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.

HOUSE ENROLLED ACT No. 1301

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 5-10-8.1-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. A provider shall submit only the following forms for payment by an administrator:

(1) ~~HCFA-1500.~~ **CMS-1500.**

(2) ~~HCFA-1450~~ ~~(UB-92).~~ **CMS-1450 (UB-04).**

(3) American Dental Association (ADA) claim form.

SECTION 2. 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.

SECTION 3. IC 12-15-12-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 13. (a) The office and an entity with which the office contracts for the payment of claims shall accept claims submitted on any of the following forms by an individual or organization that is a contractor or subcontractor of the office:

(1) ~~HCFA-1500.~~ **CMS-1500.**

(2) ~~HCFA-1450~~ ~~(UB-92).~~ **CMS-1450 (UB-04).**

(3) American Dental Association (ADA) claim form.

(4) Pharmacy and compound drug form.

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

(1) may designate as acceptable claim forms other than a form listed in subsection (a); and

(2) may not mandate the use of a crossover claim form.

SECTION 4. 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.

SECTION 5. IC 27-1-15.6-2, AS AMENDED BY SEA 341-2018, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. **Except as otherwise provided in this section,** the following definitions apply throughout this chapter, IC 27-1-15.7, and IC 27-1-15.8:

(1) "Bureau" refers to the child support bureau established by IC 31-25-3-1.

(2) "Business entity" means a corporation, an association, a partnership, a limited liability company, a limited liability

partnership, or another legal entity.

(3) "Commissioner" means the insurance commissioner appointed under IC 27-1-1-2.

(4) "Consultant" means a person who:

(A) holds himself or herself out to the public as being engaged in the business of offering; or

(B) for a fee, offers;

any advice, counsel, opinion, or service with respect to the benefits, advantages, or disadvantages promised under any policy of insurance that could be issued in Indiana.

(5) "Delinquent" means the condition of being at least:

(A) two thousand dollars ($2,000); or

(B) three (3) months;

past due in the payment of court ordered child support.

(6) "Designated home state license" means a license issued by the commissioner to an insurance producer who:

(A) maintains the insurance producer's principal place of residence or principal place of business in a state that does not license insurance producers for the line of authority for which the insurance producer seeks licensure in Indiana; and

(B) is permitted by the commissioner to designate Indiana as the insurance producer's nonresident home state.

(7) "FINRA" refers to the independent Financial Industry Regulatory Authority.

(8) "Home state" means the District of Columbia or any state or territory of the United States in which an insurance producer:

(A) maintains the insurance producer's principal place of residence or principal place of business; and

(B) is licensed to act as an insurance producer.

This subdivision does not apply to IC 27-1-15.8.

(9) "Insurance producer" means a person required to be licensed under the laws of Indiana to sell, solicit, or negotiate insurance.

(10) "License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier.

(11) "Limited line credit insurance" includes the following:

(A) Credit life insurance.

(B) Credit disability insurance.

(C) Credit property insurance.

(D) Credit unemployment insurance.

(E) Involuntary unemployment insurance.

(F) Mortgage life insurance.

(G) Mortgage guaranty insurance.

(H) Mortgage disability insurance.

(I) Guaranteed automobile protection (gap) insurance.

(J) Any other form of insurance:

(i) that is offered in connection with an extension of credit and is limited to partially or wholly extinguishing that credit obligation; and

(ii) that the insurance commissioner determines should be designated a form of limited line credit insurance.

(12) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one (1) or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(13) "Limited lines insurance" means any of the following:

(A) The lines of insurance defined in section 18 of this chapter.

(B) Any line of insurance the recognition of which is considered necessary by the commissioner for the purpose of complying with section 8(e) of this chapter.

(C) For purposes of section 8(e) of this chapter, any form of insurance with respect to which authority is granted by a home state that restricts the authority granted by a limited lines producer's license to less than total authority in the associated major lines described in section 7(a)(1) through 7(a)(6) of this chapter.

(14) "Limited lines producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines insurance.

(15) "Limited lines travel insurance producer" means a person designated by an insurer to sell, solicit, or negotiate a travel insurance policy. The term includes the following:

(A) A managing general underwriter.

(B) A managing general agent.

(C) A limited lines producer.

(16) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(17) "Person" means an individual or a business entity.

(18) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of a company.

(19) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(20) "Surplus lines producer" means a person who sells, solicits, negotiates, or procures from an insurance company not licensed to transact business in Indiana an insurance policy that cannot be procured from insurers licensed to do business in Indiana.

(21) "Terminate" means:

(A) the cancellation of the relationship between an insurance producer and the insurer; or

(B) the termination of a producer's authority to transact insurance.

(22) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including the following:

(A) Interruption or cancellation of a trip or an event.

(B) Loss of baggage or personal effects.

(C) Damage to accommodations or rental vehicles.

(D) Sickness, accident, disability, or death that occurs during travel.

The term does not include a major medical plan that provides comprehensive medical insurance for a traveler on a trip that lasts at least six (6) months, including a traveler who is an individual who works overseas as an ~~expatriot~~ **expatriate** or is deployed as a member of the military.

(23) "Travel retailer" means a business entity that offers and delivers travel insurance on behalf of and under the direction of a limited lines travel insurance producer.

SECTION 6. IC 27-1-15.8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 1. **(a) Except as provided in this section,** the definitions in IC 27-1-15.6-2 apply throughout this chapter.

(b) As used in this chapter, "affiliate" means, with respect to an insured, an entity that controls, is controlled by, or is under common control with the insured.

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

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

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

(2) power to determine the election of a majority of the

directors or trustees;

of an entity.

