Second Regular Session of the 123rd General Assembly (2024)

HOUSE ENROLLED ACT No. 1332

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 27-1-15.7-4, AS AMENDED BY P.L.148-2017, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 4. (a) The commissioner shall approve and disapprove continuing education courses after considering recommendations made by the insurance producer education and continuing education ~~advisory council created~~ **commission established** under section ~~6~~ **6.5** of this chapter.

(b) The commissioner may not approve a course under this section if the course:

(1) is designed to prepare an individual to receive an initial license under this chapter;

(2) concerns only routine, basic office skills, including filing, keyboarding, and basic computer skills; or

(3) may be completed by a licensee without supervision by an instructor, unless the course involves an examination process that is:

(A) completed and passed by the licensee as determined by the provider of the course; and

(B) approved by the commissioner.

(c) The commissioner shall approve a course under this section that is submitted for approval by an insurance trade association or professional insurance association if:

(1) the objective of the course is to educate a manager or an owner of a business entity that is required to obtain an insurance producer license under IC 27-1-15.6-6(d);

(2) the course teaches insurance producer management and is designed to result in improved efficiency in insurance producer operations, systems use, or key functions;

(3) the course is designed to benefit consumers; and

(4) the course is not described in subsection (b).

(d) Approval of a continuing education course under this section shall be for a period of not more than two (2) years.

(e) A prospective provider of a continuing education course shall pay:

(1) a fee of forty dollars ($40) for each course submitted for approval of the commissioner under this section; or

(2) an annual fee of five hundred dollars ($500) not later than January 1 of a calendar year, which entitles the prospective provider to submit an unlimited number of courses for approval of the commissioner under this section during the calendar year.

The commissioner may waive all or a portion of the fee for a course submitted under a reciprocity agreement with another state for the approval or disapproval of continuing education courses. Fees collected under this subsection shall be deposited in the department of insurance fund established under IC 27-1-3-28.

(f) A prospective provider of a continuing education course may electronically deliver to the commissioner any supporting materials for the course.

(g) The commissioner shall adopt rules under IC 4-22-2 to establish procedures for approving continuing education courses.

SECTION 2. IC 27-1-15.7-5, AS AMENDED BY P.L.81-2012, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 5. (a) To qualify as a certified prelicensing course of study for purposes of IC 27-1-15.6-6, an insurance producer program of study must meet all of the following criteria:

(1) Be conducted or developed by an:

(A) insurance trade association;

(B) accredited college or university;

(C) educational organization certified by the insurance producer education and continuing education ~~advisory council,~~ **commission;** or

(D) insurance company licensed to do business in Indiana.

(2) Provide for self-study or instruction provided by an approved instructor in a structured setting, as follows:

(A) For life insurance producers, not less than twenty (20) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of insurance;

(ii) requirements of the insurance laws and administrative rules of Indiana; and

(iii) principles of life insurance.

(B) For health insurance producers, not less than twenty (20) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of insurance;

(ii) requirements of the insurance laws and administrative rules of Indiana; and

(iii) principles of health insurance.

(C) For life and health insurance producers, not less than forty (40) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of insurance;

(ii) requirements of the insurance laws and administrative rules of Indiana;

(iii) principles of life insurance; and

(iv) principles of health insurance.

(D) For property and casualty insurance producers, not less than forty (40) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of insurance;

(ii) requirements of the insurance laws and administrative rules of Indiana;

(iii) principles of property insurance; and

(iv) principles of liability insurance.

(E) For personal lines producers, a minimum of twenty (20) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of insurance;

(ii) requirements of the insurance laws and administrative rules of Indiana; and

(iii) principles of property and liability insurance applicable

to coverages sold to individuals and families for primarily noncommercial purposes.

(F) For title insurance producers, not less than ten (10) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of title insurance;

(ii) requirements of the insurance laws and administrative rules of Indiana;

(iii) principles of title insurance, including underwriting and escrow issues; and

(iv) principles of the federal Real Estate Settlement Procedures Act (12 U.S.C. 2608).

(G) For annuity product producers, not less than four (4) hours of instruction in a structured setting or comparable self-study on:

(i) types and classifications of annuities;

(ii) identification of the parties to an annuity;

(iii) the manner in which fixed, variable, and indexed annuity contract provisions affect consumers;

(iv) income taxation of qualified and non-qualified annuities;

(v) primary uses of annuities; and

(vi) appropriate sales practices, replacement, and disclosure requirements.

(3) Instruction provided in a structured setting must be provided only by individuals who meet the qualifications established by the commissioner under subsection (b).

(b) The commissioner, after consulting with the insurance producer education and continuing education ~~advisory council,~~ **commission,** shall adopt rules under IC 4-22-2 prescribing the criteria that a person must meet to render instruction in a certified prelicensing course of study.

(c) The commissioner shall adopt rules under IC 4-22-2 prescribing the subject matter that an insurance producer program of study must cover to qualify for certification as a certified prelicensing course of study under this section.

(d) The commissioner may make recommendations that the commissioner considers necessary for improvements in course materials.

(e) The commissioner shall designate a program of study that meets the requirements of this section as a certified prelicensing course of

study for purposes of IC 27-1-15.6-6.

(f) For each person that provides one (1) or more certified prelicensing courses of study, the commissioner shall annually determine, of all individuals who received classroom instruction in the certified prelicensing courses of study provided by the person, the percentage who passed the examination required by IC 27-1-15.6-5. The commissioner shall determine only one (1) passing percentage under this subsection for all lines of insurance described in IC 27-1-15.6-7(a) for which the person provides classroom instruction in certified prelicensing courses of study.

(g) The commissioner may, after notice and opportunity for a hearing, do the following:

(1) Withdraw the certification of a course of study that does not maintain reasonable standards, as determined by the commissioner for the protection of the public.

(2) Disqualify a person that is currently qualified under subsection (b) to render instruction in a certified prelicensing course of study from rendering the instruction if the passing percentage calculated under subsection (f) is less than forty-five percent (45%).

