also a rejection of uninsured motorist coverage in an underlying commercial policy
 3 of insurance is also a rejection of uninsured motorist coverage or
 4 underinsured motorist coverage in a commercial umbrella or excess
 5 liability policy.

6 (f) An insurer is not required to make available the coverage
 7 described in subsection (a) in connection with coverage that:

8 (1) is related to or included in a commercial policy of property
 9 and casualty insurance described in Class 2 or Class 3 of
 10 IC 27-1-5-1; and

11 (2) covers a loss related to a motor vehicle:

12 (A) of which the insured is not the owner; and

13 (B) that is used:

14 (i) by the insured or an agent of the insured; and

15 (ii) for purposes authorized by the insured.

16 (g) For purposes of subsection (f), "owner" means:

17 (1) a person who holds the legal title to a motor vehicle;

18 (2) a person who rents or leases a motor vehicle and has exclusive
 19 use of the motor vehicle for more than thirty (30) days;

20 (3) the conditional vendee or lessee under an agreement for the
 21 conditional sale or lease of a motor vehicle; or

22 (4) the mortgagor under an agreement for the conditional sale or
 23 lease of a motor vehicle under which the mortgagor has:

24 (A) the right to purchase; and

25 (B) an immediate right of possession of;

26 the motor vehicle upon the performance of the conditions stated
 27 in the agreement.

28 (h) The following apply to the coverage described in subsection (a)
 29 in relation to a personal umbrella or excess liability policy:

30 (1) An insurer is not required to make available the coverage
 31 described in subsection (a) under a personal umbrella or excess
 32 liability policy.

33 (2) An insurer that reduces or removes, through a rider or an
 34 endorsement, coverage described in subsection (a) under a
 35 personal umbrella or excess liability policy shall:

36 (A) through the United States mail; or

37 (B) by electronic means;

38 provide to the named insured written notice of the reduction or
 39 removal.

40 (3) An insurer that makes available the coverage described in
 41 subsection (a) under a personal umbrella or excess liability
 42 policy:



- 1 (A) may make available the coverage in limits determined by
 2 the insurer; and
 3 (B) is not required to make available the coverage in limits
 4 equal to the limits specified in the personal umbrella or excess
 5 liability policy.

6 SECTION 13. IC 27-8-5.7-7 IS AMENDED TO READ AS
 7 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 7. A provider shall
 8 submit only the following forms for payment by an insurer:

- 9 (1) ~~HCFA-1500~~. **CMS-1500.**
 10 (2) ~~HCFA-1450 (UB-92)~~. **CMS-1450 (UB-04).**
 11 (3) American Dental Association (ADA) claim form.

12 SECTION 14. IC 27-8-8-0.3, AS AMENDED BY P.L.276-2013,
 13 SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 14 JULY 1, 2018]: Sec. 0.3. (a) The association's coverage obligations
 15 under this chapter with respect to a member insurer that has a coverage
 16 date before March 28, 2006, are not affected by changes made by
 17 P.L.193-2006.

18 (b) The association's coverage obligations under this chapter with
 19 respect to a member insurer that has a coverage date before March 28,
 20 2006, are governed by this chapter as it existed on January 1, 2006.

21 (c) The amendments made during the 2013 regular session of the
 22 general assembly to section 2.1 of this chapter do not apply to a
 23 member insurer that has been placed under an order of rehabilitation
 24 or liquidation before January 1, 2013.

25 (d) The amendment made during the 2013 regular session of the
 26 general assembly to section 2.3(e) of this chapter does not apply to a
 27 member insurer that has a coverage date before January 1, 2012.

28 (e) The amendments made during the 2013 regular session of the
 29 general assembly to section 2.3(f) of this chapter do not apply to a
 30 member insurer that has been placed under an order of rehabilitation
 31 or liquidation before January 1, 2013.

32 **(f) The amendments made during the 2018 regular session of the
 33 general assembly to this chapter:**

34 **(1) do not apply to a member insurer that has been placed
 35 under an order of rehabilitation or liquidation before July 1,
 36 2018; and**

37 **(2) apply to a member insurer that is placed under an order
 38 of rehabilitation or liquidation after June 30, 2018.**

39 SECTION 15. IC 27-8-8-2, AS AMENDED BY P.L.276-2013,
 40 SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 41 JULY 1, 2018]: Sec. 2. (a) The definitions in this section apply
 42 throughout this chapter.



- 1 (b) "Account" means one (1) of the two (2) accounts created under
 2 section 3 of this chapter.
- 3 (c) "Annuity contract", except as provided in section 2.3(e) of this
 4 chapter, includes:
 5 (1) a guaranteed investment contract;
 6 (2) a deposit administration contract;
 7 (3) a structured settlement annuity;
 8 (4) an annuity issued to or in connection with a government
 9 lottery; and
 10 (5) an immediate or a deferred annuity contract.
- 11 (d) "Assessment base year" means, for an impaired insurer or
 12 insolvent insurer, the most recent calendar year for which required
 13 premium information is available preceding the calendar year during
 14 which the impaired insurer's or insolvent insurer's coverage date
 15 occurs.
- 16 (e) "Association", except when the context otherwise requires,
 17 means the Indiana life and health insurance guaranty association
 18 created by section 3 of this chapter.
- 19 (f) "Benefit plan" means a specific plan, fund, or program that is
 20 established or maintained by an employer or an employee organization,
 21 or both, that:
 22 (1) provides retirement income to employees; or
 23 (2) results in a deferral of income by employees for a period
 24 extending to or beyond the termination of employment.
- 25 (g) "Board" refers to the board of directors of the association
 26 selected under IC 27-8-8-4.
- 27 (h) "Called", when used in the context of assessments, means that
 28 notice has been issued by the association to member insurers requiring
 29 the member insurers to pay, within a time frame set forth in the notice,
 30 an assessment that has been authorized by the board.
- 31 (i) "Commissioner" refers to the insurance commissioner appointed
 32 under IC 27-1-1-2.
- 33 (j) "Contractual obligation" means an enforceable obligation under
 34 a covered policy for which and to the extent that coverage is provided
 35 under section 2.3 of this chapter.
- 36 (k) "Coverage date" means, with respect to a member insurer, the
 37 date on which the earlier of the following occurs:
 38 (1) The member insurer becomes an insolvent insurer.
 39 (2) The association determines that the association will provide
 40 coverage under section 5(a) of this chapter with respect to the
 41 member insurer.
- 42 (l) "Covered policy" means a:



- 1 (1) nongroup policy or contract;
 2 (2) certificate under a group policy or contract; or
 3 (3) part of a policy, contract, or certificate described in
 4 subdivisions (1) and (2);

5 for which coverage is provided under section 2.3 of this chapter.

6 (m) "Extracontractual claims" includes claims that relate to bad faith
 7 in the payment of claims, punitive or exemplary damages, or attorney's
 8 fees and costs.

9 (n) "Funding agreement" has the meaning set forth in
 10 IC 27-1-12.7-1.

11 (o) **"Health benefit plan" means a hospital or medical expense**
 12 **policy or certificate, a health maintenance organization subscriber**
 13 **contract or certificate, or another similar health contract. The**
 14 **term does not include the following:**

15 (1) **Accident only, credit, dental only, vision only, Medicare**
 16 **supplement, or disability income insurance.**

17 (2) **Coverage for:**

18 (A) **long term care;**

19 (B) **home health care;**

20 (C) **community based care; or**

21 (D) **a combination of coverage specified in clauses (A)**
 22 **through (C).**

23 (3) **Coverage for onsite medical clinics.**

24 (4) **Specified disease, hospital confinement indemnity, or**
 25 **limited benefit health insurance if the types of coverage do not**
 26 **provide coordination of benefits and are provided under**
 27 **separate policies, contracts, or certificates.**

28 (p) **"Health care provider" means a health care provider that**
 29 **renders health care services covered under a health insurance**
 30 **policy or contract for which coverage is provided under section 2.3**
 31 **of this chapter.**

32 (q) "Impaired insurer" means a member insurer that is:

33 (1) not an insolvent insurer; and

34 (2) placed under an order of rehabilitation or conservation by a
 35 court with jurisdiction.

36 (r) "Insolvent insurer" means a member insurer that is placed
 37 under an order of liquidation with a finding of insolvency by a court
 38 with jurisdiction.

39 (s) "Member insurer" means any person that holds a certificate
 40 of authority to transact in Indiana any kind of insurance **or health**
 41 **maintenance organization business** for which coverage is provided
 42 under section 2.3 of this chapter. The term includes an insurer whose



1 certificate of authority to transact such insurance in Indiana may have
 2 been suspended, revoked, not renewed, or voluntarily withdrawn but
 3 does not include the following:

4 (1) A for-profit or nonprofit hospital or medical service
 5 organization.

6 ~~(2) A health maintenance organization under IC 27-13.~~

7 ~~(3) (2)~~ A fraternal benefit society under IC 27-11.

8 ~~(4) (3)~~ The Indiana Comprehensive Health Insurance Association
 9 or any other mandatory state pooling plan or arrangement.

10 ~~(5) (4)~~ An assessment company or another person that operates on
 11 an assessment plan (as defined in IC 27-1-2-3(y)).

12 ~~(6) (5)~~ An interinsurance or reciprocal exchange authorized by
 13 IC 27-6-6.

14 ~~(7) A prepaid limited service health maintenance organization or~~
 15 ~~a limited service health maintenance organization under~~
 16 ~~IC 27-13-34.~~

17 ~~(8) (6)~~ A farm mutual insurance company under IC 27-5.1.

18 ~~(9) (7)~~ A person operating as a Lloyds under IC 27-7-1.

19 ~~(10) (8)~~ The political subdivision risk management fund
 20 established by IC 27-1-29-10 and the political subdivision
 21 catastrophic liability fund established by IC 27-1-29.1-7.

22 ~~(11) (9)~~ The small employer health reinsurance board established
 23 by IC 27-8-15.5-5.

24 ~~(12) (10)~~ A person similar to any person described in subdivisions
 25 (1) through ~~(11)~~ (9).

26 ~~(13) (t)~~ "Moody's Corporate Bond Yield Average" means:

27 (1) the monthly average of the composite yield on seasoned
 28 corporate bonds as published by Moody's Investors Service, Inc.;
 29 or

30 (2) if the monthly average described in subdivision (1) is no
 31 longer published, an alternative publication of interest rates or
 32 yields determined appropriate by the association.

33 ~~(14) (u)~~ "Multiple employer welfare arrangement" has the meaning
 34 set forth in IC 27-1-34-1.

35 ~~(15) (v)~~ "Owner" means the person:

36 (1) identified as the legal owner of a policy or contract according
 37 to the terms of the policy or contract; or

38 (2) otherwise vested with legal title to a policy or contract through
 39 a valid assignment completed in accordance with the terms of the
 40 policy or contract and properly recorded as the owner on the
 41 books of the insurer.

42 The term does not include a person with a mere beneficial interest in



- 1 a policy or contract.
- 2 ~~(w)~~ **(w)** "Person" means an individual, a corporation, a limited
3 liability company, a partnership, an association, a governmental entity,
4 a voluntary organization, a trust, a trustee, or another business entity or
5 organization.
- 6 ~~(v)~~ **(x)** "Plan sponsor" refers to only one (1) of the following with
7 respect to a benefit plan:
- 8 (1) The employer, in the case of a benefit plan established or
9 maintained by a single employer.
- 10 (2) The holding company or controlling affiliate, in the case of a
11 benefit plan established or maintained by affiliated companies
12 comprising a consolidated corporation.
- 13 (3) The employee organization, in the case of a benefit plan
14 established or maintained by an employee organization.
- 15 (4) In a case of a benefit plan established or maintained:
- 16 (A) by two (2) or more employers;
- 17 (B) by two (2) or more employee organizations; or
- 18 (C) jointly by one (1) or more employers and one (1) or more
19 employee organizations;
- 20 and that is not of a type described in subdivision (2), the
21 association, committee, joint board of trustees, or other similar
22 group of representatives of the parties that establish or maintain
23 the benefit plan.
- 24 ~~(w)~~ **(y)** "Premiums" means amounts, deposits, and considerations
25 received on covered policies, less returned premiums, returned
26 deposits, returned considerations, dividends, and experience credits.
27 The term does not include the following:
- 28 (1) Amounts, deposits, and considerations received for policies or
29 contracts or parts of policies or contracts for which coverage is
30 not provided under section 2.3(d) of this chapter, as qualified by
31 section 2.3(e) of this chapter, except that an assessable premium
32 must not be reduced on account of the limitations set forth in
33 section 2.3(e)(3), 2.3(e)(15), or 2.3(f)(2) of this chapter.
- 34 (2) Premiums in excess of five million dollars (\$5,000,000) on an
35 unallocated annuity contract not issued or not connected with a
36 governmental benefit plan established under Section 401, 403(b),
37 or 457 of the United States Internal Revenue Code.
- 38 ~~(x)~~ **(z)** "Principal place of business" refers to the single state in
39 which individuals who establish policy for the direction, control, and
40 coordination of the operations of an entity as a whole primarily exercise
41 the direction, control, and coordination, as determined by the
42 association in the association's reasonable judgment by considering the



- 1 following factors:
- 2 (1) The state in which the primary executive and administrative
- 3 headquarters of the entity is located.
- 4 (2) The state in which the principal office of the chief executive
- 5 officer of the entity is located.
- 6 (3) The state in which the board of directors or similar governing
- 7 person of the entity conducts the majority of the board of
- 8 directors' or governing person's meetings.
- 9 (4) The state in which the executive or management committee of
- 10 the board of directors or similar governing person of the entity
- 11 conducts the majority of the committee's meetings.
- 12 (5) The state from which the management of the overall
- 13 operations of the entity is directed.

14 However, in the case of a plan sponsor, if more than fifty percent (50%)

15 of the participants in the plan sponsor's benefit plan are employed in a

16 single state, that state is considered to be the principal place of business

17 of the plan sponsor. The principal place of business of a plan sponsor

18 of a benefit plan described in subsection ~~(v)(4)~~, **(x)(3)**, if more than

19 fifty percent (50%) of the participants in the plan sponsor's benefit plan

20 are not employed in a single state, is considered to be the principal

21 place of business of the association, committee, joint board of trustees,

22 or other similar group of representatives of the parties that establish or

23 maintain the benefit plan and, in the absence of a specific or clear

24 designation of a principal place of business, is considered to be the

25 principal place of business of the employer or employee organization

26 that has the largest investment in the benefit plan in question on the

27 coverage date.