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

(1) With respect to an insured:

(A) the state in which the insured maintains:

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

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

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

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

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

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

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

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

SECTION 7. IC 27-1-15.8-4, AS AMENDED BY P.L.173-2007, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) In addition to all other charges, fees, and taxes that may be imposed by law, a surplus lines producer licensed under this chapter shall, on or before February 1 ~~and August 1~~ of each year, collect from the insured and remit to the department for the use and benefit of the state of Indiana an amount equal to two and one-half percent (2 1/2%) of all gross premiums upon all policies and contracts procured:

(1) by the surplus lines producer;

(2) under the provisions of this section;

(3) for insureds whose home state is Indiana; and

(4) during the preceding ~~six (6)~~ **twelve (12)** month period ending

December 31. ~~and June 30, respectively.~~

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

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

(1) the description and location of the insured property or risk and the name of the insured;

(2) the gross premiums charged in the policy or contract;

(3) the name and home office address of the insurer whose policy or contract is issued, and the kind of insurance effected; and

(4) a statement that:

(A) the licensee, after diligent effort, was unable to procure from any insurer authorized to transact the particular class of insurance business in Indiana the full amount of insurance required to protect the insured; and

(B) the insurance placed under this chapter is not placed for the purpose of procuring it at a premium rate lower than would be accepted by an insurer authorized and licensed to transact insurance business in Indiana.

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

(d) A licensed surplus lines producer shall keep a separate account of all business transacted under this section. The account may be inspected at any time by the commissioner or the commissioner's 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 8. IC 27-1-37.5-10, AS ADDED BY HEA 1143-2018, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 10. (a) This section applies to a request for prior authorization delivered to a health plan after December 31, 2019.

(b) A health plan shall accept a request for prior authorization delivered to the health plan by a covered individual's health care provider through a secure electronic transmission. A health care provider shall submit a request for prior authorization through a secure electronic transmission. A health plan shall provide for:

(1) a secure electronic transmission; and

(2) acknowledgment of receipt, by use of a transaction number or another reference code;

of a request for prior authorization and any supporting information.

(c) Subsection (b) does not apply and a health plan that requires prior authorization shall accept a request for prior authorization that is not submitted through a secure electronic transmission if a covered individual's health care provider and the health plan have entered into an agreement under which the health plan agrees to process prior authorization requests that are not submitted through a secure electronic transmission because:

(1) secure electronic transmission of prior authorization requests would cause financial hardship for the health care provider;

(2) the area in which the health care provider is located lacks sufficient Internet access; or

(3) ~~a sufficient~~ **the health care provider has an insufficient** number of covered individuals as patients or customers, as determined by the commissioner, to warrant the financial expense that compliance with subsection (b) would require.

(d) If a covered individual's health care provider is described in subsection (c), the health plan shall accept from the health care provider a request for prior authorization as follows:

(1) The prior authorization request must be made on the standardized prior authorization form established by the department under section 16 of this chapter.

(2) The health plan shall provide for secure electronic transmission and acknowledgement of receipt of the standardized prior authorization form and any supporting information for the prior authorization by use of a transaction number or another reference code.

SECTION 9. 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.

SECTION 10. IC 27-8-5.7-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 7. A provider shall submit only the following forms for payment by an insurer:

(1) ~~HCFA-1500.~~ **CMS-1500.**

(2) ~~HCFA-1450~~ ~~(UB-92).~~ **CMS-1450 (UB-04).**

(3) American Dental Association (ADA) claim form.

SECTION 11. 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.

SECTION 12. IC 27-8-8-2, AS AMENDED BY P.L.276-2013, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. (a) The definitions in this section apply throughout this chapter.

(b) "Account" means one (1) of the two (2) accounts created under section 3 of this chapter.

(c) "Annuity contract", except as provided in section 2.3(e) of this chapter, includes:

(1) a guaranteed investment contract;

(2) a deposit administration contract;

(3) a structured settlement annuity;

(4) an annuity issued to or in connection with a government lottery; and

(5) an immediate or a deferred annuity contract.

(d) "Assessment base year" means, for an impaired insurer or

insolvent insurer, the most recent calendar year for which required premium information is available preceding the calendar year during which the impaired insurer's or insolvent insurer's coverage date occurs.

(e) "Association", except when the context otherwise requires, means the Indiana life and health insurance guaranty association created by section 3 of this chapter.

(f) "Benefit plan" means a specific plan, fund, or program that is established or maintained by an employer or an employee organization, or both, that:

(1) provides retirement income to employees; or

(2) results in a deferral of income by employees for a period extending to or beyond the termination of employment.

(g) "Board" refers to the board of directors of the association selected under IC 27-8-8-4.

(h) "Called", when used in the context of assessments, means that notice has been issued by the association to member insurers requiring the member insurers to pay, within a time frame set forth in the notice, an assessment that has been authorized by the board.

(i) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(j) "Contractual obligation" means an enforceable obligation under a covered policy for which and to the extent that coverage is provided under section 2.3 of this chapter.

(k) "Coverage date" means, with respect to a member insurer, the date on which the earlier of the following occurs:

(1) The member insurer becomes an insolvent insurer.

(2) The association determines that the association will provide coverage under section 5(a) of this chapter with respect to the member insurer.

(l) "Covered policy" means a:

(1) nongroup policy or contract;

(2) certificate under a group policy or contract; or

(3) part of a policy, contract, or certificate described in subdivisions (1) and (2);

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

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

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

(o) "Health benefit plan" means a hospital or medical expense

policy or certificate, a health maintenance organization subscriber contract or certificate, or another similar health contract. The term does not include the following:

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

(2) Coverage for:

(A) long term care;

(B) home health care;

(C) community based care; or

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

(3) Coverage for onsite medical clinics.