(h) Current course materials for a prelicensing course of study that is certified under this section must be submitted to the commissioner upon request, but not less frequently than once every three (3) years.

SECTION 3. IC 27-1-15.7-6 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 6. (a) As used in this section, "council" refers to the insurance producer education and continuing education advisory council created under subsection (b).~~

~~(b) The insurance producer education and continuing education advisory council is created within the department. The council consists of the commissioner and fifteen (15) members appointed by the governor as follows:~~

~~(1) Two (2) members recommended by the Professional Insurance Agents of Indiana.~~

~~(2) Two (2) members recommended by the Independent Insurance Agents of Indiana.~~

~~(3) Two (2) members recommended by the Indiana Association of Insurance and Financial Advisors.~~

~~(4) Two (2) members recommended by the Indiana State Association of Health Underwriters.~~

~~(5) Two (2) representatives of direct writing or exclusive producer's insurance companies.~~

~~(6) One (1) representative of the Association of Life Insurance~~

~~Companies.~~

~~(7) One (1) member recommended by the Insurance Institute of Indiana.~~

~~(8) One (1) member recommended by the Indiana Land Title Association.~~

~~(9) Two (2) other individuals.~~

~~(c) Members of the council serve for a term of three (3) years. Members may not serve more than two (2) consecutive terms.~~

~~(d) Before making appointments to the council, the governor must:~~

~~(1) solicit; and~~

~~(2) select appointees to the council from;~~

~~nominations made by organizations and associations that represent individuals and corporations selling insurance in Indiana.~~

~~(e) The council shall meet at least semiannually.~~

~~(f) A member of the council is entitled to the minimum salary per diem provided under IC 4-10-11-2.1(b). A member is also entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the state department of administration and approved by the state budget agency.~~

~~(g) The council shall review and make recommendations to the commissioner with respect to course materials, curriculum, and credentials of instructors of each prelicensing course of study for which certification by the commissioner is sought under section 5 of this chapter and shall make recommendations to the commissioner with respect to educational requirements for insurance producers.~~

~~(h) A member of the council or designee of the commissioner shall be permitted access to any classroom while instruction is in progress to monitor the classroom instruction.~~

~~(i) The council shall make recommendations to the commissioner concerning the following:~~

~~(1) Continuing education courses for which the approval of the commissioner is sought under section 4 of this chapter.~~

~~(2) Rules proposed for adoption by the commissioner that would affect continuing education.~~

SECTION 4. IC 27-1-15.7-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 6.5. (a) As used in this section, "commission" refers to the insurance producer education and continuing education commission established by subsection (b).**

(b) The insurance producer education and continuing education commission is established within the department. The

commissioner shall appoint the following seven (7) individuals:

(1) One (1) individual nominated by the Professional Insurance Agents of Indiana or its successor organization.

(2) One (1) individual nominated by the Independent Insurance Agents of Indiana or its successor organization.

(3) One (1) individual nominated by the Indiana Association of Insurance and Financial Advisors or its successor organization.

(4) One (1) individual nominated by the Indiana State Association of Health Underwriters or its successor organization.

(5) One (1) individual nominated by the Association of Life Insurance Companies or its successor organization.

(6) One (1) individual nominated by the Insurance Institute of Indiana or its successor organization.

(7) One (1) individual nominated by the Indiana Land Title Association or its successor organization.

The commissioner shall solicit nominations from the entities set forth in this subsection. The commissioner may deny to make the appointment of an individual nominated under this subsection only if the commissioner determines that the individual is not in good standing with the department or is not qualified. If the commissioner denies the appointment of an individual nominated under this subsection, the commissioner shall provide the nominating entity with the reason for the denial and allow the nominating entity to submit an alternative nomination.

(c) A member of the commission serves for a term of three (3) years that expires June 30, 2027, and every third year thereafter. A member may not serve more than two (2) consecutive terms.

(d) The commissioner shall appoint a member of the commission to serve as chairperson, who serves at the will of the commissioner. The commission shall meet:

(1) at the call of the chairperson; and

(2) at least semiannually.

The department shall staff the commission. Four (4) members constitute a quorum of the commission.

(e) The commissioner shall fill a vacancy on the commission with a nomination from the entity that nominated the predecessor or the entity's successor. The individual appointed to fill the vacancy shall serve for the remainder of the predecessor's term.

(f) A member of the commission is entitled to the minimum salary per diem provided under IC 4-10-11-2.1(b). A member is

also entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties, in accordance with state travel policies and procedures established by the Indiana department of administration and approved by the budget agency. Money paid under this subsection shall be paid from amounts appropriated to the department.

(g) The commission shall review and make recommendations to the commissioner concerning the following:

(1) Course materials and curriculum and instructor credentials for prelicensing courses of study for which certification by the commissioner is sought under section 5 of this chapter.

(2) Continuing education requirements for insurance producers.

(3) Continuing education courses for which the approval of the commissioner is sought under section 4 of this chapter.

(4) Rules proposed for adoption by the commissioner concerning continuing education under this chapter.

(h) A member of the commission or a designee of the commissioner is permitted access to any classroom while instruction is in progress to monitor the classroom instruction.

SECTION 5. IC 27-1-18-5 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 5. At the time of filing its annual statement, an alien or foreign company shall submit, on a form prescribed by the department, a condensed statement of its assets and liabilities as of December 31 of the preceding year. If the department, on examination of such statement, determines from information available to it that it is true and correct, it shall cause such statement to be published in a newspaper in this state selected by the department. In the event the department determines that the statement submitted by a company is inaccurate or incorrect, it shall, after giving the company notice of the proposed changes and an opportunity to be heard, certify the corrected statement and proceed with its publication as above provided. The company shall bear the expenses of the publication, but in no event shall an amount exceeding forty dollars ($40) be charged for such publication. Any cost of publication that exceeds forty dollars ($40) must be borne by the newspaper publishing the statement.~~

SECTION 6. IC 27-1-23-1, AS AMENDED BY P.L.72-2016, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1. As used in this chapter, the following terms shall have the respective meanings set forth in this section, unless the context shall otherwise require:

(a) An "acquiring party" is the specific person by whom an acquisition of control of a domestic insurer or of any corporation controlling a domestic insurer is to be effected, and each person who directly, or indirectly through one (1) or more intermediaries, controls the person specified.