28 ~~(y)~~ **(aa)** "Receivership court" refers to the court in an insolvent

29 insurer's or impaired insurer's state that has jurisdiction over the

30 conservation, rehabilitation, or liquidation of the insolvent insurer or

31 impaired insurer.

32 ~~(z)~~ **(bb)** "Resident" means the following:

- 33 (1) An individual who resides in Indiana on the applicable
- 34 coverage date.
- 35 (2) A person that is not an individual and has the person's
- 36 principal place of business in Indiana on the applicable coverage
- 37 date.

38 ~~(aa)~~ **(cc)** "State" includes a state, the District of Columbia, Puerto

39 Rico, and a United States possession, territory, or protectorate.

40 ~~(bb)~~ **(dd)** "Structured settlement annuity" means an annuity

41 purchased to fund periodic payments for a plaintiff or other claimant

42 in payment for or with respect to personal injury suffered by the



- 1 plaintiff or other claimant.
- 2 ~~(ee)~~ **(ee)** "Supplemental contract" means a written agreement
3 entered into for the distribution of proceeds under a life, health, or
4 annuity policy or contract.
- 5 ~~(dd)~~ **(ff)** "Unallocated annuity contract" means an annuity contract
6 or group annuity certificate:
- 7 (1) the owner of which is not a natural person; and
8 (2) that does not identify at least one (1) specific natural person
9 as an annuitant;
- 10 except to the extent of any annuity benefits guaranteed to a natural
11 person by an insurer under the contract or certificate. For purposes of
12 this chapter, an unallocated annuity contract shall not be considered a
13 group policy or group contract.
- 14 SECTION 16. IC 27-8-8-2.1, AS AMENDED BY P.L.276-2013,
15 SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
16 JULY 1, 2018]: Sec. 2.1. (a) For purposes of this chapter:
- 17 (1) a policy or contract issued on a blanket basis is a group policy
18 or group contract;
19 (2) each individual insured under a policy or contract issued on a
20 blanket basis is a certificate holder under the policy or contract;
21 and
22 (3) a policy or contract issued on a franchise plan to members of
23 a qualified group is a nongroup policy or nongroup contract.
- 24 (b) For purposes of this chapter, a benefit plan may have only one
25 (1) plan sponsor.
- 26 (c) For purposes of this chapter, an individual who, on the
27 applicable coverage date:
- 28 (1) is a citizen of the United States; and
29 (2) resides in a:
30 (A) foreign country; or
31 (B) United States possession, territory, or protectorate;
32 that does not have an association similar to the association created
33 by this chapter;
- 34 is considered to be a resident of the state of domicile of the insurer that
35 issued the policies or contracts.
- 36 **(d) For purposes of this chapter, benefits provided under a long**
37 **term care insurance rider to:**
38 **(1) a life insurance policy; or**
39 **(2) an annuity contract;**
40 **are considered to be the same kind of benefits as the benefits under**
41 **the life insurance policy or annuity contract to which the rider**
42 **benefits relate.**



1 SECTION 17. IC 27-8-8-2.3, AS AMENDED BY P.L.276-2013,
 2 SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 3 JULY 1, 2018]: Sec. 2.3. (a) Except as otherwise excluded or limited
 4 by this chapter, this chapter provides coverage for policies and
 5 contracts specified in subsection (d) as follows:

6 (1) To a person, other than a certificate holder **or enrollee** under
 7 a group policy or a group contract, that, regardless of where the
 8 person resides, is the **health care provider**, beneficiary,
 9 nonowner assignee, or payee of a person covered under
 10 subdivision (2).

11 (2) To a person that is a certificate holder under a group policy or
 12 group contract, and to a person that is the owner of a nongroup
 13 policy or nongroup contract that is not an unallocated annuity
 14 contract or a structured settlement annuity, and that:

15 (A) is a resident; or

16 (B) is not a resident if all the following conditions are
 17 satisfied:

18 (i) The member insurer that issued the policy or contract is
 19 domiciled in Indiana.

20 (ii) The state in which the person resides has an association
 21 similar to the association.

22 (iii) The nonresident is not eligible for coverage by the other
 23 association referred to in item (ii) solely because the
 24 member insurer was not licensed in the state of residence at
 25 the time specified in the guaranty association law of the state
 26 of residence.

27 (3) For an unallocated annuity contract, subdivisions (1) and (2)
 28 do not apply, and this chapter provides coverage to the following:

29 (A) A person that is the owner of the unallocated annuity
 30 contract, if the contract was issued to or in connection with a
 31 benefit plan whose plan sponsor is a resident or, if the plan
 32 sponsor is not a resident, if all the following conditions are
 33 satisfied:

34 (i) The member insurer that issued the unallocated annuity
 35 contract is domiciled in Indiana.

36 (ii) The state in which the plan sponsor resides has an
 37 association similar to the association.

38 (iii) The other association referred to in item (ii) does not
 39 provide coverage of the unallocated annuity contract solely
 40 because the member insurer was not licensed in the state of
 41 residence at the time specified in the guaranty association
 42 law of the state of residence.



- 1 (B) A person that is the owner of an unallocated annuity
 2 contract issued to or in connection with a government lottery,
 3 if the owner is a resident or, if the owner is not a resident, if all
 4 the following conditions are satisfied:
 5 (i) The member insurer that issued the unallocated annuity
 6 contract is domiciled in Indiana.
 7 (ii) The state in which the owner resides has an association
 8 similar to the association.
 9 (iii) The other association referred to in item (ii) does not
 10 provide coverage of the unallocated annuity contract solely
 11 because the member insurer was not licensed in the state of
 12 residence at the time specified in the guaranty association
 13 law of the state of residence.
- 14 (4) For a structured settlement annuity, subdivisions (1) and (2)
 15 do not apply, and this chapter provides coverage to a person that
 16 is a payee under the structured settlement annuity (or beneficiary
 17 of a payee if the payee is deceased), if the payee:
 18 (A) is a resident, regardless of where the contract owner
 19 resides; or
 20 (B) is not a resident if all the following conditions are
 21 satisfied:
 22 (i) The member insurer that issued the structured settlement
 23 annuity is domiciled in Indiana.
 24 (ii) The state in which the payee resides has an association
 25 similar to the association.
 26 (iii) Neither the payee nor the beneficiary of the payee (if the
 27 payee is deceased) is eligible for coverage by the other
 28 association referred to in item (ii) solely because the
 29 member insurer was not licensed in the state of residence at
 30 the time specified in the guaranty association law of the state
 31 of residence.
- 32 (b) This chapter does not provide coverage to a person that is:
 33 (1) a payee or beneficiary of a contract owner that is a resident, if
 34 the payee or beneficiary is afforded any coverage by the
 35 association of another state; or
 36 (2) otherwise covered under subsection(a)(3), if any coverage is
 37 provided to the person by the association of another state.
- 38 (c) To avoid duplicate coverage, if a person that would otherwise
 39 receive coverage under this chapter is provided coverage under the
 40 laws of another state, the person is not eligible for coverage under this
 41 chapter. In determining the application of this subsection when a
 42 person may be covered by the association of more than one (1) state as



1 an owner, a payee, a beneficiary, or an assignee, this chapter must be
 2 construed in conjunction with the laws of the other state to result in
 3 coverage by only one (1) association.

4 (d) Except as otherwise excluded or limited by this chapter, this
 5 chapter provides coverage to the persons specified in subsection (a)
 6 for:

7 (1) direct nongroup life **insurance and health insurance policies**
 8 **or contracts, including health maintenance organization**
 9 **subscriber contracts and certificates; or**

10 **(2) direct nongroup annuity policies and contracts; and**

11 **(3) supplemental contracts to direct nongroup life, health, or**
 12 **annuity policies and contracts described in subdivisions (1) and**
 13 **(2);**

14 ~~(2)~~ **(4) certificates under direct group life insurance and health**
 15 **and annuity insurance policies and contracts;**

16 **(5) certificates under direct group annuity contracts; and**

17 ~~(3)~~ **(6) unallocated annuity contracts;**

18 issued by member insurers.

19 (e) This chapter does not provide coverage for or with respect to the
 20 following:

21 (1) A part of a certificate, policy, or contract:

22 (A) not guaranteed by the **member** insurer; or

23 (B) under which the risk is borne by the payee, certificate
 24 holder, or the policy or contract owner.

25 (2) A reinsurance policy or contract, unless and to the extent that
 26 assumption certificates have been issued under the reinsurance
 27 policy or contract.

28 (3) A part of a certificate, policy, or contract to the extent that the
 29 certificate's, policy's, or contract's interest rate, crediting rate, or
 30 similar factor employed in calculating returns or changes in
 31 values, whether expressly stated in the certificate, policy, or
 32 contract or determined by use of an index or other external
 33 referent stated in the certificate, policy, or contract, either:

34 (A) when averaged over a period of four (4) years immediately
 35 before the applicable coverage date, exceeds the rate of
 36 interest determined by subtracting two (2) percentage points
 37 from Moody's Corporate Bond Yield Average averaged for the
 38 same four (4) year period or for a lesser period if the
 39 certificate, policy, or contract was issued less than four (4)
 40 years before the applicable coverage date; or

41 (B) in effect under the certificate, policy, or contract on and
 42 after the applicable coverage date, exceeds the rate of interest



- 1 determined by subtracting three (3) percentage points from
 2 Moody's Corporate Bond Yield Average as most recently
 3 available on the applicable coverage date.
- 4 **However, this subdivision does not apply to a part of a**
 5 **certificate, policy, or contract (including a rider) that provides**
 6 **long term care or another health insurance benefit.**
- 7 (4) The obligations of a plan or program of an employer, an
 8 association, or another person to provide life, health, or annuity
 9 benefits to the employer's, association's, or other person's
 10 employees, members, or others, including obligations arising
 11 under and benefits payable by the employer, association, or other
 12 person under a multiple employer welfare arrangement.
- 13 (5) A minimum premium group insurance plan.
- 14 (6) A stop-loss or excess loss insurance policy or contract
 15 providing for the indemnification of or payment to a policy owner,
 16 a contract owner, a plan, or another person obligated to pay life,
 17 health, or annuity benefits or to provide services in connection
 18 with a benefit plan or another plan, fund, or program for the
 19 provision of employee welfare or pension benefits.
- 20 (7) An administrative services only contract.
- 21 (8) A part of a certificate, policy, or contract to the extent that the
 22 certificate, policy, or contract provides for:
- 23 (A) dividends or experience rating credits;
 24 (B) voting rights; or
 25 (C) payment of fees or allowances to a person, including the
 26 certificate holder or policy or contract owner, in connection
 27 with service with respect to or administration of the certificate,
 28 policy, or contract.
- 29 (9) A certificate, policy, or contract issued in Indiana by a
 30 member insurer when the member insurer did not have a
 31 certificate of authority to issue the certificate, policy, or contract
 32 in Indiana.
- 33 (10) An unallocated annuity contract issued to or in connection
 34 with a benefit plan protected by the federal Pension Benefit
 35 Guaranty Corporation, regardless of whether the federal Pension
 36 Benefit Guaranty Corporation has yet been required to make
 37 payments with respect to the benefit plan.
- 38 (11) An unallocated annuity contract or part of an unallocated
 39 annuity contract that is not issued to or in connection with a
 40 benefit plan or a government lottery.
- 41 (12) A certificate, policy, or contract or part of a certificate,
 42 policy, or contract with respect to which the Class B assessments



1 contemplated by section 6 of this chapter may not be made or
2 collected under federal or state law.

3 (13) An obligation or claim that does not arise under the express
4 written terms of the policy or contract issued by the member
5 insurer to the contract owner or policy owner, including any of the
6 following obligations and claims:

7 (A) Obligations and claims based on marketing materials.

8 (B) Obligations and claims based on side letters, riders, or
9 other documents issued by the member insurer without
10 meeting applicable policy **or contract** form filing or approval
11 requirements.

12 (C) Obligations and claims based on actual or alleged
13 misrepresentations.

14 (D) Obligations and claims that are extracontractual claims.

15 (E) Obligations and claims for penalties or consequential,
16 incidental, punitive, or exemplary damages.

17 (14) An obligation to provide a book value accounting guaranty
18 for defined contribution benefit plan participants by reference to
19 a portfolio of assets that is owned by the:

20 (A) benefit plan; or

21 (B) benefit plan's trustee;

22 that is not an affiliate of the member insurer.

23 (15) A part of a certificate, policy, or contract to the extent the:

24 (A) certificate, policy, or contract provides for the certificate's,
25 policy's, or contract's interest rate, crediting rate, or similar
26 factor employed in calculating returns or changes in values, to
27 be determined by use of an index or other external referent
28 stated in the certificate, policy, or contract; and

29 (B) returns or changes in value have not been credited to the
30 certificate, policy, or contract, or as to which the certificate
31 holder's or policy or contract owner's rights are subject to
32 forfeiture, as of the applicable coverage date.