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

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

~~(o)~~ **(q)** "Impaired insurer" means a member insurer that is:

(1) not an insolvent insurer; and

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

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

~~(q)~~ **(s)** "Member insurer" means any person that holds a certificate of authority to transact in Indiana any kind of insurance **or health maintenance organization business** for which coverage is provided under section 2.3 of this chapter. The term includes an insurer whose certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily withdrawn but does not include the following:

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

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

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

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

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

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

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

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

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

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

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

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

~~(r)~~ **(t)** "Moody's Corporate Bond Yield Average" means:

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

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

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

~~(t)~~ **(v)** "Owner" means the person:

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

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

The term does not include a person with a mere beneficial interest in a policy or contract.

~~(u)~~ **(w)** "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a governmental entity, a voluntary organization, a trust, a trustee, or another business entity or organization.

~~(v)~~ **(x)** "Plan sponsor" refers to only one (1) of the following with respect to a benefit plan:

(1) The employer, in the case of a benefit plan established or maintained by a single employer.

(2) The holding company or controlling affiliate, in the case of a benefit plan established or maintained by affiliated companies

comprising a consolidated corporation.

(3) The employee organization, in the case of a benefit plan established or maintained by an employee organization.

(4) In a case of a benefit plan established or maintained:

(A) by two (2) or more employers;

(B) by two (2) or more employee organizations; or

(C) jointly by one (1) or more employers and one (1) or more employee organizations;

and that is not of a type described in subdivision (2), the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan.

~~(w)~~ **(y)** "Premiums" means amounts, deposits, and considerations received on covered policies, less returned premiums, returned deposits, returned considerations, dividends, and experience credits. The term does not include the following:

(1) Amounts, deposits, and considerations received for policies or contracts or parts of policies or contracts for which coverage is not provided under section 2.3(d) of this chapter, as qualified by section 2.3(e) of this chapter, except that an assessable premium must not be reduced on account of the limitations set forth in section 2.3(e)(3), 2.3(e)(15), or 2.3(f)(2) of this chapter.

(2) Premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued or not connected with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

~~(x)~~ **(z)** "Principal place of business" refers to the single state in which individuals who establish policy for the direction, control, and coordination of the operations of an entity as a whole primarily exercise the direction, control, and coordination, as determined by the association in the association's reasonable judgment by considering the following factors:

(1) The state in which the primary executive and administrative headquarters of the entity is located.

(2) The state in which the principal office of the chief executive officer of the entity is located.

(3) The state in which the board of directors or similar governing person of the entity conducts the majority of the board of directors' or governing person's meetings.

(4) The state in which the executive or management committee of the board of directors or similar governing person of the entity conducts the majority of the committee's meetings.

(5) The state from which the management of the overall operations of the entity is directed.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are employed in a single state, that state is considered to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subsection ~~(v)(4),~~ **(x)(4),** if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are not employed in a single state, is considered to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan and, in the absence of a specific or clear designation of a principal place of business, is considered to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question on the coverage date.

~~(y)~~ **(aa)** "Receivership court" refers to the court in an insolvent insurer's or impaired insurer's state that has jurisdiction over the conservation, rehabilitation, or liquidation of the insolvent insurer or impaired insurer.

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

(1) An individual who resides in Indiana on the applicable coverage date.

(2) A person that is not an individual and has the person's principal place of business in Indiana on the applicable coverage date.

~~(aa)~~ **(cc)** "State" includes a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

~~(bb)~~ **(dd)** "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

~~(cc)~~ **(ee)** "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

~~(dd)~~ **(ff)** "Unallocated annuity contract" means an annuity contract or group annuity certificate:

(1) the owner of which is not a natural person; and

(2) that does not identify at least one (1) specific natural person as an annuitant;

except to the extent of any annuity benefits guaranteed to a natural person by an insurer under the contract or certificate. For purposes of

this chapter, an unallocated annuity contract shall not be considered a group policy or group contract.

SECTION 13. IC 27-8-8-2.1, AS AMENDED BY P.L.276-2013, SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2.1. (a) For purposes of this chapter:

(1) a policy or contract issued on a blanket basis is a group policy or group contract;

(2) each individual insured under a policy or contract issued on a blanket basis is a certificate holder under the policy or contract; and

(3) a policy or contract issued on a franchise plan to members of a qualified group is a nongroup policy or nongroup contract.

(b) For purposes of this chapter, a benefit plan may have only one (1) plan sponsor.

(c) For purposes of this chapter, an individual who, on the applicable coverage date:

(1) is a citizen of the United States; and

(2) resides in a:

(A) foreign country; or

(B) United States possession, territory, or protectorate;

that does not have an association similar to the association created by this chapter;

is considered to be a resident of the state of domicile of the insurer that issued the policies or contracts.

(d) For purposes of this chapter, benefits provided under a long term care insurance rider to:

(1) a life insurance policy; or

(2) an annuity contract;

are considered to be the same kind of benefits as the benefits under the life insurance policy or annuity contract to which the rider benefits relate.

SECTION 14. IC 27-8-8-2.3, AS AMENDED BY P.L.276-2013, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2.3. (a) Except as otherwise excluded or limited by this chapter, this chapter provides coverage for policies and contracts specified in subsection (d) as follows:

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

(2) To a person that is a certificate holder under a group policy or

group contract, and to a person that is the owner of a nongroup policy or nongroup contract that is not an unallocated annuity contract or a structured settlement annuity, and that:

(A) is a resident; or

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

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

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

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

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

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

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

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

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

(B) A person that is the owner of an unallocated annuity contract issued to or in connection with a government lottery, if the owner is a resident or, if the owner is not a resident, if all the following conditions are satisfied:

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

(ii) The state in which the owner resides has an association similar to the association.