(b) An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(c) A "beneficial owner" of a voting security includes any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, revocable or irrevocable proxy, or otherwise has or shares:

(1) voting power including the power to vote, or to direct the voting of, the security; or

(2) investment power which includes the power to dispose, or to direct the disposition, of the security.

(d) "Commissioner" means the insurance commissioner of this state.

(e) "Control" (including the terms "controlling", "controlled by", and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the beneficial ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office. Control shall be presumed to exist if any person beneficially owns ten percent (10%) or more of the voting securities of any other person. The commissioner may determine this presumption has been rebutted only by a showing made in the manner provided by section 3(k) of this chapter that control does not exist in fact, after giving all interested persons notice and an opportunity to be heard. Control shall be presumed again to exist upon the acquisition of beneficial ownership of each additional five percent (5%) or more of the voting securities of the other person. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(f) "Department" means the department of insurance created by IC 27-1-1-1.

(g) A "domestic insurer" is an insurer organized under the laws of this state.

(h) "Earned surplus" means an amount equal to the unassigned funds of an insurer as set forth in the most recent annual statement of

an insurer that is submitted to the commissioner, excluding surplus arising from unrealized capital gains or revaluation of assets.

(i) "Enterprise risk" means an activity, circumstance, event, or series of events that involves at least one (1) affiliate of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or the insurer's insurance holding company system as a whole, including an activity, circumstance, event, or series of events that would cause the:

(1) insurer's risk based capital to fall into company action level under IC 27-1-36; or

(2) insurer to be in hazardous financial condition subject to IC 27-1-3-7 and rules adopted under IC 27-1-3-7.

(j) This subsection is effective beginning January 1, 2026. "Group Capital Calculation Instructions" refers to the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

~~(j)~~ **(k)** "Group wide supervisor" means the regulatory official who is:

(1) authorized by the commissioner to conduct and coordinate group wide supervision of an internationally active insurance group; and

(2) determined by the commissioner to have sufficient significant contact with the internationally active insurance group to enable group wide supervision.

~~(k)~~ **(l)** An "insurance holding company system" consists of two (2) or more affiliated persons, one (1) or more of which is an insurer.

~~(l)~~ **(m)** "Insurer" has the same meaning as set forth in IC 27-1-2-3, except that it does not include:

(1) agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state; or

(2) nonprofit medical and hospital service associations.

The term includes a health maintenance organization (as defined in IC 27-13-1-19) and a limited service health maintenance organization (as defined in IC 27-13-1-27).

~~(m)~~ **(n)** "Internationally active insurance group" means an insurance holding company system that:

(1) includes an insurer that is registered under section 3 of this chapter; and

(2) meets the following requirements:

(A) The insurance holding company system has premiums written in at least three (3) countries.

(B) The percentage of the insurance holding company system's gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums.

(C) Based on a three (3) year rolling average, the:

(i) total assets of the insurance holding company system are at least fifty billion dollars ($50,000,000,000); or

(ii) total gross written premiums of the insurance holding company system are at least ten billion dollars ($10,000,000,000).

~~(n)~~ **(o)** "NAIC" refers to the National Association of Insurance Commissioners.

(p) This subsection is effective beginning January 1, 2026. "NAIC Liquidity Stress Test Framework" refers to a separate NAIC publication that includes:

(1) a history of the NAIC's development of regulatory liquidity stress testing;

(2) the Scope Criteria applicable for a specific data year; and

(3) the Liquidity Stress Test instructions and reporting templates for a specific data year, such Scope Criteria, instructions, and a reporting template as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(q) This subsection is effective beginning January 1, 2026. "Scope Criteria", as detailed in the NAIC Liquidity Stress Test Framework, refers to the designated exposure bases, along with the minimum magnitudes of the designated exposure bases, for the specified data year, which are used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year.

~~(o)~~ **(r)** "Supervisory college" means a temporary or permanent forum:

(1) comprised of regulators, including other state, federal, and international regulators, responsible for the supervision of:

(A) a domestic insurer that is part of an insurance holding company system that has international operations;

(B) an insurance holding company system described in clause (A); or

(C) an affiliate of:

(i) a domestic insurer described in clause (A); or

(ii) an insurance holding company system described in clause (B); and

(2) established to facilitate communication and cooperation between the regulators described in subdivision (1).

~~(p)~~ **(s)** A "person" is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert. The term does not include the following:

(1) A securities broker performing no more than the usual and customary broker's function.

(2) A joint venture partnership that is exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.

~~(q)~~ **(t)** A "policyholder" of a domestic insurer includes any person who owns an insurance policy or annuity contract issued by the domestic insurer, any person reinsured by the domestic insurer under a reinsurance contract or treaty between the person and the domestic insurer, and any health maintenance organization with which the domestic insurer has contracted to provide services or protection against the cost of care.

~~(r)~~ **(u)** "Securityholder" means a person that owns a security of a specified person, including common stock, preferred stock, debt obligations, and any other security that:

(1) is convertible to; or

(2) evidences the right to acquire;

a common stock, preferred stock, or debt obligation.

~~(s)~~ **(v)** A "subsidiary" of a specified person is an affiliate controlled by that person directly or indirectly through one **(1)** or more intermediaries.

~~(t)~~ **(w)** "Surplus" means the total of gross paid in and contributed surplus, special surplus funds, and unassigned surplus, less treasury stock at cost.