33 If a certificate's, policy's, or contract's returns or changes in values
34 are credited to the certificate, policy, or contract less frequently
35 than annually, for purposes of determining the returns and values
36 that have been credited and are not subject to forfeiture under this
37 subdivision, the returns and changes in value determined by using
38 the procedures defined in the certificate, policy, or contract must
39 be considered credited as if the contractual date of crediting
40 returns or changes in values were the applicable coverage date,
41 and those credited returns or changes in value are not subject to
42 forfeiture under this subdivision, but will be subject to any other



- 1 applicable limitations under this chapter.
 2 (16) A funding agreement.
 3 (17) An annuity not subject to regulation as described in
 4 IC 27-1-12.4.
 5 (18) A certificate, policy, or contract that provides a hospital,
 6 medical, prescription drug, or other health care benefit under:
 7 (A) Part C of Title XVIII of the federal Social Security Act (42
 8 U.S.C. 1395w-21 through 1395w-28);
 9 (B) Part D of Title XVIII of the federal Social Security Act (42
 10 U.S.C. 1395w-101 through 1395w-153);
 11 **(C) Title XIX of the federal Social Security Act (42 U.S.C.**
 12 **1396 et seq.); or**
 13 ~~(D)~~ **(D)** regulations adopted under a law specified in clause
 14 (A), ~~or~~ (B), ~~or~~ (C).
 15 (f) The benefits that the association is obligated to cover do not
 16 exceed the lesser of the following:
 17 (1) The contractual obligations for which the member insurer is
 18 liable or would have been liable if the member insurer were not
 19 an impaired insurer or insolvent insurer.
 20 (2) The applicable limitations as follows:
 21 (A) With respect to certificates, policies, and contracts not
 22 subject to clause (B), (C), (E), or (F), with respect to one (1)
 23 life, regardless of the number of policies or contracts, the
 24 following limitations:
 25 (i) Three hundred thousand dollars (\$300,000) in life
 26 insurance death benefits, but not more than one hundred
 27 thousand dollars (\$100,000) in net cash surrender and net
 28 cash withdrawal values.
 29 (ii) One hundred thousand dollars (\$100,000) in health
 30 insurance benefits (other than **those relating to** disability
 31 **income** insurance, ~~basic hospital, medical, and surgical~~
 32 ~~insurance, major medical insurance, health benefit plans,~~
 33 and long term care insurance), including net cash surrender
 34 and net cash withdrawal values.
 35 (iii) Three hundred thousand dollars (\$300,000) in ~~health~~
 36 ~~insurance benefits that are~~ disability **income** insurance.
 37 (iv) Three hundred thousand dollars (\$300,000) in ~~health~~
 38 ~~insurance benefits under one (1) or more~~ long term care
 39 insurance ~~policies~~ **benefits** (as defined in IC 27-8-12-5).
 40 (v) Five hundred thousand dollars (\$500,000) in health
 41 ~~benefit plan insurance~~ benefits. ~~that are basic hospital,~~
 42 ~~medical, and surgical insurance or major medical insurance.~~



- 1 (vi) Two hundred fifty thousand dollars (\$250,000) in the
 2 present value of annuity benefits, including net cash
 3 surrender and net cash withdrawal values.
- 4 (B) With respect to unallocated annuity contracts issued to or
 5 in connection with a governmental benefit plan established
 6 under Section 401, 403(b), or 457 of the United States Internal
 7 Revenue Code, two hundred fifty thousand dollars (\$250,000)
 8 in the present value of annuity benefits, including net cash
 9 surrender and net cash withdrawal values, per participant.
- 10 (C) With respect to structured settlement annuities, two
 11 hundred fifty thousand dollars (\$250,000) in the present value
 12 of annuity benefits, including net cash surrender and net cash
 13 withdrawal values, per payee.
- 14 (D) In addition to the foregoing limitations, the association is
 15 not obligated to cover more than:
- 16 (i) an aggregate of three hundred thousand dollars
 17 (\$300,000) in benefits with respect to any one (1) person
 18 under clauses (A), (B), and (C), except with respect to
 19 benefits for ~~basic hospital, medical, and surgical insurance~~
 20 ~~and major medical health benefit plans insurance~~ under
 21 clause (A)(v), an aggregate of five hundred thousand dollars
 22 (\$500,000) with respect to any one (1) person; or
- 23 (ii) with respect to one (1) owner of multiple nongroup
 24 policies of life insurance, whether the policy owner is an
 25 individual, a firm, a corporation, or another person, and
 26 whether the persons insured are officers, managers,
 27 employees, or other persons, five million dollars
 28 (\$5,000,000) in benefits, including net cash surrender and
 29 net cash withdrawal values, regardless of the number of
 30 policies and contracts held by the owner.
- 31 (E) With respect to unallocated annuity contracts issued to or
 32 in connection with a government lottery, five million dollars
 33 (\$5,000,000) in benefits per contract owner, regardless of the
 34 number of contracts held by the contract owner.
- 35 (F) With respect to unallocated annuity contracts:
- 36 (i) issued to or in connection with a benefit plan; and
 37 (ii) not subject to clause (B);
- 38 five million dollars (\$5,000,000) in benefits per plan sponsor,
 39 regardless of the number of unallocated annuity contracts
 40 entitled to coverage under this chapter.
- 41 (g) The limitations set forth in subsection (f) are limitations on the
 42 benefits for which the association is obligated before taking into



- 1 account the:
- 2 (1) association's subrogation and assignment rights; or
- 3 (2) extent to which the benefits could be provided out of the
- 4 assets of the impaired insurer or insolvent insurer attributable to
- 5 covered policies.
- 6 The costs of discharging the association's obligations under this chapter
- 7 may be met by the use of assets attributable to covered policies or
- 8 reimbursed to the association under the association's subrogation and
- 9 assignment rights.
- 10 (h) In discharging the association's obligations to provide coverage
- 11 under this chapter, the association is not required to:
- 12 (1) guarantee, assume, **reissue**, reinsure, or perform;
- 13 (2) cause to be guaranteed, assumed, **reissued**, reinsured, or
- 14 performed; or
- 15 (3) otherwise assure the discharge of;
- 16 the obligations of the insolvent insurer or impaired insurer under a
- 17 covered policy that do not materially affect the economic values or
- 18 economic benefits of the covered policy.
- 19 SECTION 18. IC 27-8-8-3, AS AMENDED BY P.L.193-2006,
- 20 SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 21 JULY 1, 2018]: Sec. 3. (a) There is created a nonprofit legal entity
- 22 referred to as the Indiana Life and Health Insurance Guaranty
- 23 Association. A member insurer shall be and remain a member of the
- 24 association as a condition of the member insurer's authority to transact
- 25 insurance in Indiana. The association shall perform its functions under
- 26 the plan of operation established and approved under section 7 of this
- 27 chapter. The association shall exercise its powers through a board of
- 28 directors established under section 4 of this chapter. For purposes of
- 29 administration and assessment the association shall maintain the
- 30 following two (2) accounts:
- 31 (1) The health ~~insurance~~ account.
- 32 (2) The life insurance and annuity account, which includes the
- 33 following subaccounts:
- 34 (A) The life insurance subaccount.
- 35 (B) The annuity subaccount, which includes annuity contracts
- 36 issued to or in connection with a governmental benefit plan
- 37 established under Section 401, 403(b), or 457 of the United
- 38 States Internal Revenue Code, but otherwise excludes
- 39 unallocated annuities.
- 40 (C) The unallocated annuity subaccount, which excludes
- 41 annuity contracts issued to or in connection with a
- 42 governmental benefit plan established under Section 401,



- 1 403(b), or 457 of the United States Internal Revenue Code.
- 2 (b) The association is under the immediate supervision of the
- 3 commissioner and subject to the applicable provisions of the insurance
- 4 laws of Indiana.
- 5 SECTION 19. IC 27-8-8-4, AS AMENDED BY P.L.193-2006,
- 6 SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 7 JULY 1, 2018]: Sec. 4. (a) The board of directors of the association
- 8 shall consist of not less than ~~five (5)~~ **seven (7)** nor more than ~~nine (9)~~
- 9 **eleven (11)** member insurers serving terms established in the plan of
- 10 operation. The members of the board shall be selected by member
- 11 insurers subject to the approval of the commissioner.
- 12 (b) Vacancies on the board shall be filled for the remaining period
- 13 of the term by a majority vote of the remaining board members, subject
- 14 to the approval of the commissioner.
- 15 (c) To select the initial board and initially organize the association,
- 16 the commissioner shall give notice to all member insurers of the time
- 17 and place of the organizational meeting. At the organizational meeting,
- 18 each member insurer is entitled to one (1) vote in person or by proxy.
- 19 If the board is not selected within sixty (60) days after notice of the
- 20 organizational meeting, the commissioner may appoint the initial
- 21 members of the board.
- 22 (d) In approving selections to the board, the commissioner shall
- 23 consider whether all member insurers are fairly represented.
- 24 (e) Members of the board may be reimbursed from the assets of the
- 25 association for expenses incurred by the members as members of the
- 26 board. The association shall not otherwise compensate members of the
- 27 board for the members' services on the board.
- 28 SECTION 20. IC 27-8-8-5, AS AMENDED BY P.L.193-2006,
- 29 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 30 JULY 1, 2018]: Sec. 5. (a) If a member insurer is an impaired insurer,
- 31 the association may, in the association's sole discretion and subject to
- 32 any conditions imposed by the association that do not impair the
- 33 contractual obligations of the impaired insurer and that are approved
- 34 by the commissioner:
- 35 (1) guarantee, assume, **reissue**, reinsure, or perform, or cause to
- 36 be guaranteed, assumed, **reissued**, reinsured, or performed, the
- 37 contractual obligations of any of the covered policies of the
- 38 impaired insurer or otherwise assure the discharge of the
- 39 contractual obligations of the covered policies of the impaired
- 40 insurer; and
- 41 (2) provide money, pledges, loans, notes, guarantees, or use other
- 42 means as determined by the association in the association's sole



- 1 discretion to be necessary or appropriate to effectuate subdivision
 2 (1).
 3 (b) An obligation undertaken by the association under subsection (a)
 4 with respect to a covered policy of an impaired insurer ceases on the
 5 date the covered policy is replaced by the policy owner, insured, or
 6 association.
 7 (c) If a member insurer is an insolvent insurer, the association shall,
 8 in the association's sole discretion, do one (1) of the following for each
 9 covered policy:
 10 (1) Guarantee, assume, **reissue**, reinsure, or perform, or cause to
 11 be guaranteed, assumed, **reissued**, reinsured, or performed, the
 12 contractual obligations of the covered policy or otherwise assure
 13 the discharge of the contractual obligations of the covered policy.
 14 (2) Terminate existing benefits and coverage and provide benefits
 15 and coverages in accordance with the following provisions:
 16 (A) ~~For premiums identical to the premiums that would have~~
 17 ~~been payable under the covered policy;~~ Assure payment of
 18 benefits arising under the contractual obligations, except for
 19 terms of conversion and nonrenewability, for:
 20 (i) with respect to a group covered policy, claims incurred
 21 not later than the earlier of the next renewal date under the
 22 covered policy or forty-five (45) days, but not less than thirty
 23 (30) days, after the coverage date for the insolvent insurer;
 24 and
 25 (ii) with respect to a nongroup covered policy, claims
 26 incurred not later than the earlier of the next renewal date
 27 under the covered policy or one (1) year, but in no event less
 28 than thirty (30) days, after the coverage date for the
 29 insolvent insurer.
 30 (B) Make diligent efforts to provide each:
 31 (i) known insured or annuitant, for a nongroup covered
 32 policy; and
 33 (ii) owner, for a group covered policy;
 34 at least thirty (30) days notice of the termination of the benefits
 35 provided.
 36 (C) Make available substitute coverage, on an individual basis,
 37 to each:
 38 (i) owner of a nongroup covered policy if the owner had a
 39 right to continue the nongroup covered policy in force until
 40 a specified age or for a specified period, during which time
 41 the insurer had no unilateral right to make changes in the
 42 nongroup covered policy's provisions or had only a



1 unilateral right to make changes in premiums only by class;
 2 and
 3 (ii) insured or annuitant under a group covered policy if the
 4 insured or annuitant is not eligible for any replacement
 5 group coverage and had a right, before termination of the
 6 group covered policy, to convert to individual coverage.
 7 (D) In making available any substitute coverage under clause
 8 (C), the association may offer to reissue the terminated
 9 coverage or to issue an alternative policy or contract. If made
 10 available under clause (C), alternative or reissued policies and
 11 contracts must be offered without requiring evidence of
 12 insurability and must not impose any waiting period or
 13 coverage exclusion, other than a waiting period or coverage
 14 exclusion provided for in this chapter, that would not have
 15 applied under the terminated covered policy. The association
 16 may cause any alternative or reissued policy or contract to be
 17 assumed or reinsured.
 18 (E) Use of alternative policies and contracts by the association
 19 is subject to the approval of the ~~domiciliary insurance~~
 20 ~~regulatory authority and the receivership court:~~ **commissioner.**
 21 The association may adopt alternative policies and contracts
 22 of various types for future issuance without regard to any
 23 particular impairment or insolvency. Alternative policies and
 24 contracts must contain at least the minimum statutory
 25 provisions required in Indiana and provide benefits that are
 26 reasonable in relation to the premium charged. The association
 27 shall set the premium in accordance with a table of rates
 28 adopted by the association. The premium must:
 29 (i) reflect the amount of insurance to be provided and the
 30 age and class of risk of each insured; and
 31 (ii) not reflect changes in the health of the insured after the
 32 terminated covered policy was last underwritten.
 33 Subject to coverage exceptions, exclusions, and limitations
 34 provided for in this chapter, an alternative policy or contract
 35 issued by the association must provide coverage similar, in
 36 material respects, to the coverage under the terminated
 37 covered policy as determined by the association.
 38 (F) If the association elects to reissue terminated coverage at
 39 a premium rate different from the premium rate charged under
 40 the terminated covered policy, the association shall set the
 41 premium in accordance with a table of rates adopted by the
 42 association. The premium:



1 (i) must reflect the amount of insurance to be provided and
 2 the age and class of risk of each insured; and

3 (ii) is subject to approval of the ~~domiciliary insurance~~
 4 ~~regulatory authority and the receivership court-~~
 5 ~~commissioner.~~

6 (G) The association's obligations with respect to coverage
 7 under a covered policy of an insolvent insurer or under a
 8 reissued or alternative policy or contract ceases on the date the
 9 coverage or covered policy is replaced by another similar
 10 policy by the policy owner, insured, or association.

11 (H) Subject to subsection (u), when proceeding under this
 12 subdivision with respect to a covered policy carrying
 13 guaranteed minimum interest rates, the association shall assure
 14 the payment or crediting of a rate of interest consistent with
 15 section 2.3(e)(3) of this chapter.

16 (3) Take any combination of the actions set forth in subdivisions
 17 (1) and (2).

18 (d) The association may provide money, pledges, loans, or
 19 guarantees, or use other means that the association, in the association's
 20 sole discretion, determines are necessary or appropriate to discharge
 21 the association's duties under subsection (c).

22 (e) Failure to pay premiums within thirty-one (31) days after the
 23 date that payment is due under the terms of a guaranteed, assumed,
 24 alternative, or reissued policy or contract or substitute coverage
 25 terminates the association's obligations under this chapter with respect
 26 to the policy, contract, or coverage, except with respect to claims
 27 incurred or net cash surrender value due under this chapter.

28 (f) Premiums due for coverage after the coverage date for an
 29 impaired insurer or insolvent insurer belong to and are payable at the
 30 direction of the association, and the association is liable for unearned
 31 premiums payable to policy or contract owners with respect to
 32 premiums received by the association.

33 (g) The protection provided by this chapter does not apply where
 34 any guaranty protection is provided to residents of this state by the laws
 35 of the domiciliary state of the impaired insurer or insolvent insurer if
 36 the domiciliary state is a state other than Indiana.