(iii) The other association referred to in item (ii) does not provide coverage of the unallocated annuity contract solely because the member insurer was not licensed in the state of

residence at the time specified in the guaranty association law of the state of residence.

(4) For a structured settlement annuity, subdivisions (1) and (2) do not apply, and this chapter provides coverage to a person that is a payee under the structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(A) is a resident, regardless of where the contract owner resides; or

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

(i) The member insurer that issued the structured settlement annuity is domiciled in Indiana.

(ii) The state in which the payee resides has an association similar to the association.

(iii) Neither the payee nor the beneficiary of the payee (if the payee is deceased) is eligible for coverage by the other association referred to in item (ii) solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(b) This chapter does not provide coverage to a person that is:

(1) a payee or beneficiary of a contract owner that is a resident, if the payee or beneficiary is afforded any coverage by the association of another state; or

(2) otherwise covered under subsection (a)(3), if any coverage is provided to the person by the association of another state.

(c) To avoid duplicate coverage, if a person that would otherwise receive coverage under this chapter is provided coverage under the laws of another state, the person is not eligible for coverage under this chapter. In determining the application of this subsection when a person may be covered by the association of more than one (1) state as an owner, a payee, a beneficiary, or an assignee, this chapter must be construed in conjunction with the laws of the other state to result in coverage by only one (1) association.

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

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

(2) direct nongroup annuity ~~policies and~~ contracts; ~~and~~

(3) supplemental contracts to direct nongroup ~~life, health, or~~

~~annuity~~ policies and contracts **described in subdivisions (1) and (2);**

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

(5) certificates under direct group annuity contracts; and

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

issued by member insurers.

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

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

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

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

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

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

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

(B) in effect under the certificate, policy, or contract on and after the applicable coverage date, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available on the applicable coverage date.

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.

(4) The obligations of a plan or program of an employer, an association, or another person to provide life, health, or annuity benefits to the employer's, association's, or other person's employees, members, or others, including obligations arising under and benefits payable by the employer, association, or other

person under a multiple employer welfare arrangement.

(5) A minimum premium group insurance plan.

(6) A stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan, or another person obligated to pay life, health, or annuity benefits or to provide services in connection with a benefit plan or another plan, fund, or program for the provision of employee welfare or pension benefits.

(7) An administrative services only contract.

(8) A part of a certificate, policy, or contract to the extent that the certificate, policy, or contract provides for:

(A) dividends or experience rating credits;

(B) voting rights; or

(C) payment of fees or allowances to a person, including the certificate holder or policy or contract owner, in connection with service with respect to or administration of the certificate, policy, or contract.

(9) A certificate, policy, or contract issued in Indiana by a member insurer when the member insurer did not have a certificate of authority to issue the certificate, policy, or contract in Indiana.

(10) An unallocated annuity contract issued to or in connection with a benefit plan protected by the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet been required to make payments with respect to the benefit plan.

(11) An unallocated annuity contract or part of an unallocated annuity contract that is not issued to or in connection with a benefit plan or a government lottery.

(12) A certificate, policy, or contract or part of a certificate, policy, or contract with respect to which the Class B assessments contemplated by section 6 of this chapter may not be made or collected under federal or state law.

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

(A) Obligations and claims based on marketing materials.

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

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

(D) Obligations and claims that are extracontractual claims.

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

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

(A) benefit plan; or

(B) benefit plan's trustee;

that is not an affiliate of the member insurer.

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

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

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

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

(16) A funding agreement.

(17) An annuity not subject to regulation as described in IC 27-1-12.4.

(18) A certificate, policy, or contract that provides a hospital, medical, prescription drug, or other health care benefit under:

(A) Part C of Title XVIII of the federal Social Security Act (42 U.S.C. 1395w-21 through 1395w-28);

(B) Part D of Title XVIII of the federal Social Security Act (42 U.S.C. 1395w-101 through 1395w-153);

(C) Title XIX of the federal Social Security Act (42 U.S.C.

1396 et seq.); or

~~(C)~~ **(D)** regulations adopted under a law specified in clause (A), ~~or~~ (B), **or (C).**

(f) The benefits that the association is obligated to cover do not exceed the lesser of the following:

(1) The contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an impaired insurer or insolvent insurer.

(2) The applicable limitations as follows:

(A) With respect to certificates, policies, and contracts not subject to clause (B), (C), (E), or (F), with respect to one (1) life, regardless of the number of policies or contracts, the following limitations:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values.

(ii) One hundred thousand dollars ($100,000) in health insurance benefits (other than **those relating to** disability **income** insurance, ~~basic hospital, medical, and surgical insurance, major medical insurance,~~ **health benefit plans,** and long term care insurance), including net cash surrender and net cash withdrawal values.

(iii) Three hundred thousand dollars ($300,000) in ~~health insurance benefits that are~~ disability **income** insurance.

(iv) Three hundred thousand dollars ($300,000) in ~~health insurance benefits under one (1) or more~~ long term care insurance ~~policies~~ **benefits** (as defined in IC 27-8-12-5).

(v) Five hundred thousand dollars ($500,000) in health **benefit plan** ~~insurance~~ benefits. ~~that are basic hospital, medical, and surgical insurance or major medical insurance.~~

(vi) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) With respect to unallocated 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, two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participant.

(C) With respect to structured settlement annuities, two hundred fifty thousand dollars ($250,000) in the present value

of annuity benefits, including net cash surrender and net cash withdrawal values, per payee.