~~(u)~~ **(x)** "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

SECTION 7. IC 27-1-23-3, AS AMENDED BY P.L.124-2018, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 3. (a) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are

substantially similar to those contained in:

(1) this section;

(2) section 4(a) and 4(c) of this chapter; and

(3) section 4(b) of this chapter or a provision such as the following:

> Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each such change or addition.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by July 1 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within such extended time. The commissioner may require any authorized insurer which is a member of an insurance holding company system but not subject to registration under this section to furnish a copy of the registration statement or other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(b) Every insurer subject to registration shall file a registration statement on a form prescribed by the commissioner, which shall contain current information about all of the following:

(1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer.

(2) The identity of every member of the insurance holding company system.

(3) The following agreements in force, relationships subsisting, and transactions that are currently outstanding or that have occurred during the last calendar year between such insurer and its affiliates:

(A) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(B) purchases, sales, or exchanges of assets;

(C) transactions not in the ordinary course of business;

(D) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(E) all management and service contracts and all cost-sharing

arrangements;

(F) reinsurance agreements;

(G) dividends and other distributions to shareholders; and

(H) consolidated tax allocation agreements.

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(5) If requested by the commissioner, financial statements of the insurance holding company system, the parent corporation of the insurer, or all affiliates, including annual audited financial statements filed with the federal Securities and Exchange Commission under the Securities Act of 1933 (15 U.S.C. 77a et seq.) or the federal Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.).

(6) Statements reflecting that the insurer's:

(A) board of directors oversees corporate governance and internal controls; and

(B) officers or senior management have approved and implemented and maintain and monitor corporate governance and internal control procedures.

(7) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms prescribed by the commissioner.

(8) Other information that the commissioner requires under rules adopted under IC 4-22-2.

(c) Every registration statement must contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) No information need be disclosed on the registration statement filed pursuant to subsection (b) if such information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, involving one-half of one ~~per cent~~ **percent** (0.5%) or less of an insurer's admitted assets as of the ~~31st~~ **thirty-first** day of December next preceding shall not be deemed material for purposes of this section. **Beginning January 1, 2026, the definition of materiality set forth in this subsection does not apply for purposes of the Group Capital Calculation or the Liquidity Stress Test Framework.**

(e) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms prescribed by the

commissioner within fifteen (15) days after the end of the month in which it learns of each such change or addition.

(f) A person within an insurance holding company system subject to registration under this chapter shall provide complete and accurate information to an insurer when that information is reasonably necessary to enable the insurer to comply with this chapter.

(g) The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is subject to the provisions of this section.

(h) The commissioner may require or allow two (2) or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(i) The commissioner may allow an insurer which is authorized to do business in this state and which is a member of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) and to file all information and material required to be filed under this section.

(j) The provisions of this section shall not apply to any insurer, information, or transaction if and to the extent that the commissioner by rule or order shall exempt the same from the provisions of this section.

(k) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section which may arise out of the insurer's relationship with such person unless and until the commissioner disallows such disclaimer. A disclaimer of affiliation is considered to have been granted unless the commissioner, less than thirty (30) days after receiving a disclaimer, notifies the person filing the disclaimer that the disclaimer is disallowed. The commissioner shall disallow such disclaimer only after furnishing all parties in interest with notice and opportunity to be heard.

(l) The person that ultimately controls an insurer that is subject to registration shall file with the lead state commissioner of the insurance holding company system (as determined by the procedures in the Financial Analysis Handbook) an annual enterprise risk report that

identifies, to the best of the person's knowledge, the material risks within the insurance holding company system that could pose enterprise risk to the insurer.

(m) This subsection is effective beginning January 1, 2026. Except as otherwise provided in subdivisions (1) through (7), the ultimate controlling person of every insurer subject to registration shall file, concurrently with the registration, an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC Group Capital Calculation Instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. Insurance holding company systems described in the following are exempt from filing the group capital calculation:

(1) An insurance holding company system that has only one (1) insurer within its holding company structure, writes business only in its domestic state, is licensed only in its domestic state, and assumes no business from any other insurer.

(2) An insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect. If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing.

(3) An insurance holding company system whose non-United States group wide supervisor is located within a Reciprocal Jurisdiction as described in IC 27-6-10.1 that recognizes the United States state regulatory approach to group supervision and group capital.

(4) An insurance holding company system:

(A) that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group wide supervisor,

who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the Financial Analysis Handbook adopted by the NAIC; and

(B) whose non-United States group wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the world wide group capital assessment for United States insurance groups that operate in that jurisdiction.

(5) Notwithstanding the provisions of subdivisions (3) and (4), a lead state commissioner shall require the group capital calculation for United States operations of any non-United States based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(6) Notwithstanding the exemptions from filing the group capital calculation stated in subdivisions (1) through (4), the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation.

(7) If the lead state commissioner determines that an insurance holding company system no longer meets one (1) or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(n) This subsection is effective beginning January 1, 2026. The ultimate controlling person of every insurer that is subject to registration and is also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year's Liquidity Stress Test. The filing shall be made to the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC, subject to the following:

(1) The NAIC Liquidity Stress Test Framework includes

Scope Criteria applicable to a specific data year. These Scope Criteria are reviewed at least annually by the NAIC Financial Stability Task Force or its successor. Any change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured shall be effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one (1) threshold of the Scope Criteria are considered scoped into the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines that the insurer should not be scoped into the NAIC Liquidity Stress Test Framework for that data year. Similarly, insurers that do not trigger at least one (1) threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines that the insurer should be scoped into the NAIC Liquidity Stress Test Framework for that data year.

(2) The performance of, and the filing of the results from, a specific year's Liquidity Stress Test shall comply with the NAIC Liquidity Stress Test Framework's instructions and reporting templates for that year and any lead state commissioner determinations, in consultation with the NAIC Financial Stability Task Force or its successor, that are provided within the NAIC Liquidity Stress Test Framework.

~~(m)~~ **(o)** The commissioner may impose on a person a civil penalty of one hundred dollars ($100) per day that the person fails to file, within the period specified, a:

(1) registration statement; or

(2) summary of a registration statement or enterprise risk filing;

required by this section. The commissioner shall deposit a civil penalty collected under this subsection in the department of insurance fund established by IC 27-1-3-28.