37 (h) In carrying out its duties under subsection (c), the association
 38 may, subject to approval by a court in Indiana, impose:

39 (1) permanent policy or contract liens, if the association finds
 40 that:

41 (A) the amounts that can be assessed under this chapter are
 42 less than the amounts needed to assure full and prompt



- 1 performance of the association's duties under this chapter; or
 2 (B) economic or financial conditions, as they affect member
 3 insurers, are sufficiently adverse so as to render the imposition
 4 of the permanent policy or contract liens to be in the public
 5 interest; and
 6 (2) temporary moratoriums or liens on payments of cash values
 7 and policy loans or any other right to withdraw funds held in
 8 conjunction with a covered policy, in addition to any contractual
 9 provisions for deferral of cash or policy loan value.
- 10 In addition, in the event of a temporary moratorium or moratorium
 11 charge imposed by the receivership court on payments of cash values
 12 or policy loans or any other right to withdraw funds held in conjunction
 13 with a covered policy out of the assets of the impaired insurer or
 14 insolvent insurer, the association may defer the payment of cash values,
 15 policy loans, or other rights by the association for the period of the
 16 moratorium or moratorium charge imposed by the receivership court,
 17 except for claims covered by the association to be paid in accordance
 18 with a hardship procedure established by the liquidator or rehabilitator
 19 and approved by the receivership court.
- 20 (i) A deposit in Indiana, held by law or required by the
 21 commissioner for the benefit of creditors, including policy owners, that
 22 is not turned over to the domiciliary receiver before or promptly after
 23 the coverage date for an impaired insurer or insolvent insurer under
 24 IC 27-9-4-3 must be promptly paid to the association. The association:
 25 (1) may retain a part of an amount paid to the association under
 26 this subsection equal to the percentage determined by dividing the
 27 aggregate amount of policy owners' claims related to the
 28 impairment or insolvency for which the association provides
 29 statutory benefits by the aggregate amount of all policy owners'
 30 claims in Indiana related to the impairment or insolvency; and
 31 (2) shall remit to the domiciliary receiver the difference between
 32 the amount paid to the association and the amount retained by the
 33 association under this subsection.
- 34 An amount retained by the association under this subsection must be
 35 treated as a distribution of estate assets under IC 27-9-3-32 or similar
 36 provision of the state of domicile of the impaired insurer or insolvent
 37 insurer.
- 38 (j) If the association fails to act within a reasonable period of time
 39 as provided in subsection (c) with respect to an insolvent insurer, the
 40 commissioner has the powers and duties of the association under this
 41 chapter with respect to the insolvent insurer.
- 42 (k) The association may, upon the commissioner's request, assist



1 and advise the commissioner concerning rehabilitation, payment of
 2 claims, continuance of coverage, or the performance of other
 3 contractual obligations of an impaired insurer or insolvent insurer.

4 (l) The association has standing and the right to appear or intervene
 5 before a court or an agency in Indiana or elsewhere with jurisdiction
 6 over an impaired insurer or insolvent insurer for which the association
 7 is or may become obligated under this chapter or with jurisdiction over
 8 a person or property against which the association may have rights
 9 through subrogation or otherwise. Standing extends to all matters
 10 germane to the rights, powers, and duties of the association, including
 11 proposals for reinsuring, modifying, or guaranteeing the policies or
 12 contracts of the impaired insurer or insolvent insurer and the
 13 determination of the policies or contracts and contractual obligations.

14 (m) A person receiving benefits under this chapter is considered to
 15 have assigned:

16 (1) the person's rights under; and

17 (2) any cause of action against another person for losses arising
 18 under, resulting from, or otherwise relating to;

19 the covered policy to the association to the extent of the benefits
 20 received because of this chapter, whether the benefits are payments of
 21 or on account of contractual obligations or continuation of coverage or
 22 provision of substitute or alternative coverage. The association may
 23 require an assignment to it of those rights and causes of action by a
 24 payee, policy or contract owner, certificate holder, beneficiary, insured,
 25 or annuitant as a condition precedent to the receipt of any right or
 26 benefits conferred by this chapter on the person.

27 (n) The subrogation rights of the association under subsections (m)
 28 and (o) have the same priority against the assets of the impaired insurer
 29 or insolvent insurer as those possessed by the person entitled to receive
 30 benefits under this chapter.

31 (o) In addition to the rights conferred by subsections (m) and (n),
 32 the association has all common law rights of subrogation and any other
 33 equitable or legal remedy with respect to a covered policy that would
 34 have been available to the:

35 (1) impaired insurer or insolvent insurer;

36 (2) owner, beneficiary, **enrollee, health care provider**, or payee
 37 of a policy or contract with respect to the policy or contract,
 38 including, in the case of a structured settlement annuity, rights of
 39 the owner, beneficiary, or payee of the annuity, to the extent of
 40 benefits received under this chapter, against a person:

41 (A) who is originally or by succession responsible for the
 42 losses arising from the personal injury relating to the annuity



- 1 or payment for the annuity; and
 2 (B) whose responsibility is not solely because of the person
 3 serving as an assignee in respect of a qualified assignment
 4 under Section 130 of the Internal Revenue Code; and
 5 (3) certificate holder, or the beneficiary or payee of the certificate
 6 holder, with respect to a certificate.
 7 (p) If subsection (m), (n), or (o) is invalid or ineffective with respect
 8 to a person or claim, the amount payable by the association with
 9 respect to the related covered policies must be reduced by the amount
 10 realized by another person with respect to the person or claim that is
 11 attributable to the covered policies.
 12 (q) If the association provides benefits with respect to a covered
 13 policy and a person recovers amounts to which the association has
 14 rights as described in subsection (m), (n), or (o), the person shall pay
 15 to the association the part of the recovery attributable to the covered
 16 policies.
 17 (r) The association may do the following:
 18 (1) Enter into contracts necessary or appropriate to carry out the
 19 provisions and purposes of this chapter.
 20 (2) Sue or, subject to section 14 of this chapter, be sued, including
 21 taking legal actions necessary or appropriate to recover unpaid
 22 assessments under section 6 of this chapter and to resolve claims
 23 or potential claims against or on behalf of the association.
 24 (3) Borrow money to effect the purposes of this chapter and issue
 25 notes or other evidences of indebtedness of the association with
 26 respect to borrowings. Notes or other evidences of indebtedness
 27 described in this subdivision that are not in default are legal
 28 investments for domestic **member** insurers and may be carried as
 29 admitted assets.
 30 (4) Employ or retain persons necessary or appropriate to handle
 31 the financial transactions of the association and to perform other
 32 functions necessary or appropriate under this chapter.
 33 (5) Take legal action necessary or appropriate to avoid or recover
 34 payment of improper claims.
 35 (6) Exercise, for the purposes of this chapter and to the extent
 36 approved by the commissioner, the powers of a domestic life or
 37 health insurer. However, in no case may the association issue
 38 **insurance** policies or **annuity** contracts other than those issued to
 39 perform the association's obligations under this chapter.
 40 (7) Request information from a person seeking coverage from the
 41 association to aid the association in determining and discharging
 42 the association's obligations under this chapter with respect to the



- 1 person. The person shall promptly comply with the request.
 2 (8) Settle claims and potential claims by or against the
 3 association.
 4 (9) Exercise all rights, privileges, and powers granted to the
 5 association by any other laws of Indiana or another jurisdiction.
 6 **(10) In accordance with the terms of the policy or contract,**
 7 **file for an actuarially justified rate or premium increase for**
 8 **a covered policy.**
 9 ~~(10)~~ **(11)** Take other necessary or appropriate action to discharge
 10 the association's duties and obligations under this chapter or to
 11 exercise the association's rights and powers under this chapter.
 12 (s) The association may belong to one (1) or more organizations of
 13 one (1) or more other state associations of similar purpose to further the
 14 purpose and administer the powers and duties of the association.
 15 (t) The association has discretion and may exercise reasonable
 16 business judgment to determine the means by which the association is
 17 to discharge, in an economical and efficient manner, the association's
 18 obligations under this chapter.
 19 (u) In discharging the association's obligations and exercising the
 20 association's rights and powers under subsections (a) and (c), the
 21 association may, subject to approval of the receivership court, provide
 22 substitute coverage for a covered policy that provides for the covered
 23 policy's interest rate, crediting rate, or similar factor employed in
 24 calculating returns or changes in value to be determined by use of an
 25 index or other external referent stated in the covered policy by issuing
 26 an alternative policy or contract in accordance with the following
 27 provisions:
 28 (1) Instead of the index or other external referent stated in the
 29 covered policy, the alternative policy or contract may provide for:
 30 (A) a fixed interest rate;
 31 (B) payment of dividends with minimum guarantees; or
 32 (C) a different method for calculating returns or changes in
 33 value.
 34 (2) A:
 35 (A) requirement for evidence of insurability; or
 36 (B) waiting period or an exclusion, other than a waiting period
 37 or an exclusion provided for in this chapter;
 38 that would not have applied under the covered policy may not be
 39 imposed.
 40 (3) The alternative policy or contract must provide coverage
 41 similar, in material respects, to the coverage under the covered
 42 policy, after taking into account the exceptions, exclusions, and



1 limitations provided for in this chapter, as determined by the
 2 association.

3 SECTION 21. IC 27-8-8-5.2, AS ADDED BY P.L.193-2006,
 4 SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 5 JULY 1, 2018]: Sec. 5.2. (a) At any time within one (1) year after the
 6 coverage date for an impaired insurer or insolvent insurer, the
 7 association may elect, subject to subdivisions (1) through (4), to
 8 succeed to the rights and obligations of the impaired insurer or
 9 insolvent insurer that accrue on or after the coverage date and that
 10 relate to covered policies under one (1) or more indemnity reinsurance
 11 agreements entered into by the impaired insurer or insolvent insurer as
 12 a ceding insurer. However, the association may not exercise an election
 13 with respect to a reinsurance agreement if the receiver, rehabilitator, or
 14 liquidator of the impaired insurer or insolvent insurer has previously
 15 and expressly disaffirmed the reinsurance agreement. The election by
 16 the association must be effected by a notice to the receiver,
 17 rehabilitator, or liquidator and to the affected reinsurers specifying the
 18 reinsurance agreement concerning which the association has made the
 19 foregoing election. If the association makes an election, the following
 20 apply with respect to the agreements selected by the association:

21 (1) The association is responsible for:

22 (A) all unpaid premiums due under the agreements for periods
 23 before and after the coverage date; and
 24 (B) the performance of all other obligations of the impaired
 25 insurer or insolvent insurer to be performed after the coverage
 26 date;

27 that relate to covered policies. The association may charge
 28 covered policies that are only partially covered by the association,
 29 through reasonable allocation methods, the costs for reinsurance
 30 in excess of the obligations of the association.

31 (2) The association is entitled to any amount payable by the
 32 reinsurer under the selected agreements:

33 (A) with respect to losses or events that occur during periods
 34 after the coverage date; and
 35 (B) that relate to covered policies.

36 Of the amount received from the reinsurer, the association is
 37 obliged to pay to the beneficiary under the covered policy on
 38 account of which the amount was paid a portion of the amount
 39 equal to the excess of the amount received by the association over
 40 benefits paid by the association on account of the covered policy
 41 less the retention of the impaired insurer or insolvent insurer
 42 applicable to the loss or event.



1 (3) Within thirty (30) days after the association's election, the
 2 association and each indemnity reinsurer shall calculate the net
 3 balance due to or from the association under each reinsurance
 4 agreement as of the date of the association's election, giving full
 5 credit to all items paid by the:

6 (A) impaired insurer or insolvent insurer, or the impaired
 7 insurer's or insolvent insurer's receiver, rehabilitator, or
 8 liquidator; or

9 (B) indemnity reinsurer;

10 during the period between the coverage date and the date of the
 11 association's election. Either the association or indemnity
 12 reinsurer shall pay the net balance due the other not more than
 13 five (5) days after the completion of the calculation. If the
 14 receiver, rehabilitator, or liquidator has received any amount due
 15 the association under subdivision (2), the receiver, rehabilitator,
 16 or liquidator shall remit the amount to the association as promptly
 17 as practicable.

18 (4) If the association, within sixty (60) days of the election, pays
 19 the premiums due for periods before and after the coverage date
 20 that relate to covered policies, the reinsurer is not entitled to:

21 (A) terminate the reinsurance agreements insofar as the
 22 agreements relate to covered policies; or

23 (B) set off any unpaid premium due for periods before the
 24 coverage date against amounts due the association.

25 (b) If the association transfers any of the association's obligations to
 26 another insurer, and if the association and the other insurer agree, the
 27 other insurer succeeds to the rights and obligations of the association
 28 under subsection (a) with respect to the transferred obligations
 29 effective as of the date agreed upon by the association and the other
 30 insurer and regardless of whether the association has made the election
 31 referred to in subsection (a), except that the:

32 (1) indemnity reinsurance agreements automatically terminate for
 33 new reinsurance unless the indemnity reinsurer and the other
 34 insurer agree to the contrary; and

35 (2) obligations of the association described in subsection (a)(2) no
 36 longer apply on and after the date the indemnity reinsurance
 37 agreement is transferred to the third party insurer.

38 This subsection does not apply if the association has previously notified
 39 the receiver, rehabilitator, or liquidator and the affected reinsurer in
 40 writing that the association will not exercise the election referred to in
 41 subsection (a).

42 (c) Subsections (a) and (b) supersede any other law or affected



1 reinsurance agreement that provides for or requires payment of
 2 reinsurance proceeds, on account of losses or events that occur after the
 3 coverage date, to the receiver, liquidator, or rehabilitator of the
 4 impaired insurer or insolvent insurer. The receiver, rehabilitator, or
 5 liquidator remains entitled to amounts payable by the reinsurer under
 6 the reinsurance agreement with respect to losses or events that occur
 7 before the coverage date, subject to applicable setoff provisions.

8 (d) Except as provided in subsections (a), (b), and (c), this chapter
 9 does not alter or modify the terms and conditions of indemnity
 10 reinsurance agreements of the insolvent insurer.

11 (e) This chapter does not:

- 12 (1) abrogate or limit the rights of a reinsurer to claim that the
 13 reinsurer is entitled to rescind a reinsurance agreement; or
 14 (2) give a policy owner, **insured**, or beneficiary an independent
 15 cause of action against an indemnity reinsurer that is not
 16 otherwise set forth in the indemnity reinsurance agreement.