(D) In addition to the foregoing limitations, the association is not obligated to cover more than:

(i) an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) person under clauses (A), (B), and (C), except with respect to benefits for ~~basic hospital, medical, and surgical insurance and major medical~~ **health benefit plans** ~~insurance~~ under clause (A)(v), an aggregate of five hundred thousand dollars ($500,000) with respect to any one (1) person; or

(ii) with respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, a firm, a corporation, or another person, and whether the persons insured are officers, managers, employees, or other persons, five million dollars ($5,000,000) in benefits, including net cash surrender and net cash withdrawal values, regardless of the number of policies and contracts held by the owner.

(E) With respect to unallocated annuity contracts issued to or in connection with a government lottery, five million dollars ($5,000,000) in benefits per contract owner, regardless of the number of contracts held by the contract owner.

(F) With respect to unallocated annuity contracts:

(i) issued to or in connection with a benefit plan; and

(ii) not subject to clause (B);

five million dollars ($5,000,000) in benefits per plan sponsor, regardless of the number of unallocated annuity contracts entitled to coverage under this chapter.

(g) The limitations set forth in subsection (f) are limitations on the benefits for which the association is obligated before taking into account the:

(1) association's subrogation and assignment rights; or

(2) extent to which the benefits could be provided out of the assets of the impaired insurer or insolvent insurer attributable to covered policies.

The costs of discharging the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association under the association's subrogation and assignment rights.

(h) In discharging the association's obligations to provide coverage under this chapter, the association is not required to:

(1) guarantee, assume, **reissue,** reinsure, or perform;

(2) cause to be guaranteed, assumed, **reissued,** reinsured, or performed; or

(3) otherwise assure the discharge of;

the obligations of the insolvent insurer or impaired insurer under a covered policy that do not materially affect the economic values or economic benefits of the covered policy.

SECTION 15. 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.

SECTION 16. IC 27-8-8-4, AS AMENDED BY P.L.193-2006, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 4. (a) The board of directors of the association shall consist of not less than ~~five (5)~~ **seven (7)** nor more than ~~nine (9)~~ **eleven (11)** member insurers serving terms established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner.

(b) Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(c) To select the initial board and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. At the organizational meeting, each member insurer is entitled to one (1) vote in person or by proxy. If the board is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members of the board.

(d) In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

(e) Members of the board may be reimbursed from the assets of the association for expenses incurred by the members as members of the board. The association shall not otherwise compensate members of the board for the members' services on the board.

SECTION 17. IC 27-8-8-5, AS AMENDED BY P.L.193-2006, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. (a) If a member insurer is an impaired insurer, the association may, in the association's sole discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(1) guarantee, assume, **reissue,** reinsure, or perform, or cause to be guaranteed, assumed, **reissued,** reinsured, or performed, the contractual obligations of any of the covered policies of the impaired insurer or otherwise assure the discharge of the contractual obligations of the covered policies of the impaired insurer; and

(2) provide money, pledges, loans, notes, guarantees, or use other means as determined by the association in the association's sole discretion to be necessary or appropriate to effectuate subdivision (1).

(b) An obligation undertaken by the association under subsection (a) with respect to a covered policy of an impaired insurer ceases on the date the covered policy is replaced by the policy owner, insured, or association.

(c) If a member insurer is an insolvent insurer, the association shall, in the association's sole discretion, do one (1) of the following for each covered policy:

(1) Guarantee, assume, **reissue,** reinsure, or perform, or cause to be guaranteed, assumed, **reissued,** reinsured, or performed, the

contractual obligations of the covered policy or otherwise assure the discharge of the contractual obligations of the covered policy.

(2) Terminate existing benefits and coverage and provide benefits and coverages in accordance with the following provisions:

(A) ~~For premiums identical to the premiums that would have been payable under the covered policy,~~ Assure payment of benefits arising under the contractual obligations, except for terms of conversion and nonrenewability, for:

(i) with respect to a group covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or forty-five (45) days, but not less than thirty (30) days, after the coverage date for the insolvent insurer; and

(ii) with respect to a nongroup covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or one (1) year, but in no event less than thirty (30) days, after the coverage date for the insolvent insurer.

(B) Make diligent efforts to provide each:

(i) known insured or annuitant, for a nongroup covered policy; and

(ii) owner, for a group covered policy;

at least thirty (30) days notice of the termination of the benefits provided.

(C) Make available substitute coverage, on an individual basis, to each:

(i) owner of a nongroup covered policy if the owner had a right to continue the nongroup covered policy in force until a specified age or for a specified period, during which time the insurer had no unilateral right to make changes in the nongroup covered policy's provisions or had only a unilateral right to make changes in premiums only by class; and

(ii) insured or annuitant under a group covered policy if the insured or annuitant is not eligible for any replacement group coverage and had a right, before termination of the group covered policy, to convert to individual coverage.

(D) In making available any substitute coverage under clause (C), the association may offer to reissue the terminated coverage or to issue an alternative policy or contract. If made available under clause (C), alternative or reissued policies and contracts must be offered without requiring evidence of

insurability and must not impose any waiting period or coverage exclusion, other than a waiting period or coverage exclusion provided for in this chapter, that would not have applied under the terminated covered policy. The association may cause any alternative or reissued policy or contract to be assumed or reinsured.

(E) Use of alternative policies and contracts by the association is subject to the approval of the ~~domiciliary insurance regulatory authority and the receivership court.~~ **commissioner.** The association may adopt alternative policies and contracts of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies and contracts must contain at least the minimum statutory provisions required in Indiana and provide benefits that are reasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium must:

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

(ii) not reflect changes in the health of the insured after the terminated covered policy was last underwritten.