SECTION 8. IC 27-1-24.5-20, AS ADDED BY P.L.68-2020, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 20. (a) The commissioner shall do the following:

(1) Prescribe an application for use in applying for a license to operate as a pharmacy benefit manager.

(2) Adopt rules under IC 4-22-2 to establish the following:

(A) Pharmacy benefit manager licensing requirements.

(B) Licensing fees.

(C) A license application.

(D) Financial standards for pharmacy benefit managers.

(E) Reporting requirements described in ~~section~~ **sections** 21 **and 29** of this chapter.

(F) The time frame for the resolution of an appeal under section 22 of this chapter.

(b) The commissioner may do the following:

(1) Charge a license application fee and renewal fees established under subsection (a)(2) in an amount not to exceed five hundred dollars ($500) to be deposited in the department of insurance fund established by IC 27-1-3-28.

(2) Examine or audit the books and records of a pharmacy benefit manager one (1) time per year to determine if the pharmacy benefit manager is in compliance with this chapter.

(3) Adopt rules under IC 4-22-2 to:

(A) implement this chapter; and

(B) specify requirements for the following:

(i) Prohibited market conduct practices.

(ii) Data reporting in connection with violations of state law.

(iii) Maximum allowable cost list compliance and enforcement requirements, including the requirements of sections 22 and 23 of this chapter.

(iv) Prohibitions and limits on pharmacy benefit manager practices that require licensure under IC 25-22.5.

(v) Pharmacy benefit manager affiliate information sharing.

(vi) Lists of health plans administered by a pharmacy benefit manager in Indiana.

(c) Financial information and proprietary information submitted by a pharmacy benefit manager to the department is confidential.

SECTION 9. IC 27-1-25-11.1, AS AMENDED BY P.L.124-2018, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 11.1. (a) If the home state of a person is Indiana, the person shall:

(1) apply to act as an administrator in Indiana upon the uniform application for third party administrator license;

(2) pay an application fee in an amount determined by the commissioner; and

(3) receive a license from the commissioner;

before performing the function of an administrator in Indiana. The commissioner shall deposit a fee paid under subdivision (2) into the department of insurance fund established by IC 27-1-3-28.

(b) For the purposes of this section:

(1) if:

(A) an administrator is incorporated in Indiana; or

(B) Indiana is the administrator's principal place of business within the United States;

the administrator shall apply to Indiana for a resident administrator license; and

(2) if:

(A) neither the state in which an administrator is incorporated nor the state that is the administrator's principal place of business have adopted this chapter or a substantially similar law governing administrators; and

(B) the administrator has not designated any other state that has adopted this chapter or a substantially similar law governing administrators as its home state;

the administrator shall apply to Indiana for licensure as its designated home state.

~~(b)~~ **(c)** The uniform application for third party administrator license must include or be accompanied by the following:

(1) Basic organizational documents of the applicant, including:

(A) articles of incorporation;

(B) articles of association;

(C) partnership agreement;

(D) trade name certificate;

(E) trust agreement;

(F) shareholder agreement;

(G) other applicable documents; and

(H) amendments to the documents specified in clauses (A) through (G).

(2) Bylaws, rules, regulations, or other documents that regulate the internal affairs of the applicant.

(3) The NAIC biographical affidavits for individuals who are responsible for the conduct of affairs of the applicant, including:

(A) members of the applicant's:

(i) board of directors;

(ii) board of trustees;

(iii) executive committee; or

(iv) other governing board or committee;

(B) principal officers, if the applicant is a corporation;

(C) partners or members, if the applicant is:

(i) a partnership;

(ii) an association; or

(iii) a limited liability company;

(D) shareholders or members that hold, directly or indirectly, at least ten percent (10%) of the:

(i) voting stock;

(ii) voting securities; or

(iii) voting interest;

of the applicant; and

(E) any other person who exercises control or influence over the affairs of the applicant.

(4) Financial information reflecting a positive net worth, including:

(A) audited annual financial statements prepared by an independent certified public accountant for the two (2) most recent fiscal years; or

(B) if the applicant has been in business for less than two (2) fiscal years, financial statements or reports that are:

(i) prepared in accordance with GAAP; and

(ii) certified by an officer of the applicant;

for any completed fiscal years and for any month during the current fiscal year for which financial statements or reports have been completed.

If an audited financial statement or report required under clause (A) or (B) is prepared on a consolidated basis, the statement or report must include a columnar consolidating or combining worksheet that includes the amounts shown on the consolidated audited financial statement or report, separately reported on the worksheet for each entity included on the statement or report, and an explanation of consolidating and eliminating entries.

(5) Information determined by the commissioner to be necessary for a review of the current financial condition of the applicant.

(6) A description of the business plan of the applicant, including:

(A) information on staffing levels and activities proposed in Indiana and nationwide; and

(B) details concerning the applicant's ability to provide a sufficient number of experienced and qualified personnel for:

(i) claims processing;

(ii) record keeping; and

(iii) underwriting.

(7) Any other information required by the commissioner.

~~(c)~~ **(d)** An administrator that applies for licensure under this section shall make copies of written agreements with insurers available for inspection by the commissioner.

~~(d)~~ **(e)** An administrator that applies for licensure under this section shall:

(1) produce the administrator's accounts, records, and files for examination; and

(2) make the administrator's officers available to provide information concerning the affairs of the administrator;

whenever reasonably required by the commissioner.

~~(e)~~ **(f)** The commissioner may refuse to issue a license under this section if the commissioner determines that:

(1) the administrator or an individual who is responsible for the conduct of the affairs of the administrator:

(A) is not:

(i) competent;

(ii) trustworthy;

(iii) financially responsible; or

(iv) of good personal and business reputation; or

(B) has had an:

(i) insurance certificate of authority or insurance license; or

(ii) administrator certificate of authority or administrator license;

denied or revoked for cause by any jurisdiction;

(2) the financial information provided under subsection ~~(b)(4)~~ **(c)(4)** does not reflect that the applicant has a positive net worth; or

(3) any of the grounds set forth in section 12.4 of this chapter exists with respect to the administrator.