17 SECTION 22. IC 27-8-8-6, AS AMENDED BY P.L.193-2006,
 18 SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 19 JULY 1, 2018]: Sec. 6. (a) For the purpose of providing funds
 20 necessary to carry out the powers and duties of the association and
 21 necessary to pay administrative costs and expenses incurred by the
 22 commissioner in supervising the association and discharging the
 23 commissioner's obligations under this chapter, the board shall assess
 24 the member insurers, separately for each account, at a time and for
 25 amounts as the board finds necessary. Assessments are due not less
 26 than thirty (30) days after prior written notice to the member insurers
 27 and accrue interest at six percent (6%) per annum on and after the due
 28 date.

29 (b) There are two (2) classes of assessments as follows:

- 30 (1) Class A assessments are assessments that are authorized and
 31 called by the board for the purpose of meeting administrative and
 32 legal costs and other expenses. Class A assessments may be
 33 authorized and called whether or not related to a particular
 34 impaired insurer or insolvent insurer.
 35 (2) Class B assessments are assessments that are authorized and
 36 called by the board to the extent necessary to carry out the powers
 37 and duties of the association under this chapter with regard to an
 38 impaired insurer or insolvent insurer.

39 (c) The amount of a Class A assessment must be determined by the
 40 board and may be authorized and called on a pro rata or non-pro rata
 41 basis. If pro rata, the board may provide that the assessment be credited
 42 against future Class B assessments. ~~The total of all non-pro rata~~



1 assessments must not exceed one hundred fifty dollars (\$150) per
2 member insurer in any one (1) calendar year.

3 (d) The amount of a Class B assessment, **except for assessments**
4 **related to long term care insurance**, must be allocated for assessment
5 purposes: among

6 **(1) between the accounts; and**

7 **(2) among the subaccounts of the life insurance and annuity**
8 **account;**

9 under an allocation formula that may be based on the premiums or
10 reserves of the impaired insurer or insolvent insurer or another standard
11 considered by the board in the board's sole discretion as fair and
12 reasonable under the circumstances.

13 **(e) The amount of a Class B assessment related to long term**
14 **care insurance must be allocated for assessment purposes**
15 **according to the following:**

16 **(1) The allocation to:**

17 **(A) accident and health insurance member insurers is fifty**
18 **percent (50%) of the assessment; and**

19 **(B) life insurance and annuity member insurers is fifty**
20 **percent (50%) of the assessment.**

21 **(2) The share of the assessment that must be allocated to the**
22 **life insurance and annuity account must be determined as**
23 **follows:**

24 **STEP ONE: Determine the life insurance and annuity**
25 **member insurers' share of the following:**

26 **(A) The health account.**

27 **(B) The life insurance and annuity account.**

28 **STEP TWO: Determine the remainder of:**

29 **(A) fifty-hundredths (0.50); minus**

30 **(B) the life insurance and annuity member insurers'**
31 **share of the health account.**

32 **STEP THREE: Determine the remainder of:**

33 **(A) the life insurance and annuity member insurers'**
34 **share of the life insurance and annuity account; minus**

35 **(B) the life insurance and annuity member insurers'**
36 **share of the health account.**

37 **STEP FOUR: Divide the remainder determined under**
38 **STEP TWO by the remainder determined under STEP**
39 **THREE.**

40 For purposes of this subsection, "life insurance and annuity
41 member insurer" means a member insurer for which the sum of
42 the member insurer's assessable life insurance premiums and



1 **annuity premiums is equal to or greater than the member insurer's**
 2 **total assessable health insurance premiums, including assessable**
 3 **health maintenance organization premiums and excluding**
 4 **assessable premiums written for disability insurance and long term**
 5 **care insurance. For purposes of this subsection, "accident and**
 6 **health insurance member insurer" means a member insurer that**
 7 **is not a life insurance and annuity member insurer. For purposes**
 8 **of this subsection, assessable premiums must be measured within**
 9 **Indiana.**

10 ~~(e)~~ **(f)** Class B assessments against member insurers for each
 11 account and subaccount with respect to an impaired insurer or
 12 insolvent insurer must be allocated among the assessed member
 13 insurers in the proportion that the premiums received in Indiana by
 14 each assessed member insurer on policies and contracts covered by the
 15 account or subaccount during the assessment base year for the impaired
 16 insurer or insolvent insurer bears to premiums received in Indiana by
 17 all assessed members on policies and contracts covered by the same
 18 account or subaccount during the same assessment base year.

19 ~~(f)~~ **(g)** Assessments for funds to meet the requirements of the
 20 association with respect to an impaired insurer or insolvent insurer
 21 must not be authorized or called until necessary to implement the
 22 purposes of this chapter. Classification of assessments under subsection
 23 (b) and computation of assessments under subsections (c), (d), ~~and~~ (e),
 24 **and (f)** must be made with a reasonable degree of accuracy,
 25 recognizing that exact determinations are not always possible. The
 26 association shall notify each member insurer of the member insurer's
 27 anticipated share of an assessment that has been authorized but not yet
 28 called not more than one hundred eighty (180) days after the
 29 assessment is authorized.

30 ~~(g)~~ **(h)** The association may abate or defer, in whole or in part, the
 31 assessment of a member insurer if, in the opinion of the board, payment
 32 of the assessment would endanger the ability of the member insurer to
 33 fulfill its policy and contract obligations. In the event an assessment
 34 against a member insurer is abated or deferred in whole or in part, the
 35 amount by which the assessment is abated or deferred may be assessed
 36 against the other member insurers in a manner consistent with the basis
 37 for assessments set forth in this section. Once the conditions that
 38 caused a deferral have been removed or rectified, the member insurer
 39 shall pay assessments that were deferred under a repayment plan
 40 approved by the association.

41 ~~(h)~~ **(i)** Subject to subsection ~~(i)~~, **(j)**, the total of all assessments
 42 authorized by the association in one (1) calendar year against a member



1 insurer for a given subaccount of the life insurance and annuity account
 2 or for the health ~~insurance~~ account with respect to any single
 3 assessment base year must not exceed two percent (2%) of the member
 4 insurer's premiums received in Indiana on the policies and contracts
 5 covered by the subaccount or account during the applicable assessment
 6 base year.

7 ~~(h)~~ **(j)** If two (2) or more assessments are authorized in one (1)
 8 calendar year with respect to impaired insurers or insolvent insurers
 9 having different assessment base years, the annual premium used for
 10 purposes of determining the aggregate assessment percentage
 11 limitation referenced in subsection ~~(h)~~ **(i)** must be equal to the higher
 12 of the annual premiums for the applicable subaccount or account as
 13 calculated under this section.

14 ~~(j)~~ **(k)** If the maximum assessment, together with other assets of the
 15 association in an account, does not provide in one (1) year in the
 16 account an amount sufficient to carry out the responsibilities of the
 17 association, additional funds must be assessed as soon as permitted by
 18 this chapter.

19 ~~(k)~~ **(l)** The board may provide in the plan of operation a method of
 20 or procedure for allocating funds among claims relating to one (1) or
 21 more impaired insurers or insolvent insurers when the maximum
 22 assessment is insufficient to cover anticipated claims.

23 ~~(l)~~ **(m)** If the maximum assessment for a subaccount of the life
 24 insurance and annuity account in one (1) year does not provide an
 25 amount sufficient to carry out the responsibilities of the association, the
 26 board shall, under subsection ~~(e)~~; **(f)**, access the other subaccounts of
 27 the life insurance and annuity account for the necessary additional
 28 amount, subject to the maximum stated in subsections ~~(h)~~ **and (i) and**
 29 **(j)**.

30 ~~(m)~~ **(n)** The board may, by an equitable method or procedure as
 31 established in the plan of operation, refund to member insurers, in
 32 proportion to the contribution of each member insurer to the account,
 33 the amount by which the assets of the account exceed the amount the
 34 board determines is necessary to carry out the obligations of the
 35 association with regard to the account, including assets accruing from
 36 assignment, subrogation, net realized gains, and income from
 37 investments. A reasonable amount may be retained in an account to
 38 provide funds for the continuing expenses of the association and for the
 39 future discharge of the association's obligations.

40 ~~(n)~~ **(o)** It is proper for a member insurer, in determining its premium
 41 rates and policyowner dividends as to any type of insurance within the
 42 scope of this chapter, to consider the amount reasonably necessary to



1 meet its assessment obligations under this chapter.

2 ~~(o)~~ **(p)** The association shall issue to each member insurer paying an
 3 assessment under this chapter, other than a Class A assessment, a
 4 certificate of contribution, in a form prescribed by the commissioner,
 5 for the amount of the assessment paid. All outstanding certificates are
 6 of equal dignity and priority without reference to amounts or dates of
 7 issue. A certificate of contribution may be shown by the member
 8 insurer in its financial statement as an asset in the form and for the
 9 amount and period of time as the commissioner may approve.

10 SECTION 23. IC 27-8-8-8, AS AMENDED BY P.L.193-2006,
 11 SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 12 JULY 1, 2018]: Sec. 8. (a) The commissioner shall do the following:

13 (1) Upon request of the board, provide the association with a
 14 statement of the premiums in Indiana and other appropriate states
 15 for each member insurer.

16 (2) When an impairment is declared and the amount of the
 17 impairment is determined, serve a demand on the impaired
 18 insurer to make good the impairment within a reasonable time.
 19 Notice to the impaired insurer shall constitute notice to its
 20 shareholders. The failure of the **impaired** insurer to promptly
 21 comply with the demand shall not excuse the association from the
 22 performance of its powers and duties under this chapter.

23 (3) In any liquidation or rehabilitation proceeding involving a
 24 domestic insurer, be appointed as the liquidator or rehabilitator.

25 (b) The commissioner may suspend or revoke, after notice and
 26 hearing, the certificate of authority to transact insurance in Indiana of
 27 a member insurer that fails to pay an assessment when due or fails to
 28 comply with the plan of operation. As an alternative, the commissioner
 29 may levy a forfeiture on a member insurer that fails to pay an
 30 assessment when due. A forfeiture shall not exceed five percent (5%)
 31 of the unpaid assessment per month, but no forfeiture shall be less than
 32 one hundred dollars (\$100) per month.

33 (c) A final action of the association or the board may be appealed to
 34 the commissioner by a member insurer if the appeal is taken within
 35 sixty (60) days of the member insurer's receipt of notice of the final
 36 action being appealed. A final action or order of the commissioner is
 37 subject to judicial review in a court with jurisdiction in accordance
 38 with the Indiana law that applies to the actions or orders of the
 39 commissioner.

40 (d) The liquidator, rehabilitator, or conservator of an impaired
 41 insurer or insolvent insurer may notify all interested persons of the
 42 effect of this chapter.



1 SECTION 24. IC 27-8-8-9, AS AMENDED BY P.L.193-2006,
 2 SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 3 JULY 1, 2018]: Sec. 9. (a) To aid in the detection and prevention of
 4 **member** insurer insolvencies or impairments, the commissioner shall
 5 do the following:

6 (1) Notify the insurance regulatory authorities of all the other
 7 states not more than thirty (30) days after the date an action taken
 8 by the commissioner occurs when the commissioner takes any of
 9 the following actions against a member insurer:

10 (A) Revokes the member insurer's certificate of authority.

11 (B) Suspends the member insurer's certificate of authority.

12 (C) Issues a formal order that the member insurer restrict its
 13 premium writing, obtain additional contributions to surplus,
 14 withdraw from Indiana, reinsure all or any part of its business,
 15 or increase capital, surplus, or any other account for the
 16 security of policy owners or creditors.

17 (2) Report to the association when the commissioner takes any of
 18 the actions set forth in subdivision (1) or when the commissioner
 19 has received a report from any other insurance regulatory
 20 authority indicating that an action has been taken in another state.
 21 The report to the association must contain all significant details
 22 of the action taken or of the report received from another
 23 insurance regulatory authority.

24 (3) Report to the association when the commissioner has
 25 reasonable cause to believe from an examination, whether
 26 completed or in process, of a member insurer that the member
 27 insurer may be impaired or insolvent.

28 (4) Furnish to the association the NAIC Insurance Regulatory
 29 Information System (IRIS) ratios and listings of companies not
 30 included in the ratios developed by the National Association of
 31 Insurance Commissioners. The association may use the
 32 information contained in the ratios and listings in carrying out its
 33 duties and responsibilities under this chapter. The report and the
 34 information contained in the report must be kept confidential by
 35 the association until made public by the commissioner or other
 36 lawful authority.

37 (b) The commissioner may seek the advice and recommendations
 38 of the association concerning a matter affecting the commissioner's
 39 duties and responsibilities in regard to the financial condition of
 40 member insurers and ~~companies~~ **insurers** seeking admission to transact
 41 insurance business in Indiana.

42 (c) The association may, upon majority vote by the board, make



1 reports and recommendations to the commissioner on any matter
 2 germane to the solvency, liquidation, rehabilitation, or conservation of
 3 a member insurer or germane to the solvency of any **company insurer**
 4 seeking to do an insurance business in Indiana. The reports and
 5 recommendations are not public documents.

6 (d) The association may, upon majority vote by the board, notify the
 7 commissioner of any information indicating that a member insurer may
 8 be impaired or insolvent.

9 (e) The association may, upon majority vote by the board, make
 10 recommendations to the commissioner for the detection and prevention
 11 of **member** insurer insolvencies.

12 SECTION 25. IC 27-8-8-10, AS AMENDED BY P.L.193-2006,
 13 SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 14 JULY 1, 2018]: Sec. 10. (a) Records must be kept of all meetings of the
 15 board to discuss the activities of the association in carrying out its
 16 powers and duties under sections 5, 5.2, and 5.4 of this chapter.
 17 Records of the association with respect to an impaired insurer or
 18 insolvent insurer must not be disclosed except:

- 19 (1) after the termination of the liquidation, rehabilitation, or
 20 conservation proceeding involving the impaired insurer or
 21 insolvent insurer; or
- 22 (2) upon the order of a court with jurisdiction if the order is made
 23 before the time described in subdivision (1).

24 This subsection does not limit the duty of the association to submit a
 25 report of its activities under section 12 of this chapter.