Subject to coverage exceptions, exclusions, and limitations provided for in this chapter, an alternative policy or contract issued by the association must provide coverage similar, in material respects, to the coverage under the terminated covered policy as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from the premium rate charged under the terminated covered policy, the association shall set the premium in accordance with a table of rates adopted by the association. The premium:

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

(ii) is subject to approval of the ~~domiciliary insurance regulatory authority and the receivership court.~~ **commissioner.**

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

(H) Subject to subsection (u), when proceeding under this

subdivision with respect to a covered policy carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 2.3(e)(3) of this chapter.

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

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

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

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

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

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

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

(A) the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter; or

(B) economic or financial conditions, as they affect member insurers, are sufficiently adverse so as to render the imposition of the permanent policy or contract liens to be in the public interest; and

(2) temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with a covered policy, in addition to any contractual provisions for deferral of cash or policy loan value.

In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payments of cash values

or policy loans or any other right to withdraw funds held in conjunction with a covered policy out of the assets of the impaired insurer or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(i) A deposit in Indiana, held by law or required by the commissioner for the benefit of creditors, including policy owners, that is not turned over to the domiciliary receiver before or promptly after the coverage date for an impaired insurer or insolvent insurer under IC 27-9-4-3 must be promptly paid to the association. The association:

(1) may retain a part of an amount paid to the association under this subsection equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to the impairment or insolvency for which the association provides statutory benefits by the aggregate amount of all policy owners' claims in Indiana related to the impairment or insolvency; and

(2) shall remit to the domiciliary receiver the difference between the amount paid to the association and the amount retained by the association under this subsection.

An amount retained by the association under this subsection must be treated as a distribution of estate assets under IC 27-9-3-32 or similar provision of the state of domicile of the impaired insurer or insolvent insurer.

(j) If the association fails to act within a reasonable period of time as provided in subsection (c) with respect to an insolvent insurer, the commissioner has the powers and duties of the association under this chapter with respect to the insolvent insurer.

(k) The association may, upon the commissioner's request, assist and advise the commissioner concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired insurer or insolvent insurer.

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

contracts of the impaired insurer or insolvent insurer and the determination of the policies or contracts and contractual obligations.

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

(1) the person's rights under; and

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

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

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

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

(1) impaired insurer or insolvent insurer;

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

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

(B) whose responsibility is not solely because of the person serving as an assignee in respect of a qualified assignment under Section 130 of the Internal Revenue Code; and

(3) certificate holder, or the beneficiary or payee of the certificate holder, with respect to a certificate.

(p) If subsection (m), (n), or (o) is invalid or ineffective with respect to a person or claim, the amount payable by the association with respect to the related covered policies must be reduced by the amount realized by another person with respect to the person or claim that is attributable to the covered policies.

(q) If the association provides benefits with respect to a covered policy and a person recovers amounts to which the association has rights as described in subsection (m), (n), or (o), the person shall pay to the association the part of the recovery attributable to the covered policies.

(r) The association may do the following:

(1) Enter into contracts necessary or appropriate to carry out the provisions and purposes of this chapter.

(2) Sue or, subject to section 14 of this chapter, be sued, including taking legal actions necessary or appropriate to recover unpaid assessments under section 6 of this chapter and to resolve claims or potential claims against or on behalf of the association.

(3) Borrow money to effect the purposes of this chapter and issue notes or other evidences of indebtedness of the association with respect to borrowings. Notes or other evidences of indebtedness described in this subdivision that are not in default are legal investments for domestic **member** insurers and may be carried as admitted assets.

(4) Employ or retain persons necessary or appropriate to handle the financial transactions of the association and to perform other functions necessary or appropriate under this chapter.

(5) Take legal action necessary or appropriate to avoid or recover payment of improper claims.

(6) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or health insurer. However, in no case may the association issue ~~insurance~~ policies or ~~annuity~~ contracts other than those issued to perform the association's obligations under this chapter.

(7) Request information from a person seeking coverage from the association to aid the association in determining and discharging the association's obligations under this chapter with respect to the person. The person shall promptly comply with the request.

(8) Settle claims and potential claims by or against the association.

(9) Exercise all rights, privileges, and powers granted to the association by any other laws of Indiana or another jurisdiction.

(10) In accordance with the terms of the policy or contract, file for an actuarially justified rate or premium increase for a covered policy.

~~(10)~~ **(11)** Take other necessary or appropriate action to discharge the association's duties and obligations under this chapter or to exercise the association's rights and powers under this chapter.

(s) The association may belong to one (1) or more organizations of one (1) or more other state associations of similar purpose to further the purpose and administer the powers and duties of the association.

(t) The association has discretion and may exercise reasonable business judgment to determine the means by which the association is to discharge, in an economical and efficient manner, the association's obligations under this chapter.

(u) In discharging the association's obligations and exercising the association's rights and powers under subsections (a) and (c), the association may, subject to approval of the receivership court, provide substitute coverage for a covered policy that provides for the covered policy's interest rate, crediting rate, or similar factor employed in calculating returns or changes in value to be determined by use of an index or other external referent stated in the covered policy by issuing an alternative policy or contract in accordance with the following provisions:

(1) Instead of the index or other external referent stated in the covered policy, the alternative policy or contract may provide for:

(A) a fixed interest rate;

(B) payment of dividends with minimum guarantees; or

(C) a different method for calculating returns or changes in value.

(2) A:

(A) requirement for evidence of insurability; or

(B) waiting period or an exclusion, other than a waiting period or an exclusion provided for in this chapter;

that would not have applied under the covered policy may not be imposed.

(3) The alternative policy or contract must provide coverage similar, in material respects, to the coverage under the covered policy, after taking into account the exceptions, exclusions, and limitations provided for in this chapter, as determined by the association.