~~(f)~~ **(g)** An administrator that applies for a license under this section shall immediately notify the commissioner of a material change in:

(1) the ownership or control of the administrator; or

(2) another fact or circumstance that affects the administrator's qualification for a license.

The commissioner, upon receiving notice under this subsection, shall report the change to the centralized insurance producer license registry described in IC 27-1-15.6-7.

~~(g)~~ **(h)** An administrator that applies for a license under this section and will administer a governmental plan or a church plan shall obtain a bond as required under section 4(g) of this chapter.

~~(h)~~ **(i)** A license that is issued under this section is valid:

(1) for one (1) year after the date of issuance, unless subdivision (2) applies; or

(2) until:

(A) the license is:

(i) surrendered; or

(ii) suspended or revoked by the commissioner; or

(B) the administrator:

(i) ceases to do business in Indiana; or

(ii) is not in compliance with this chapter.

SECTION 10. IC 27-1-25-12.3, AS AMENDED BY P.L.124-2018, SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 12.3. (a) An administrator that is licensed under section 11.1 of this chapter shall, not later than July 1 of each year unless the commissioner grants an extension of time for good cause, file a report for the previous calendar year that complies with the following:

(1) The report must contain financial information reflecting a positive net worth prepared in accordance with section ~~11.1(b)(4)~~ **11.1(c)(4)** of this chapter.

(2) The report must be in the form and contain matters prescribed by the commissioner.

(3) The report must be verified by at least two (2) officers of the administrator.

(4) The report must include the complete names and addresses of insurers with which the administrator had a written agreement during the preceding fiscal year.

(5) The report must be accompanied by a filing fee in an amount determined by the commissioner.

The commissioner shall collect a filing fee paid under subdivision (5) and deposit the fee into the department of insurance fund established by IC 27-1-3-28.

(b) The commissioner shall review a report filed under subsection (a) not later than September 1 of the year in which the report is filed. Upon completion of the review, the commissioner shall:

(1) issue a certification to the administrator:

(A) indicating that:

(i) the financial statement reflects a positive net worth; and

(ii) the administrator is currently licensed and in good standing; or

(B) noting deficiencies found in the report; or

(2) update the centralized insurance producer license registry described in IC 27-1-15.6-7:

(A) indicating that the administrator is solvent and in compliance with this chapter; or

(B) noting deficiencies found in the report.

SECTION 11. IC 27-1-31-3, AS AMENDED BY P.L.196-2021,

SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 3. (a) **Except as provided in subsection (b),** if an insurer refuses to renew a policy of insurance written by the insurer, the insurer shall mail written notice of nonrenewal to the insured:

(1) at least forty-five (45) days before the expiration date of the policy, if the coverage provided is for one (1) year, or less; or

(2) at least forty-five (45) days before the anniversary date of the policy, if the coverage provided is for more than one (1) year.

(b) This subsection does not apply to worker's compensation insurance. If an insurer refuses to renew a policy of insurance written by the insurer, the insurer shall mail written notice of nonrenewal to the insured at least sixty (60) days before the anniversary date of the policy if the coverage is provided to a municipality (as defined in IC 36-1-2-11) or county entity.

~~(b)~~ **(c)** A notice of nonrenewal is not required if:

(1) the insured is transferred from an insurer to an affiliate of the insurer for future coverage; and

(2) the transfer results in the same or broader coverage.

SECTION 12. IC 27-1-37-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 9. (a) This section applies to health provider contracts entered into or renewed after June 30, 2024.**

(b) If a party to a health provider contract intends to terminate the contractual relationship with another party to the health provider contract, the terminating party must provide written notice to the other party of the decision to terminate the contractual relationship not less than ninety (90) days before the health provider contract terminates.

SECTION 13. IC 27-1-37.1-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.5. This chapter does not apply to the termination of a health provider contract under IC 27-1-37-9.**

SECTION 14. IC 27-1-49-9, AS ADDED BY P.L.166-2023, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 9. **(a)** The department may enforce the requirements of this chapter to the extent permissible under applicable law.

(b) A violation of this chapter is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

(c) The department may adopt rules under IC 4-22-2 to set forth fines for violations of this chapter.

SECTION 15. IC 27-1-50-9, AS ADDED BY P.L.166-2023, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 9. **(a)** At the time of contracting, an insurer shall ~~provide~~ **only offer to** plan sponsors the ~~option of~~ **following plans:**

(1) A plan that applies one hundred percent (100%) of the rebates to reduce premiums for all covered individuals equally.

(2) A plan ~~calculating~~ **that calculates** defined cost sharing for covered individuals of the plan sponsor at the point of sale based on a price that is reduced by ~~some or~~ **an amount equal to at least eighty-five percent (85%) of** all of the rebates received or estimated to be received by the insurer concerning the dispensing or administration of the prescription drug.

(b) A plan sponsor may choose one (1) of the plans offered under subsection (a).

SECTION 16. IC 27-1-50-11, AS ADDED BY P.L.166-2023, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 11. An insurer shall disclose the following information to a plan sponsor on at least an annual basis:

(1) The approximate amount of rebates expected to be received by the insurer concerning the dispensing or administration of prescription drugs to the covered individuals of the plan sponsor.

(2) An explanation that the plan sponsor may choose to:

(A) apply the rebates to reduce premiums for all covered individuals; or

(B) calculate defined cost sharing for a covered individual at the point of sale based on a price that is reduced by **an amount equal to at least eighty-five percent (85%) of all** rebates received or estimated to be received by the insurer concerning the dispensing or administration of the covered individual's prescription drugs.

(3) An explanation that, in the individual market, IC 27-1-49 requires that covered individual defined cost sharing be calculated at the point of sale based on a price that is reduced by at least eighty-five percent (85%) of the rebates concerning the dispensing or administration of the covered individual's prescription drugs.