26 (b) For the purpose of carrying out its obligations under this chapter,
 27 the association is a creditor of the impaired insurer or insolvent insurer
 28 to the extent of assets attributable to covered policies reduced by any
 29 amounts that the association has received, from a person other than the
 30 impaired insurer or insolvent insurer, as subrogee under section 5(m),
 31 5(o), and 5(q) of this chapter. Assets of the impaired insurer or
 32 insolvent insurer attributable to covered policies shall be used to
 33 continue all covered policies and pay all contractual obligations of the
 34 impaired insurer or insolvent insurer as required by this chapter.
 35 "Assets attributable to covered policies", as used in this subsection, is
 36 that proportion of the assets that the reserves that should have been
 37 established for such policies bear to the reserves that should have been
 38 established for all policies of insurance written by the impaired insurer
 39 or insolvent insurer.

40 (c) As a creditor of an impaired insurer or insolvent insurer under
 41 subsection (b) and consistent with IC 27-9-3-32, the association and
 42 other similar associations are entitled to receive disbursements of



1 assets out of the marshaled assets, as the assets become available to
 2 reimburse the association or another similar association, as a credit
 3 against contractual obligations under this chapter. If the liquidator has
 4 not, within one hundred twenty (120) days after a member insurer
 5 becomes an insolvent insurer, made an application to the court for the
 6 approval of a proposal to disburse assets out of marshaled assets to
 7 guaranty associations having obligations because of the insolvency, the
 8 association is entitled to make application to the receivership court for
 9 approval of the association's own proposal to disburse the assets.

10 (d) Before the termination of a liquidation, rehabilitation, or
 11 conservation proceeding, the court may take into consideration the
 12 contributions of the respective parties, including the association, the
 13 shareholders, **and the policy owners, and the insureds** of the impaired
 14 insurer or insolvent insurer, and any other party with a bona fide
 15 interest, in making an equitable distribution of the ownership rights of
 16 the impaired insurer or insolvent insurer. In making the determination,
 17 the court shall consider the welfare of the policy owners **and insureds**
 18 of the continuing or successor **member** insurer.

19 (e) A distribution to stockholders of an impaired insurer or insolvent
 20 insurer must not be made until the total amount of valid claims of the
 21 association, with interest, for funds expended in carrying out the
 22 association's powers and duties under sections 5, 5.2, 5.4, and 5.5 of
 23 this chapter with respect to the impaired insurer or insolvent insurer,
 24 have been fully recovered by the association.

25 SECTION 26. IC 27-8-8-11, AS AMENDED BY P.L.193-2006,
 26 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 27 JULY 1, 2018]: Sec. 11. (a) Subject to subsections (b) through (d), if
 28 an order for liquidation or rehabilitation of **an a member** insurer
 29 domiciled in Indiana has been entered, the receiver appointed under the
 30 order shall have a right to recover on behalf of the **member** insurer,
 31 from any affiliate that controlled it, the amount of distributions, other
 32 than stock dividends paid by the **member** insurer on its capital stock,
 33 made at any time during the five (5) years preceding the filing of the
 34 petition for liquidation or rehabilitation.

35 (b) A distribution described in subsection (a) is not recoverable if
 36 the **member** insurer shows that when the distribution was paid the
 37 distribution was lawful and reasonable, and that the **member** insurer
 38 did not know and could not reasonably have known that the distribution
 39 might adversely affect the ability of the **member** insurer to fulfill the
 40 **member** insurer's policy and contract obligations.

41 (c) A person who was an affiliate that controlled the **member**
 42 insurer at the time a distribution described in subsection (a) was paid



1 is liable up to the amount of distributions the person received. A person
 2 who was an affiliate that controlled the **member** insurer at the time the
 3 distributions were declared shall be liable up to the amount of
 4 distributions that would have been received if the distributions had
 5 been paid immediately. If two (2) or more persons are liable with
 6 respect to the same distributions, they are jointly and severally liable.

7 (d) The maximum amount recoverable under this section shall be
 8 the amount needed in excess of all other available assets of the
 9 insolvent insurer to pay the policy and contract obligations of the
 10 insolvent insurer.

11 (e) If a person liable under subsection (c) is insolvent, the affiliates
 12 that controlled the person at the time the distribution was paid shall be
 13 jointly and severally liable for any resulting deficiency in the amount
 14 recovered from the insolvent affiliate.

15 SECTION 27. IC 27-8-8-16.2 IS ADDED TO THE INDIANA
 16 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
 17 [EFFECTIVE JULY 1, 2018]: **Sec. 16.2. (a) A member insurer that**
 18 **is not eligible to take a credit under section 16 of this chapter may,**
 19 **after approval by the commissioner, place a surcharge on the**
 20 **member insurer's premiums in a sum reasonably calculated to**
 21 **recoup the member insurer's assessments over a reasonable period,**
 22 **as approved by the commissioner.**

23 (b) Any amount recouped under subsection (a) is not considered
 24 to be a premium for any other purpose, including computation of
 25 gross premium tax, medical loss ratio, or insurance producer
 26 commission.

27 (c) In lieu of the surcharge allowed by subsection (a), a member
 28 insurer that is not eligible to take a credit under section 16 of this
 29 chapter may assign the credit to the member insurer's affiliate (as
 30 defined in IC 27-1-23-1(b)).

31 SECTION 28. IC 27-8-8-18, AS AMENDED BY P.L.193-2006,
 32 SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 33 JULY 1, 2018]: Sec. 18. (a) A person, including ~~an~~ **a member** insurer,
 34 insurance producer, employee, agent, or affiliate of ~~an~~ **a member**
 35 insurer, shall not make, publish, disseminate, circulate, or place before
 36 the public or cause, directly or indirectly, to be made, published,
 37 disseminated, circulated, or placed before the public, in any newspaper,
 38 magazine, or other publication, or in the form of a notice, circular,
 39 pamphlet, letter, or poster, or over any radio station or television
 40 station, or in any other way, an advertisement, an announcement, or a
 41 statement, written or oral, that uses the existence of the association for
 42 the purpose of the sale of, solicitation of, or inducement to purchase



1 any form of insurance covered by this chapter. This section does not
 2 apply to the association or any other entity that does not sell or solicit
 3 insurance.

4 (b) ~~Not later than January 1, 2007,~~ The association shall:

5 (1) prepare a summary document:

6 (A) describing the general purposes and current limitations of
 7 this chapter; and

8 (B) complying with subsection (c); and

9 (2) submit the summary document to the commissioner for
 10 approval.

11 Sixty (60) days after the date on which the commissioner approves the
 12 summary document, a member insurer may not deliver a policy or
 13 contract to a policy or contract owner unless the summary document is
 14 delivered to the policy or contract owner at the time of delivery of the
 15 policy or contract. The summary document must also be available upon
 16 request by a policy owner. The distribution, delivery, or contents or
 17 interpretation of the summary document does not guarantee that the
 18 policy or contract or the owner of the policy or contract is covered in
 19 the event of the impairment or insolvency of a member insurer. The
 20 summary document must be revised by the association as amendment
 21 to this chapter requires. Failure to receive the summary document does
 22 not give a policy owner, a contract owner, a certificate holder, or an
 23 insured greater rights than the rights specified in this chapter.

24 (c) The summary document prepared under subsection (b) must
 25 contain a clear and conspicuous disclaimer on the face of the summary
 26 document. The commissioner shall approve the form and content of the
 27 disclaimer. The disclaimer must, at a minimum, convey all the
 28 following:

29 (1) State the name and address of the association and the
 30 department of insurance.

31 (2) Prominently warn that:

32 (A) the association might not cover the policy or contract; and

33 (B) even if coverage were currently provided, coverage is:

34 (i) subject to substantial limitations and exclusions;

35 (ii) generally conditioned on continued residence in Indiana;

36 and

37 (iii) subject to possible change as a result of future
 38 amendments to this chapter and court decisions.

39 (3) State the types of policies for which the association currently
 40 provides coverage.

41 (4) State that the member insurer and the member insurer's agents
 42 are prohibited by law from using the existence of the association



1 for the purpose of selling, soliciting, or inducing purchase of any
2 form of insurance.

3 (5) State that the policy owner or contract owner should not rely
4 on coverage under this chapter when selecting an insurer.

5 (6) Explain:

6 (A) rights available following; and

7 (B) procedures for filing a complaint to allege;
8 a violation of any provision of this chapter.

9 (7) Provide other information as directed by the commissioner,
10 including sources for information that:

11 (A) is not proprietary; and

12 (B) is subject to disclosure under IC 5-14-3;
13 concerning the financial condition of an insurer.

14 (d) A member insurer shall retain evidence of compliance with
15 subsection (b) until the policy or contract for which the notice is given
16 is no longer in effect.

17 SECTION 29. IC 27-8-10-5.1, AS AMENDED BY P.L.213-2015,
18 SECTION 252, IS AMENDED TO READ AS FOLLOWS
19 [EFFECTIVE JULY 1, 2018]: Sec. 5.1. (a) A person is not eligible for
20 an association policy if the person is eligible for any of the coverage
21 described in subdivisions (1) and (2). A person other than a federally
22 eligible individual may not apply for an association policy unless the
23 person has applied for:

24 (1) Medicaid; and

25 (2) coverage under the:

26 (A) preexisting condition insurance plan program established
27 by the Secretary of Health and Human Services under Section
28 1101 of Title I of the federal Patient Protection and Affordable
29 Care Act (P.L. 111-148); and

30 (B) healthy Indiana plan under IC 12-15-44.2;

31 not more than sixty (60) days before applying for the association
32 policy.

33 (b) Except as provided in subsection (c), a person is not eligible for
34 an association policy if, at the effective date of coverage, the person has
35 or is eligible for coverage under any insurance plan that equals or
36 exceeds the minimum requirements for accident and sickness insurance
37 policies issued in Indiana as set forth in IC 27. However, an offer of
38 coverage described in IC 27-8-5-2.5(e) (expired July 1, 2007, and
39 removed), IC 27-8-5-2.7, IC 27-8-5-19.2(e) (expired July 1, 2007, and
40 repealed), or IC 27-8-5-19.3 does not affect an individual's eligibility
41 for an association policy under this subsection. Coverage under any
42 association policy is in excess of, and may not duplicate, coverage



1 under any other form of health insurance.

2 (c) Except as provided in ~~IC 27-13-16-4~~ and subsection (a), a person
3 is eligible for an association policy upon a showing that:

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

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

11 (3) the person is a federally eligible individual.

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

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

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

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

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

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

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

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

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

34 (2) chiefly dependent upon the person in whose name the contract
35 is issued for support and maintenance.

36 However, proof of such incapacity and dependency must be furnished
37 to the carrier within one hundred twenty (120) days of the child's
38 attainment of the limiting age, and subsequently as may be required by
39 the carrier, but not more frequently than annually after the two (2) year
40 period following the child's attainment of the limiting age.

41 (f) An association policy that provides coverage for a family
42 member of the person in whose name the contract is issued must, as to



1 the family member's coverage, also provide that the health insurance
 2 benefits applicable for children are payable with respect to a newly
 3 born child of the person in whose name the contract is issued from the
 4 moment of birth. The coverage for newly born children must consist of
 5 coverage of injury or illness, including the necessary care and treatment
 6 of medically diagnosed congenital defects and birth abnormalities. If
 7 payment of a specific premium is required to provide coverage for the
 8 child, the contract may require that notification of the birth of a child
 9 and payment of the required premium must be furnished to the carrier
 10 within thirty-one (31) days after the date of birth in order to have the
 11 coverage continued beyond the thirty-one (31) day period.

12 (g) Except as provided in subsection (h), an association policy may
 13 contain provisions under which coverage is excluded during a period
 14 of three (3) months following the effective date of coverage as to a
 15 given covered individual for preexisting conditions, as long as medical
 16 advice or treatment was recommended or received within a period of
 17 three (3) months before the effective date of coverage. This subsection
 18 may not be construed to prohibit preexisting condition provisions in an
 19 insurance policy that are more favorable to the insured.

20 (h) If a person applies for an association policy within six (6)
 21 months after termination of the person's coverage under a health
 22 insurance arrangement and the person meets the eligibility
 23 requirements of subsection (c), then an association policy may not
 24 contain provisions under which:

25 (1) coverage as to a given individual is delayed to a date after the
 26 effective date or excluded from the policy; or

27 (2) coverage as to a given condition is denied;

28 on the basis of a preexisting health condition. This subsection may not
 29 be construed to prohibit preexisting condition provisions in an
 30 insurance policy that are more favorable to the insured.

31 (i) For purposes of this section, coverage under a health insurance
 32 arrangement includes, but is not limited to, coverage pursuant to the
 33 Consolidated Omnibus Budget Reconciliation Act of 1985.

34 SECTION 30. IC 27-13-2-5 IS AMENDED TO READ AS
 35 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. An application for
 36 a certificate of authority to operate a health maintenance organization
 37 must set forth or be accompanied by the following:

38 (1) A copy of the organizational documents of the applicant, such
 39 as the articles of incorporation, partnership agreement, trust
 40 agreement, articles of organization, or any other applicable
 41 documents, and all amendments to those documents.