SECTION 18. IC 27-8-8-5.2, AS ADDED BY P.L.193-2006, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5.2. (a) At any time within one (1) year after the coverage date for an impaired insurer or insolvent insurer, the association may elect, subject to subdivisions (1) through (4), to succeed to the rights and obligations of the impaired insurer or insolvent insurer that accrue on or after the coverage date and that relate to covered policies under one (1) or more indemnity reinsurance agreements entered into by the impaired insurer or insolvent insurer as

a ceding insurer. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the impaired insurer or insolvent insurer has previously and expressly disaffirmed the reinsurance agreement. The election by the association must be effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers specifying the reinsurance agreement concerning which the association has made the foregoing election. If the association makes an election, the following apply with respect to the agreements selected by the association:

(1) The association is responsible for:

(A) all unpaid premiums due under the agreements for periods before and after the coverage date; and

(B) the performance of all other obligations of the impaired insurer or insolvent insurer to be performed after the coverage date;

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

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

(A) with respect to losses or events that occur during periods after the coverage date; and

(B) that relate to covered policies.

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

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

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

(B) indemnity reinsurer;

during the period between the coverage date and the date of the association's election. Either the association or indemnity

reinsurer shall pay the net balance due the other not more than five (5) days after the completion of the calculation. If the receiver, rehabilitator, or liquidator has received any amount due the association under subdivision (2), the receiver, rehabilitator, or liquidator shall remit the amount to the association as promptly as practicable.

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

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

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

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

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

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

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

(c) Subsections (a) and (b) supersede any other law or affected reinsurance agreement that provides for or requires payment of reinsurance proceeds, on account of losses or events that occur after the coverage date, to the receiver, liquidator, or rehabilitator of the impaired insurer or insolvent insurer. The receiver, rehabilitator, or liquidator remains entitled to amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur before the coverage date, subject to applicable setoff provisions.

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

(e) This chapter does not:

(1) abrogate or limit the rights of a reinsurer to claim that the reinsurer is entitled to rescind a reinsurance agreement; or

(2) give a policy owner, **insured,** or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

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

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

(1) Class A assessments are assessments that are authorized and called by the board for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired insurer or insolvent insurer.

(2) Class B assessments are assessments that are authorized and called by the board to the extent necessary to carry out the powers and duties of the association under this chapter with regard to an impaired insurer or insolvent insurer.

(c) The amount of a Class A assessment must be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the assessment be credited against future Class B assessments. ~~The total of all non-pro rata assessments must not exceed one hundred fifty dollars ($150) per member insurer in any one (1) calendar year.~~

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

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

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

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

reasonable under the circumstances.

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

(1) The allocation to:

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

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

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

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

(i) The health account.

(ii) The life insurance and annuity account.

STEP TWO: Determine the remainder of:

(i) fifty-hundredths (0.50); minus

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

STEP THREE: Determine the remainder of:

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

(ii) 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.

For purposes of this subsection, "life insurance and annuity member insurer" means a member insurer for which the sum of the member insurer's assessable life insurance premiums and annuity premiums is equal to or greater than the member insurer's total assessable health insurance 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. For purposes of this subsection, assessable premiums must be measured within Indiana.

~~(e)~~ **(f)** Class B assessments against member insurers for each account and subaccount with respect to an impaired insurer or

insolvent insurer must be allocated among the assessed member insurers in the proportion that the premiums received in Indiana by each assessed member insurer on policies and contracts covered by the account or subaccount during the assessment base year for the impaired insurer or insolvent insurer bears to premiums received in Indiana by all assessed members on policies and contracts covered by the same account or subaccount during the same assessment base year.

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

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

~~(h)~~ **(i)** Subject to subsection ~~(i),~~ **(j),** the total of all assessments authorized by the association in one (1) calendar year against a member insurer for a given subaccount of the life insurance and annuity account or for the health ~~insurance~~ account with respect to any single assessment base year must not exceed two percent (2%) of the member insurer's premiums received in Indiana on the policies and contracts covered by the subaccount or account during the applicable assessment base year.

~~(i)~~ **(j)** If two (2) or more assessments are authorized in one (1) calendar year with respect to impaired insurers or insolvent insurers having different assessment base years, the annual premium used for purposes of determining the aggregate assessment percentage limitation referenced in subsection ~~(h)~~ **(i)** must be equal to the higher

of the annual premiums for the applicable subaccount or account as calculated under this section.

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

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

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

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

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

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

SECTION 20. IC 27-8-8-8, AS AMENDED BY P.L.193-2006, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2018]: Sec. 8. (a) The commissioner shall do the following:

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

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

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

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

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

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

SECTION 21. IC 27-8-8-9, AS AMENDED BY P.L.193-2006, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 9. (a) To aid in the detection and prevention of **member** insurer insolvencies or impairments, the commissioner shall do the following:

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

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

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

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

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

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

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

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

(c) The association may, upon majority vote by the board, make reports and recommendations to the commissioner on any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the solvency of any ~~company~~ **insurer** seeking to do an insurance business in Indiana. The reports and recommendations are not public documents.

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

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

SECTION 22. IC 27-8-8-10, AS AMENDED BY P.L.193-2006, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 10. (a) Records must be kept of all meetings of the board to discuss the activities of the association in carrying out its powers and duties under sections 5, 5.2, and 5.4 of this chapter. Records of the association with respect to an impaired insurer or insolvent insurer must not be disclosed except:

(1) after the termination of the liquidation, rehabilitation, or conservation proceeding involving the impaired insurer or insolvent insurer; or

(2) upon the order of a court with jurisdiction if the order is made before the time described in subdivision (1).