SECTION 17. IC 27-1-50-12, AS ADDED BY P.L.166-2023, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 12. **(a)** The department may enforce the requirements of this chapter to the extent permissible under applicable law.

(b) A violation of this chapter is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

(c) The department may adopt rules under IC 4-22-2 that:

(1) provide for the enforcement of this chapter; and

(2) set forth fines for violations of this chapter.

SECTION 18. IC 27-2-28-1, AS ADDED BY P.L.226-2023, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2024]: Sec. 1. (a) This chapter applies to a personal automobile or homeowner's policy that is issued, delivered, amended, or renewed after June 30, ~~2024.~~ **2025.**

(b) This chapter does not apply to notices required by the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.).

SECTION 19. IC 27-4-1-4, AS AMENDED BY P.L.56-2023, SECTION 244, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion,

representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract. However, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected

expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by IC 27-1-47 or another law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or

indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, so long as any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year.

(D) Paying by an insurer or insurance producer thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed insurance producer thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, an insurance producer, or a solicitor duly licensed under the laws of this state, but such broker, insurance producer, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the

property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any policy of insurance covering such property through a particular insurance company, insurance producer, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:

(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit

unions.

(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

(D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the Indiana department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation

of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

(27) Violating IC 27-2-21 concerning use of credit information.

(28) Violating IC 27-4-9-3 concerning recommendations to consumers.

(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:

(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or

(B) defined in rules adopted under subsection (b).

(30) Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.

(31) Violating IC 27-2-22 concerning retained asset accounts.

(32) Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).

(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.

(34) After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.

(35) Willfully violating IC 27-1-12-46 concerning a life insurance policy or certificate described in IC 27-1-12-46(a).

(36) Violating IC 27-1-37-7 concerning prohibiting the disclosure of health care service claims data.

(37) Violating IC 27-4-10-10 concerning virtual claims payments.

(38) Violating IC 27-1-24.5 concerning pharmacy benefit managers.

(39) Violating IC 27-7-17-16 or IC 27-7-17-17 concerning the marketing of travel insurance policies.

(40) Violating IC 27-1-49 concerning individual prescription drug rebates.

(41) Violating IC 27-1-50 concerning group prescription drug rebates.

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act (10 U.S.C. 992 note), adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.

SECTION 20. IC 27-6-8-4, AS AMENDED BY P.L.52-2013, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 4. **(a)** As used in this chapter, unless otherwise provided:

(1) The term "account" means any one (1) of the three (3) accounts created by section 5 of this chapter.

(2) The term "association" means the Indiana Insurance Guaranty Association created by section 5 of this chapter.

(3) The term "commissioner" means the commissioner of insurance of this state.

(4) The term "covered claim" means an unpaid claim which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this chapter applies issued by an insurer, if the insurer becomes an insolvent insurer after the effective date (January 1, 1972) of this chapter and (a) the claimant or insured is a resident of this state at the time of the insured event or (b) the property from which the claim arises is permanently located in this state. "Covered claim" shall be limited as provided in section 7 of this chapter, and shall not include the following:

(A) Any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. However, a claim for any such amount, asserted against a person insured under a policy issued by an insurer

which has become an insolvent insurer, which if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association, would be a "covered claim" may be filed directly with the receiver or liquidator of the insolvent insurer, but in no event may any such claim be asserted in any legal action against the insured of such insolvent insurer.

(B) Any supplementary obligation including but not limited to adjustment fees and expenses, attorney fees and expenses, court costs, interest and bond premiums, whether arising as a policy benefit or otherwise, prior to the appointment of a liquidator.

(C) Any unpaid claim that is filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. For the purpose of filing a claim under this clause, notice of a claim to the liquidator of the insolvent insurer is considered to be notice to the association or the agent of the association and a list of claims must be periodically submitted to the association (or another state's association that is similar to the association) by the liquidator.

(D) A claim that is excluded under section 11.5 of this chapter due to the high net worth of an insured.

(E) Any claim by a person who directly or indirectly controls, is controlled, or is under common control with an insolvent insurer on December 31 of the year before the order of liquidation.

All covered claims filed in the liquidation proceedings shall be referred immediately to the association by the liquidator for processing as provided in this chapter.

(5) The term "high net worth insured" means the following:

(A) For purposes of section 11.5(a) of this chapter, an insured that has a net worth (including the aggregate net worth of the insured and all subsidiaries and affiliates of the insured, calculated on a consolidated basis) that exceeds twenty-five million dollars ($25,000,000) on December 31 of the year immediately preceding the year in which the insurer becomes an insolvent insurer.

(B) For purposes of section 11.5(b) of this chapter, an insured that has a net worth (including the aggregate net worth of the insured and all subsidiaries and affiliates of the insured, calculated on a consolidated basis) that exceeds fifty million

dollars ($50,000,000) on December 31 of the year immediately preceding the year in which the insurer becomes an insolvent insurer.

(6) The term "insolvent insurer" means (a) a member insurer holding a valid certificate of authority to transact insurance in this state either at the time the policy was issued or when the insured event occurred and (b) against whom a final order of liquidation, with a finding of insolvency, to which there is no further right of appeal, has been entered by a court of competent jurisdiction in the company's state of domicile. "Insolvent insurer" shall not be construed to mean an insurer with respect to which an order, decree, judgment or finding of insolvency whether preliminary or temporary in nature or order to rehabilitation or conservation has been issued by any court of competent jurisdiction prior to January 1, 1972 or which is adjudicated to have been insolvent prior to that date.

(7) The term "member insurer" means any person who is licensed or holds a certificate of authority under IC 27-1-6-18 or IC 27-1-17-1 to transact in Indiana any kind of insurance for which coverage is provided under section 3 of this chapter, including the exchange of reciprocal or inter-insurance contracts. The term includes any insurer whose license or certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily surrendered. A "member insurer" does not include farm mutual insurance companies organized and operating pursuant to IC 27-5.1 other than a company to which IC 27-5.1-2-6 applies.