42 (2) A copy of the bylaws, rules and regulations, or similar



- 1 document regulating the conduct of the internal affairs of the
 2 applicant.
- 3 (3) A list, on a form acceptable to the commissioner, of the
 4 names, addresses, official positions, and biographical information
 5 of the persons who are to be responsible for the conduct of the
 6 affairs and daily operations of the applicant, including the
 7 following:
- 8 (A) All members of the board of directors, board of trustees,
 9 executive committee, or other governing board or committee
 10 of the applicant.
- 11 (B) The principal officers, if the applicant is a corporation.
- 12 (C) The partners or members, if the applicant is a partnership
 13 or an association.
- 14 (D) The manager or, if there is no manager, all members of a
 15 limited liability company.
- 16 (4) A copy of any contract form that has been made or is to be
 17 made between any class of providers and the health maintenance
 18 organization.
- 19 (5) A copy of any contract that has been made or is to be made
 20 between:
- 21 (A) third party administrators, agents, or persons identified
 22 under subdivision (3); and
- 23 (B) the health maintenance organization.
- 24 (6) A copy of the form of evidence of coverage that is to be issued
 25 by the health maintenance organization to an enrollee.
- 26 (7) A copy of the form of a group contract, if any, that is to be
 27 issued by the health maintenance organization to an employer, a
 28 union, a trustee, or another entity.
- 29 (8) Financial statements showing the assets, liabilities, and
 30 sources of financial support of the applicant, including:
- 31 (A) a copy of the most recent certified financial statement of
 32 the applicant; and
- 33 (B) an unaudited current financial statement.
- 34 (9) A financial feasibility plan that includes the following:
- 35 (A) Detailed enrollment projections.
- 36 (B) The methodology for determining premium rates to be
 37 charged during the first twelve (12) months of operations,
 38 certified by an actuary or other qualified person acceptable to
 39 the commissioner.
- 40 (C) A projection of:
- 41 (i) balance sheets;
- 42 (ii) cash flow statements showing any capital expenditures,



- 1 purchase and sale of investments, and deposits with the
 2 state; and
 3 (iii) income and expense statements;
 4 anticipated from the start of operations until the organization
 5 has had net income for at least one (1) year.
 6 (D) A statement of the sources of working capital as well as
 7 any other sources of funding.
 8 (10) If the applicant is not domiciled in Indiana, an executed
 9 power of attorney appointing the commissioner, the
 10 commissioner's successors in office, and authorized deputies of
 11 the commissioner as the true and lawful attorney of the applicant
 12 in and for Indiana upon whom all lawful process in any legal
 13 action or proceeding against the health maintenance organization
 14 on a cause of action arising in Indiana may be served.
 15 (11) A statement or map reasonably indicating, on a
 16 county-by-county basis, the service area to be served by the health
 17 maintenance organization.
 18 (12) A description of the internal procedures to be used by the
 19 health maintenance organization for the investigation and
 20 resolution of the complaints and grievances of enrollees.
 21 (13) A description of the proposed quality management program
 22 of the applicant, including the following:
 23 (A) The formal organizational structure.
 24 (B) Methods for developing criteria.
 25 (C) Procedures for comprehensive evaluation of the quality of
 26 care rendered to enrollees.
 27 (D) Processes to initiate corrective action and reevaluation
 28 when deficiencies in provider performance or organizational
 29 performance are identified.
 30 (14) A description of the procedures to be implemented to meet
 31 the requirements set forth in IC 27-13-12 through ~~IC 27-13-17~~.
 32 **IC 27-13-15.**
 33 (15) A list of the names, addresses, and license numbers of any
 34 providers with whom the health maintenance organization has
 35 agreements.
 36 (16) Any other information required by the commissioner to make
 37 the determination required under IC 27-13-3.
 38 SECTION 31. IC 27-13-13-5 IS AMENDED TO READ AS
 39 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. (a) A deposit made
 40 by a health maintenance organization under this chapter must be used
 41 ~~(+)~~ to protect the interest of the enrollees of the health
 42 maintenance organization. ~~and~~



1 (2) to ensure continuation of health care services to enrollees of
 2 the health maintenance organization; if the health maintenance
 3 organization is in supervision, rehabilitation, or liquidation:

4 (b) The commissioner may use the deposit for administrative costs
 5 that are attributable to a receivership of the health maintenance
 6 organization.

7 (c) If the health maintenance organization is placed in receivership,
 8 the deposit made by the organization must be treated as an asset of the
 9 organization subject to IC 27-9.

10 SECTION 32. IC 27-13-13-9 IS REPEALED [EFFECTIVE JULY
 11 1, 2018]. Sec. 9: (a) As used in this section, "noncovered health care
 12 expenditures" means the costs to a health maintenance organization for
 13 health care services:

- 14 (1) that are the obligation of the health maintenance organization;
 15 (2) for which the enrollee may be liable in the event of the health
 16 maintenance organization's insolvency; and
 17 (3) for which:

18 (A) no alternative arrangements have been made that are
 19 acceptable to the commissioner; or

20 (B) statutory deposits and net worth of the health maintenance
 21 organization are determined by the commissioner to be
 22 inadequate:

23 (b) If noncovered health care expenditures exceed ten percent (10%)
 24 of total health care expenditures; a health maintenance organization
 25 shall deposit cash or securities that are acceptable to the commissioner
 26 with:

27 (1) the commissioner; or

28 (2) an organization or trustee approved by the commissioner
 29 through which a custodial or controlled account is maintained:

30 (c) The deposit made under subsection (b) must have a fair market
 31 value:

32 (1) calculated on the first day of each month; and

33 (2) maintained for the remainder of the month;

34 of not less than one hundred twenty percent (120%) of the health
 35 maintenance organization's outstanding liability for noncovered health
 36 care expenditures for enrollees in Indiana, including incurred but not
 37 reported claims:

38 (d) The commissioner may require a health maintenance
 39 organization to file periodic reports; including reports on liability for
 40 noncovered health care expenditures and audit opinions; that the
 41 commissioner considers necessary to monitor compliance with this
 42 section:



- 1 SECTION 33. IC 27-13-16 IS REPEALED [EFFECTIVE JULY 1,
2 2018]. (Protection Against Receivership; Continuation of Benefits).
- 3 SECTION 34. IC 27-13-18 IS REPEALED [EFFECTIVE JULY 1,
4 2018]. (Enrollment Period in Event of Receivership).
- 5 SECTION 35. IC 27-13-36.2-5 IS AMENDED TO READ AS
6 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. A provider shall
7 submit only the following forms for payment by a health maintenance
8 organization:
- 9 (1) ~~HCFA-1500~~. **CMS-1500**.
10 (2) ~~HCFA-1450 (UB-92)~~. **CMS-1450 (UB-04)**.
11 (3) American Dental Association (ADA) claim form.
- 12 SECTION 36. IC 27-15-6-2 IS AMENDED TO READ AS
13 FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. The plan of
14 conversion and the amendment to the articles of incorporation of the
15 converting mutual become effective upon the date and time of ~~approval~~
16 **return** of the articles of amendment by the secretary of state as
17 provided in IC 27-1-8-8, unless a later date and time are specified in
18 the articles of amendment, in which event the plan of conversion and
19 amendment become effective and take place at the later date and time.
- 20 SECTION 37. IC 27-18 IS REPEALED [EFFECTIVE JULY 1,
21 2018]. (Surplus Lines Insurance Compact).
- 22 SECTION 38. IC 34-30-2-119.8 IS REPEALED [EFFECTIVE
23 JULY 1, 2018]. ~~Sec. 119.8: IC 27-18-6-1(a) (Concerning:~~
24 ~~(1) the members, officers, executive director, employees, and~~
25 ~~representatives; and~~
26 ~~(2) the members of the executive committee and of any other~~
27 ~~committee;~~
28 ~~of the surplus lines insurance multistate compliance compact~~
29 ~~commission):~~



COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1301, 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 2, line 38, after "to" insert "**at least fifty percent (50%) of**".

Page 2, after line 42, begin a new paragraph and insert:

"SECTION 4. IC 8-2.1-22-46, AS AMENDED BY P.L.1-2006, SECTION 152, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 46. (a) Notwithstanding any other provision of this chapter, common and contract carriers and other carriers engaged in the transportation of passengers or household goods for hire, over regular or irregular routes, whether operating pursuant to a certificate or permit or as an exempt carrier under section 2.1(5) of this chapter, shall file with the department proof of financial responsibility in the form of surety bonds or policies of insurance or shall qualify as a self-insured. The minimum level of financial responsibility required shall be **as follows:**

(1) Except as provided in subdivision (2), the minimum level established under 49 U.S.C. 13906(a)(1).

(2) For contract carriers that transport railroad employees, at least five million dollars (\$5,000,000).

(b) A person who violates this section commits a Class C infraction. However, the offense is a Class A misdemeanor if the person has a prior unrelated judgment for violating this section.

(c) In addition to any other penalty imposed upon a person for a conviction of a Class A misdemeanor under subsection (b), the law enforcement agency may impound the vehicles owned by the person. Unless the vehicle is impounded or forfeited under a law other than this section, the vehicle shall be released to the carrier when the carrier complies with this section."

Page 3, line 41, after "equal to" insert "**at least fifty percent (50%) of**".

Page 4, line 21, after "equal to" insert "**at least fifty percent (50%) of**".

Page 4, delete lines 39 through 42.

Delete pages 5 through 17.

Page 18, delete lines 1 through 15.

Page 24, delete lines 4 through 42.

Page 25, delete lines 1 through 29.

Page 25, between lines 29 and 30, begin a new paragraph and insert:



"SECTION 8. IC 27-7-5-2, AS AMENDED BY P.L.148-2013, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. (a) Except as provided in subsections (d), (f), and (h), the insurer shall make available, in each automobile liability or motor vehicle liability policy of insurance which is delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state, insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person and for injury to or destruction of property to others arising from the ownership, maintenance, or use of a motor vehicle, or in a supplement to such a policy, the following types of coverage:

- (1) in limits for bodily injury or death and for injury to or destruction of property not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death, and for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured motor vehicles for injury to or destruction of property resulting therefrom; or
- (2) in limits for bodily injury or death not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy provisions who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom.

The uninsured and underinsured motorist coverages must be provided by insurers for either a single premium or for separate premiums, in limits at least equal to the limits of liability specified in the bodily injury liability provisions of an insured's policy, unless such coverages have been rejected in writing by the insured. However, underinsured motorist coverage must be made available in limits of not less than fifty thousand dollars (\$50,000). At the insurer's option, the bodily injury liability provisions of the insured's policy may be required to be equal to the insured's underinsured motorist coverage. Insurers may not sell or provide underinsured motorist coverage in an amount less than fifty thousand dollars (\$50,000). Insurers must make underinsured motorist coverage available to all existing policyholders on the date of the first



renewal of existing policies that occurs on or after January 1, 1995, and on any policies newly issued or delivered on or after January 1, 1995. Uninsured motorist coverage or underinsured motorist coverage may be offered by an insurer in an amount exceeding the limits of liability specified in the bodily injury and property damage liability provisions of the insured's policy.

(b) A named insured of an automobile or motor vehicle liability policy has the right, in writing, to:

- (1) reject both the uninsured motorist coverage and the underinsured motorist coverage provided for in this section; or
- (2) reject either the uninsured motorist coverage alone or the underinsured motorist coverage alone, if the insurer provides the coverage not rejected separately from the coverage rejected.

A rejection of coverage under this subsection by a named insured is a rejection on behalf of all other named insureds, all other insureds, and all other persons entitled to coverage under the policy. No insured may have uninsured motorist property damage liability insurance coverage under this section unless the insured also has uninsured motorist bodily injury liability insurance coverage under this section. Following rejection of either or both uninsured motorist coverage or underinsured motorist coverage, unless later requested in writing, the insurer need not offer uninsured motorist coverage or underinsured motorist coverage in or supplemental to a renewal or replacement policy issued to the same insured by the same insurer or a subsidiary or an affiliate of the originally issuing insurer. Renewals of policies issued or delivered in this state which have undergone interim policy endorsement or amendment do not constitute newly issued or delivered policies for which the insurer is required to provide the coverages described in this section.

(c) A rejection under subsection (b) must specify:

- (1) that the named insured is rejecting:
 - (A) the uninsured motorist coverage;
 - (B) the underinsured motorist coverage; or
 - (C) both the uninsured motorist coverage and the underinsured motorist coverage;

that would otherwise be provided under the policy; and

- (2) the date on which the rejection is effective.

(d) ~~An insurer is not required to make available~~ **The following apply to** the coverage described in subsection (a) in **connection with** a commercial umbrella or excess liability policy, including a commercial umbrella or excess liability policy that is issued or delivered to a motor carrier (as defined in IC 8-2.1-17-10) that is in



compliance with the minimum levels of financial responsibility set forth in 49 CFR Part 387:

(1) An insurer is not required to make available in a commercial umbrella or excess liability policy the coverage described in subsection (a).

(2) An insurer that, through a rider or an endorsement, reduces or removes from a commercial umbrella or excess liability policy the coverage described in subsection (a) shall:

(A) through the United States mail; or

(B) by electronic means;

provide to the named insured written notice of the reduction or removal.

(3) An insurer that makes available in a commercial umbrella or excess liability policy the coverage described in subsection (a):

(A) may make available the coverage in limits determined by the insurer; and

(B) is not required to make available the coverage in limits equal to the limits specified in the commercial umbrella or excess liability policy.

(e) A rejection under subsection (b) of uninsured motorist coverage or underinsured motorist coverage in an underlying commercial policy of insurance is also a rejection of uninsured motorist coverage or underinsured motorist coverage in a commercial umbrella or excess liability policy.

(f) An insurer is not required to make available the coverage described in subsection (a) in connection with coverage that:

(1) is related to or included in a commercial policy of property and casualty insurance described in Class 2 or Class 3 of IC 27-1-5-1; and

(2) covers a loss related to a motor vehicle:

(A) of which the insured is not the owner; and

(B) that is used:

(i) by the insured or an agent of the insured; and

(ii) for purposes authorized by the insured.

(g) For purposes of subsection (f), "owner" means:

(1) a person who holds the legal title to a motor vehicle;

(2) a person who rents or leases a motor vehicle and has exclusive use of the motor vehicle for more than thirty (30) days;

(3) the conditional vendee or lessee under an agreement for the conditional sale or lease of a motor vehicle; or

(4) the mortgagor under an agreement for the conditional sale or



lease of a motor vehicle under which the mortgagor has:

(A) the right to purchase; and

(B) an immediate right of possession of;

the motor vehicle upon the performance of the conditions stated in the agreement.

(h) The following apply to the coverage described in subsection (a) in relation to a personal umbrella or excess liability policy:

(1) An insurer is not required to make available the coverage described in subsection (a) under a personal umbrella or excess liability policy.

(2) An insurer that reduces or removes, through a rider or an endorsement, coverage described in subsection (a) under a personal umbrella or excess liability policy shall:

(A) through the United States mail; or

(B) by electronic means;

provide to the named insured written notice of the reduction or removal.

(3) An insurer that makes available the coverage described in subsection (a) under a personal umbrella or excess liability policy:

(A) may make available the coverage in limits determined by the insurer; and

(B) is not required to make available the coverage in limits equal to the limits specified in the personal umbrella or excess liability policy."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1301 as introduced.)

CARBAUGH

Committee Vote: yeas 10, nays 1.



HOUSE MOTION

Mr. Speaker: I move that House Bill 1301 be amended to read as follows:

Page 14, after line 42, begin a new paragraph and insert:

"SECTION 12. IC 27-8-8-0.3, AS AMENDED BY P.L.276-2013, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 0.3. (a) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are not affected by changes made by P.L.193-2006.

(b) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are governed by this chapter as it existed on January 1, 2006.

(c) The amendments made during the 2013 regular session of the general assembly to section 2.1 of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.