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

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

(c) As a creditor of an impaired insurer or insolvent insurer under subsection (b) and consistent with IC 27-9-3-32, the association and other similar associations are entitled to receive disbursements of assets out of the marshaled assets, as the assets become available to reimburse the association or another similar association, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty (120) days after a member insurer becomes an insolvent insurer, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association is entitled to make application to the receivership court for approval of the association's own proposal to disburse the assets.

(d) Before the termination of a liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the

contributions of the respective parties, including the association, the shareholders, ~~and~~ **the** policy owners, **and the insureds** of the impaired insurer or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired insurer or insolvent insurer. In making the determination, the court shall consider the welfare of the policy owners **and insureds** of the continuing or successor **member** insurer.

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

SECTION 23. IC 27-8-8-11, AS AMENDED BY P.L.193-2006, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 11. (a) Subject to subsections (b) through (d), if an order for liquidation or rehabilitation of ~~an~~ **a member** insurer domiciled in Indiana has been entered, the receiver appointed under the order shall have a right to recover on behalf of the **member** insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the **member** insurer on its capital stock, made at any time during the five (5) years preceding the filing of the petition for liquidation or rehabilitation.

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

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

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

(e) If a person liable under subsection (c) is insolvent, the affiliates

that controlled the person at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

SECTION 24. IC 27-8-8-16.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 16.2. (a) A member insurer that is not eligible to take a credit under section 16 of this chapter may, after approval by the commissioner, place a surcharge on the member insurer's premiums in a sum reasonably calculated to recoup the member insurer's assessments over a reasonable period, as approved by the commissioner.**

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

(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)).

SECTION 25. IC 27-8-8-18, AS AMENDED BY P.L.193-2006, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 18. (a) A person, including ~~an~~ **a member** insurer, insurance producer, employee, agent, or affiliate of ~~an~~ **a member** insurer, shall not make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, an advertisement, an announcement, or a statement, written or oral, that uses the existence of the association for the purpose of the sale of, solicitation of, or inducement to purchase any form of insurance covered by this chapter. This section does not apply to the association or any other entity that does not sell or solicit insurance.

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

(1) prepare a summary document:

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

(B) complying with subsection (c); and

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

Sixty (60) days after the date on which the commissioner approves the

summary document, a member insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document must also be available upon request by a policy owner. The distribution, delivery, or contents or interpretation of the summary document does not guarantee that the policy or contract or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The summary document must be revised by the association as amendment to this chapter requires. Failure to receive the summary document does not give a policy owner, a contract owner, a certificate holder, or an insured greater rights than the rights specified in this chapter.

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

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

(2) Prominently warn that:

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

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

(i) subject to substantial limitations and exclusions;

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

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

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

(4) State that the member insurer and the member insurer's agents are prohibited by law from using the existence of the association for the purpose of selling, soliciting, or inducing purchase of any form of insurance.

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

(6) Explain:

(A) rights available following; and

(B) procedures for filing a complaint to allege;

a violation of any provision of this chapter.

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

(A) is not proprietary; and

(B) is subject to disclosure under IC 5-14-3;

concerning the financial condition of an insurer.

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

SECTION 26. 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 27. 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 28. 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 29. 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 30. IC 27-13-16 IS REPEALED [EFFECTIVE JULY 1, 2018]. (Protection Against Receivership; Continuation of Benefits).

SECTION 31. IC 27-13-18 IS REPEALED [EFFECTIVE JULY 1, 2018]. (Enrollment Period in Event of Receivership).

SECTION 32. IC 27-13-36.2-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 5. A provider shall submit only the following forms for payment by a health maintenance organization:

(1) ~~HCFA-1500.~~ **CMS-1500.**

(2) ~~HCFA-1450 (UB-92).~~ **CMS-1450 (UB-04).**

(3) American Dental Association (ADA) claim form.

SECTION 33. IC 27-15-6-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. The plan of conversion and the amendment to the articles of incorporation of the converting mutual become effective upon the date and time of ~~approval~~ **return** of the articles of amendment by the secretary of state as provided in IC 27-1-8-8, unless a later date and time are specified in the articles of amendment, in which event the plan of conversion and amendment become effective and take place at the later date and time.

SECTION 34. IC 27-18 IS REPEALED [EFFECTIVE JULY 1, 2018]. (Surplus Lines Insurance Compact).

SECTION 35. IC 34-30-2-119.8 IS REPEALED [EFFECTIVE JULY 1, 2018]. ~~Sec. 119.8. IC 27-18-6-1(a) (Concerning:~~

~~(1) the members, officers, executive director, employees, and representatives; and~~

~~(2) the members of the executive committee and of any other committee;~~

~~of the surplus lines insurance multistate compliance compact commission).~~

SECTION 36. [EFFECTIVE JULY 1, 2018] **(a) As used in this SECTION, "public-private agreement" refers to the following:**

(1) A BOT agreement (as defined in IC 5-23-2-3).

(2) A public-private agreement entered into under IC 8-15.5.

(3) A public-private agreement entered into under IC 8-15.7.

(b) The legislative council is urged to assign to an appropriate interim study committee, for study during the 2018 interim of the general assembly, the issue of bond requirements for public-private agreements.

(c) If the legislative council makes the assignment described in subsection (b), the study committee shall make recommendations concerning the issue described in subsection (b) to the legislative council not later than November 1, 2018.

(d) This SECTION expires January 1, 2019.

SECTION 37. [EFFECTIVE JULY 1, 2018] **(a) The general assembly recognizes that:**

(1) this act repeals IC 27-18; and

(2) SEA 341-2018 amends IC 27-18-1-22 and IC 27-18-1-26. The general assembly intends to repeal IC 27-18 effective July 1, 2018.

(b) This SECTION expires July 1, 2021.

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____