(8) The term "net direct written premiums" means direct gross premiums written in this state on insurance policies to which this chapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct premiums written" does not include premiums on contracts between insurers or reinsurers.

(9) The term "person" means an individual, an aggregation of individuals, a corporation, a partnership, or another entity.

(b) Notwithstanding any other provision in this chapter, an insurance policy that is issued by a member insurer and later allocated, transferred, assumed by, or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity, shall be

considered to have been issued by a member insurer which is an insolvent insurer for the purposes of this chapter in the event that the insurer to which the policy has been allocated, transferred, assumed by, or otherwise made the sole responsibility of is placed in liquidation.

(c) An insurance policy that was issued by a nonmember insurer and later allocated, transferred, assumed by, or otherwise made the sole responsibility of a member insurer under a state statute shall not be considered to have been issued by a member insurer for the purposes of this chapter.

SECTION 21. IC 27-6-8-5, AS AMENDED BY P.L.52-2013, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 5. There is created a nonprofit unincorporated legal entity to be known as the Indiana Insurance Guaranty Association (referred to in this chapter as the "association"). All insurers defined as member insurers in section ~~4(7)~~ **4(a)(7)** of this chapter shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under section 8 of this chapter and shall exercise its powers through a board of directors established under section 6 of this chapter. For purposes of administration and assessment, the association shall be divided into three (3) separate accounts:

(1) The worker's compensation insurance account.

(2) The automobile insurance account.

(3) The account for all other insurance to which this chapter applies.

SECTION 22. IC 27-6-8-11.5, AS ADDED BY P.L.52-2013, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 11.5. (a) The association is not obligated to pay a first party claim by a high net worth insured described in section ~~4(5)(A)~~ **4(a)(5)(A)** of this chapter.

(b) The association has the right to recover from a high net worth insured described in section ~~4(5)(B)~~ **4(a)(5)(B)** of this chapter all amounts paid by the association to or on behalf of the high net worth insured, regardless of whether the amounts were paid for indemnity, defense, or otherwise.

(c) The association is not obligated to pay a claim that:

(1) would otherwise be a covered claim;

(2) is an obligation to or on behalf of a person who has a net worth greater than the net worth allowed by the insurance guaranty association law of the state of residence of the claimant

at the time specified by the applicable law of the state of residence of the claimant; and

(3) has been denied by the association of the state of residence of the claimant on the basis described in subdivision (2).

(d) The association shall establish reasonable procedures, subject to the approval of the commissioner, for requesting financial information from insureds:

(1) on a confidential basis; and

(2) in the application of this section.

(e) The procedures established under subsection (d) must provide for sharing of the financial information obtained from insureds with:

(1) any other association that is similar to the association; and

(2) the liquidator for an insolvent insurer;

on the same confidential basis.

(f) If an insured refuses to provide financial information that is:

(1) requested under the procedures established under subsection (d); and

(2) available;

the association may, until the time that the financial information is provided to the association, consider the insured to be a high net worth insured for purposes of subsections (a) and (b).

(g) In an action contesting the applicability of this section to an insured that refuses to provide financial information under the procedures established under subsection (d), the insured bears the burden of proof concerning the insured's net worth at the relevant time. If the insured fails to prove that the insured's net worth at the relevant time was less than the applicable amount set forth in section ~~4(5)(A) or 4(5)(B)~~ **4(a)(5)(A) or 4(a)(5)(B)** of this chapter, the court shall award to the association the association's full costs, expenses, and reasonable attorney's fees incurred in contesting the claim.

SECTION 23. IC 27-8-11-7, AS AMENDED BY P.L.190-2023, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 7. (a) This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) As used in this section, "clean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the insurer without returning the application to the provider for a revision or clarification.

(c) As used in this section, "credentialing" means a process by

which an insurer makes a determination that:

(1) is based on criteria established by the insurer; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for coverage; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and the insurer.

(d) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

(e) The department of insurance shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by an insurer; and

(2) an insurer that performs credentialing activities.

(f) An insurer shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(g) A provider shall respond to the notification required under subsection (f) not later than five (5) business days after receipt of the notice.

(h) An insurer shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the insurer makes a final credentialing determination concerning the provider.

(i) If the insurer fails to issue a credentialing determination within fifteen (15) **business** days after receiving a completed clean credentialing application form from a provider, the insurer shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

(j) Once an insurer fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.

(k) If an insurer does not fully credential a provider that is provisionally credentialed under subsection (i), the provisional credentialing is terminated on the date the insurer notifies the provider of the adverse credentialing determination. The insurer is not required to reimburse for services rendered while the provider was provisionally credentialed.

SECTION 24. IC 27-13-43-2, AS AMENDED BY P.L.190-2023, SECTION 36, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 2. (a) As used in this section, "clean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the health maintenance organization without returning the application to the provider for a revision or clarification.

(b) As used in this section, "credentialing" means a process by which a health maintenance organization makes a determination that:

(1) is based on criteria established by the health maintenance organization; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for coverage; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and the health maintenance organization.

(c) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

(d) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by:

(1) a provider who applies for credentialing by a health maintenance organization; and

(2) a health maintenance organization that performs credentialing

activities.

(e) A health maintenance organization shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(f) A provider shall respond to the notification required under subsection (e) not later than five (5) business days after receipt of the notice.

(g) A health maintenance organization shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the health maintenance organization makes a final credentialing determination concerning the provider.

(h) If the health maintenance organization fails to issue a credentialing determination within fifteen (15) **business** days after receiving a completed clean credentialing application form from a provider, the health maintenance organization shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

(i) Once a health maintenance organization fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The health maintenance organization shall reimburse the provider at the rates determined by the contract between the provider and the health maintenance organization.

(j) If a health maintenance organization does not fully credential a provider that is provisionally credentialed under subsection (h), the provisional credentialing is terminated on the date the health maintenance organization notifies the provider of the adverse credentialing determination. The health maintenance organization is not required to reimburse for services rendered while the provider was provisionally credentialed.

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____