(d) The amendment made during the 2013 regular session of the general assembly to section 2.3(e) of this chapter does not apply to a member insurer that has a coverage date before January 1, 2012.

(e) The amendments made during the 2013 regular session of the general assembly to section 2.3(f) of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.

(f) The amendments made during the 2018 regular session of the general assembly to this chapter:

(1) do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before July 1, 2018; and

(2) apply to a member insurer that is placed under an order of rehabilitation or liquidation after June 30, 2018."

Page 16, line 15, delete "insurance"" and insert """.

Page 16, line 15, delete "coverage under".

Page 16, line 16, delete "certificate or" and insert "**certificate,**".

Page 16, line 17, delete "contract." and insert "**contract or certificate, or another similar health contract.**".

Page 16, line 33, delete "health benefit plan" and insert "**a health**".

Page 16, line 34, delete "insurance." and insert "**insurance policy or contract for which coverage is provided under section 2.3 of this chapter.**".

Page 16, delete line 42.

EH 1301—LS 6898/DI 97



PAGE 17, delete lines 1 through 3.

Page 17, line 4, delete "(v)" and insert "(s)".

Page 17, line 5, after "insurance" insert "**or health maintenance organization business**".

Page 17, line 20, delete "(6)".

Page 17, line 20, strike "A prepaid limited service health maintenance organization".

Page 17, strike lines 21 through 22.

Page 17, line 23, delete "(7)" and insert "(6)".

Page 17, line 24, delete "(8)" and insert "(7)".

Page 17, line 25, delete "(9)" and insert "(8)".

Page 17, line 28, delete "(10)" and insert "(9)".

Page 17, line 30, delete "(11)" and insert "(10)".

Page 17, line 31, delete "(10)." and insert "(9).".

Page 17, line 32, delete "(w)" and insert "(t)".

Page 17, line 39, delete "(x)" and insert "(u)".

Page 17, line 41, delete "(y)" and insert "(v)".

Page 18, line 8, delete "(z)" and insert "(w)".

Page 18, line 12, delete "(aa)" and insert "(x)".

Page 18, delete lines 30 through 34.

Page 18, line 35, delete "(cc)" and insert "(y)".

Page 19, line 7, delete "(dd)" and insert "(z)".

Page 19, line 29, delete "(aa)(3)," and insert "(x)(3),".

Page 19, line 39, delete "(ee)" and insert "(aa)".

Page 20, line 1, delete "(ff)" and insert "(bb)".

Page 20, line 7, delete "(gg)" and insert "(cc)".

Page 20, line 9, delete "(hh)" and insert "(dd)".

Page 20, line 13, delete "(ii)" and insert "(ee)".

Page 20, line 16, delete "(jj)" and insert "(ff)".

Page 21, line 17, after "holder" insert "**or enrollee**".

Page 23, line 18, delete "contracts;" and insert "**contracts, including health maintenance organization subscriber contracts and certificates;**".

Page 23, line 28, delete "Except for a part of a certificate, policy, or contract".

Page 23, delete line 29.

Page 23, line 30, delete "insurance benefit, this" and insert "This".

Page 24, between lines 14 and 15, begin a new line block indented and insert:

"However, this subdivision does not apply to a part of a certificate, policy, or contract (including a rider) that provides long term care or another health insurance benefit."



Page 26, delete lines 23 through 30.

Page 27, line 4, after "than" insert "**those relating to**".

Page 27, line 6, delete "plan insurance," and insert "**plans**".

Page 27, line 9, strike "health".

Page 27, line 10, strike "insurance benefits that are".

Page 27, line 11, strike "health".

Page 27, line 12, strike "insurance benefits under one (1) or more".

Page 27, line 13, strike "policies" and insert "**benefits**".

Page 27, line 15, strike "insurance".

Page 27, line 36, delete "plan" and insert "**plans**".

Page 27, line 36, strike "insurance".

Page 28, between lines 34 and 35, begin a new paragraph and insert:

"SECTION 17. IC 27-8-8-3, AS AMENDED BY P.L.193-2006, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. (a) There is created a nonprofit legal entity referred to as the Indiana Life and Health Insurance Guaranty Association. A member insurer shall be and remain a member of the association as a condition of the member insurer's authority to transact insurance in Indiana. The association shall perform its functions under the plan of operation established and approved under section 7 of this chapter. The association shall exercise its powers through a board of directors established under section 4 of this chapter. For purposes of administration and assessment the association shall maintain the following two (2) accounts:

(1) The health ~~insurance~~ account.

(2) The life insurance and annuity account, which includes the following subaccounts:

(A) The life insurance subaccount.

(B) The annuity subaccount, which includes annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities.

(C) The unallocated annuity subaccount, which excludes annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

(b) The association is under the immediate supervision of the commissioner and subject to the applicable provisions of the insurance laws of Indiana."

Page 30, line 4, strike "For premiums identical to the premiums that would have".



Page 30, line 5, strike "been payable under the covered policy,".

Page 30, line 5, delete "assure" and insert "Assure".

Page 34, line 24, delete "insured," and insert "**enrollee, health care provider,**".

Page 40, line 5, delete "health benefit plan" and insert "**accident and health**".

Page 40, line 9, delete "A life insurance and annuity member insurer's" and insert "**The**".

Page 40, line 10, after "assessment" insert "**that must be allocated to the life insurance and annuity account**".

Page 40, line 12, delete "insurer's" and insert "**insurers**".

Page 40, line 13, delete "insurance".

Page 40, delete lines 16 through 24, begin a new line double block indented and insert:

"(A) 0.50; minus

(B) the life insurance and annuity member insurers' share of the health account.

STEP THREE: Determine the remainder of:

(A) The life insurance and annuity member insurers' share of the life insurance and annuity account; minus

(B) the life insurance and annuity member insurers' share of the health account.

STEP FOUR: Divide the remainder determined under STEP TWO by the remainder determined under STEP THREE."

Page 40, line 27, delete "plus" and insert "**and**".

Page 40, line 29, delete "benefit plan".

Page 40, line 29, delete "premiums." and insert "**premiums, including assessable health maintenance organization premiums and excluding assessable premiums written for disability insurance and long term care insurance. For purposes of this subsection, "accident and health insurance member insurer" means a member insurer that is not a life insurance and annuity member insurer.**".

Page 41, line 24, strike "insurance".

Page 47, between lines 6 and 7, begin a new paragraph and insert:

"(c) In lieu of the surcharge allowed by subsection (a), a member insurer that is not eligible to take a credit under section 16 of this chapter may assign the credit to the member insurer's affiliate (as defined in IC 27-1-23-1(b))."

Page 47, line 22, strike "Not later than January 1, 2007,".

Page 47, line 22, delete "the" and insert "The".

Page 48, between lines 34 and 35, begin a new paragraph and insert:

"SECTION 28. IC 27-8-10-5.1, AS AMENDED BY P.L.213-2015,



SECTION 252, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for any of the coverage described in subdivisions (1) and (2). A person other than a federally eligible individual may not apply for an association policy unless the person has applied for:

- (1) Medicaid; and
- (2) coverage under the:
 - (A) preexisting condition insurance plan program established by the Secretary of Health and Human Services under Section 1101 of Title I of the federal Patient Protection and Affordable Care Act (P.L. 111-148); and
 - (B) healthy Indiana plan under IC 12-15-44.2;

not more than sixty (60) days before applying for the association policy.

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

(c) Except as provided in ~~IC 27-13-16-4~~ and 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.

SECTION 29. IC 27-13-2-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. An application for a certificate of authority to operate a health maintenance organization must set forth or be accompanied by the following:

- (1) A copy of the organizational documents of the applicant, such as the articles of incorporation, partnership agreement, trust agreement, articles of organization, or any other applicable documents, and all amendments to those documents.
- (2) A copy of the bylaws, rules and regulations, or similar document regulating the conduct of the internal affairs of the applicant.
- (3) A list, on a form acceptable to the commissioner, of the names, addresses, official positions, and biographical information of the persons who are to be responsible for the conduct of the affairs and daily operations of the applicant, including the following:
 - (A) All members of the board of directors, board of trustees, executive committee, or other governing board or committee of the applicant.
 - (B) The principal officers, if the applicant is a corporation.
 - (C) The partners or members, if the applicant is a partnership or an association.
 - (D) The manager or, if there is no manager, all members of a limited liability company.
- (4) A copy of any contract form that has been made or is to be made between any class of providers and the health maintenance



organization.

(5) A copy of any contract that has been made or is to be made between:

(A) third party administrators, agents, or persons identified under subdivision (3); and

(B) the health maintenance organization.

(6) A copy of the form of evidence of coverage that is to be issued by the health maintenance organization to an enrollee.

(7) A copy of the form of a group contract, if any, that is to be issued by the health maintenance organization to an employer, a union, a trustee, or another entity.

(8) Financial statements showing the assets, liabilities, and sources of financial support of the applicant, including:

(A) a copy of the most recent certified financial statement of the applicant; and

(B) an unaudited current financial statement.

(9) A financial feasibility plan that includes the following:

(A) Detailed enrollment projections.

(B) The methodology for determining premium rates to be charged during the first twelve (12) months of operations, certified by an actuary or other qualified person acceptable to the commissioner.

(C) A projection of:

(i) balance sheets;

(ii) cash flow statements showing any capital expenditures, purchase and sale of investments, and deposits with the state; and

(iii) income and expense statements;

anticipated from the start of operations until the organization has had net income for at least one (1) year.

(D) A statement of the sources of working capital as well as any other sources of funding.

(10) If the applicant is not domiciled in Indiana, an executed power of attorney appointing the commissioner, the commissioner's successors in office, and authorized deputies of the commissioner as the true and lawful attorney of the applicant in and for Indiana upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in Indiana may be served.

(11) A statement or map reasonably indicating, on a county-by-county basis, the service area to be served by the health maintenance organization.



(12) A description of the internal procedures to be used by the health maintenance organization for the investigation and resolution of the complaints and grievances of enrollees.

(13) A description of the proposed quality management program of the applicant, including the following:

- (A) The formal organizational structure.
- (B) Methods for developing criteria.
- (C) Procedures for comprehensive evaluation of the quality of care rendered to enrollees.
- (D) Processes to initiate corrective action and reevaluation when deficiencies in provider performance or organizational performance are identified.

(14) A description of the procedures to be implemented to meet the requirements set forth in IC 27-13-12 through ~~IC 27-13-17~~.
IC 27-13-15.

(15) A list of the names, addresses, and license numbers of any providers with whom the health maintenance organization has agreements.

(16) Any other information required by the commissioner to make the determination required under IC 27-13-3.

SECTION 30. IC 27-13-13-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. (a) A deposit made by a health maintenance organization under this chapter must be used

~~(1) to protect the interest of the enrollees of the health maintenance organization. and~~

~~(2) to ensure continuation of health care services to enrollees of the health maintenance organization, if the health maintenance organization is in supervision, rehabilitation, or liquidation.~~

(b) The commissioner may use the deposit for administrative costs that are attributable to a receivership of the health maintenance organization.

(c) If the health maintenance organization is placed in receivership, the deposit made by the organization must be treated as an asset of the organization subject to IC 27-9.

SECTION 31. IC 27-13-13-9 IS REPEALED [EFFECTIVE JULY 1, 2018]. Sec. 9: (a) As used in this section, "noncovered health care expenditures" means the costs to a health maintenance organization for health care services:

- ~~(1) that are the obligation of the health maintenance organization;~~
- ~~(2) for which the enrollee may be liable in the event of the health maintenance organization's insolvency; and~~
- ~~(3) for which:~~



(A) no alternative arrangements have been made that are acceptable to the commissioner; or

(B) statutory deposits and net worth of the health maintenance organization are determined by the commissioner to be inadequate.

(b) If noncovered health care expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall deposit cash or securities that are acceptable to the commissioner with:

(1) the commissioner; or

(2) an organization or trustee approved by the commissioner through which a custodial or controlled account is maintained.

(c) The deposit made under subsection (b) must have a fair market value:

(1) calculated on the first day of each month; and

(2) maintained for the remainder of the month;

of not less than one hundred twenty percent (120%) of the health maintenance organization's outstanding liability for noncovered health care expenditures for enrollees in Indiana, including incurred but not reported claims.

(d) The commissioner may require a health maintenance organization to file periodic reports, including reports on liability for noncovered health care expenditures and audit opinions, that the commissioner considers necessary to monitor compliance with this section.

SECTION 32. IC 27-13-16 IS REPEALED [EFFECTIVE JULY 1, 2018]. (Protection Against Receivership; Continuation of Benefits).

SECTION 33. IC 27-13-18 IS REPEALED [EFFECTIVE JULY 1, 2018]. (Enrollment Period in Event of Receivership)."

Page 49, delete lines 18 through 27.

Renumber all SECTIONS consecutively.

(Reference is to HB 1301 as printed January 26, 2018.)

CARBAUGH



HOUSE MOTION

Mr. Speaker: I move that House Bill 1301 be amended to read as follows:

Page 2, line 39, delete "fifty percent (50%)" and insert "**twenty-five percent (25%)**".

Page 4, line 25, delete "fifty percent (50%)" and insert "**twenty-five percent (25%)**".

Page 5, line 6, delete "fifty percent (50%)" and insert "**twenty-five percent (25%)**".

(Reference is to HB 1301 as printed January 26, 2018.)

LEHMAN

 COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred House Bill No. 1301, 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 5, between lines 23 and 24, begin a new paragraph and insert:
 "SECTION 8. IC 27-1-3-35 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 35. (a) The governor and the commissioner may apply to the United States Secretary of Health and Human Services for a waiver for state innovation under Section 1332 of the federal Patient Protection and Affordable Care Act (42 U.S.C. 18052).**

(b) If the waiver applied for under subsection (a) is granted, the governor and the commissioner may implement a state plan of innovation that meets the waiver requirements established under federal law and as approved by the United States Secretary of Health and Human Services."

Page 41, line 18, delete "0.50;" and insert "**fifty-hundredths (0.50);**".

Page 41, line 22, delete "The" and insert "**the**".

Page 41, line 39, delete ""assessable" refers only to premiums on" and insert "**assessable premiums must be measured within Indiana.**".

EH 1301—LS 6898/DI 97



Page 41, delete line 40.

Page 48, line 19, delete "IC 27-1-23-1(b)." and insert "**IC 27-1-23-1(b)**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1301 as reprinted February 1, 2018.)

PERFECT, Chairperson

Committee Vote: Yeas 7, Nays 0.

