# HOUSE BILL No. 1494

DIGEST OF INTRODUCED BILL

**Citations Affected:** IC 27-1-3; IC 27-8; IC 27-13-7.1; IC 5-10-8.2.

**Synopsis:** Health coverage. Requires the department of insurance to provide annual funding for payments to navigators and assisters to maintain 2017 levels of effort for consumer outreach, education, and enrollment assistance with respect to health care coverage. Requires the department of insurance to annually report to the legislative council the percentage of Indiana residents who lack health insurance coverage. Prohibits preexisting condition exclusions in individual policies of accident and sickness insurance, small employer group health insurance plans, and health maintenance organization contracts. Repeals provisions providing for preexisting condition limitations. Specifies that a policy of accident and sickness insurance, a health maintenance organization contract, and a state employee health plan must provide for availability, renewability, premium rating, and coverage without regard to health status, including preexisting conditions. Makes conforming amendments. Provides for the legislative services agency to prepare legislation for the 2020 legislative session to make conforming amendments. Makes an appropriation.

**Effective:** July 1, 2019.

## DeLaney

January 16, 2019, read first time and referred to Committee on Insurance.

Introduced

First Regular Session of the 121st General Assembly (2019)

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 2018 Regular and Special Session of the General Assembly.

# HOUSE BILL No. 1494

A BILL FOR AN ACT to amend the Indiana Code concerning insurance and to make an appropriation.

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

SECTION 1. IC 27-1-3-28, AS AMENDED BY P.L.100-2012, SECTION 65, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 28. (a) The department of insurance fund is established for the following purposes:

(1) To provide supplemental funding for the operations of the department of insurance.

(2) To pay the costs of hiring and employing staff.

(3) To enable the department of insurance to maintain accreditation by the National Association of Insurance Commissioners.

(4) To carry out any other purpose determined necessary by the department of insurance to carry out the department's duties under this title.

(b) The fund shall be administered by the commissioner. The following shall be deposited in the department of insurance fund:

(1) Audit fees remitted by insurers to the commissioner under section 15(d) of this chapter.

(2) Filing fees remitted by insurers to the commissioner under section 15(a) or 15(e) of this chapter.

(3) Any other amounts remitted to the commissioner or the department that are required by rule or statute to be deposited into the department of insurance fund.

**(4) Money appropriated under section 36 of this chapter.**

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

(e) Money in the fund at the end of a particular fiscal year does not revert to the state general fund.

(f) There is annually appropriated to the department of insurance, for the purposes set forth in subsection (a), the entire amount of money deposited in the fund in each year.

SECTION 2. IC 27-1-3-36 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 36. (a) There is annually appropriated from the state general fund to the department of insurance fund established by section 28 of this chapter two hundred ninety-seven thousand dollars ($297,000) in each state fiscal year beginning after June 30, 2019. Money appropriated under this subsection must be used to fund payments to navigators and assisters to maintain 2017 levels of effort for health care coverage consumer outreach, education, and enrollment assistance.**

**(b) The commissioner shall, not later than December 31 of each year, report the percentage of Indiana residents who lack health insurance coverage to the legislative council in an electronic format under IC 5-14-6.**

SECTION 3. IC 27-8-5-2.5 IS REPEALED [EFFECTIVE JULY 1, 2019]. ~~Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:~~

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

~~(2) Coverage issued as a supplement to liability insurance.~~

~~(3) Automobile medical payment insurance.~~

~~(4) A specified disease policy.~~

~~(5) A short term insurance plan that:~~

~~(A) may not be renewed; and~~

~~(B) has a duration of not more than six (6) months.~~

~~(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:~~

~~(A) hospital confinement, critical illness, or intensive care; or~~

~~(B) gaps for deductibles or copayments.~~

~~(7) Worker's compensation or similar insurance.~~

~~(8) A student health plan.~~

~~(9) A supplemental plan that always pays in addition to other coverage.~~

~~(10) An employer sponsored health benefit plan that is:~~

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

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

~~(b) The benefits provided by:~~

~~(1) an individual policy of accident and sickness insurance; or~~

~~(2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance to an individual who is a resident of Indiana;~~

~~may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.~~

~~(c) An individual policy of accident and sickness insurance or a certificate of coverage described in subsection (b) may not define a preexisting condition, a rider, or an endorsement more restrictively than as:~~

~~(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of the plan;~~

~~(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of the plan; or~~

~~(3) a pregnancy existing on the effective date of the plan.~~

~~(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.~~

SECTION 4. IC 27-8-5-19, AS AMENDED BY P.L.117-2015, SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2019]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured

are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

~~(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:~~

~~(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the effective date of the person's coverage; and~~

~~(B) may not apply to a loss incurred or disability beginning after the earlier of:~~

~~(i) the end of a continuous period of twelve (12) months beginning on or after the effective date of the person's coverage; or~~

~~(ii) the end of a continuous period of eighteen (18) months beginning on the effective date of the person's coverage if the person is a late enrollee.~~

~~This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.~~

~~(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:~~

~~(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person~~

~~during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and~~

~~(B) may not apply to a loss incurred or disability beginning after the earlier of the following:~~

~~(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.~~

~~(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.~~

~~This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.~~

~~(7)~~ **(5)** If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

~~(8)~~ **(6)** A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

~~(9)~~ **(7)** A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

~~(10)~~ **(8)** A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim,

forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

~~(11)~~ **(9)** A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

~~(12)~~ **(10)** A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid:

(i) not more than forty-five (45) days after the insurer's (as defined in IC 27-8-5.7-3) receipt of written proof of loss if the claim is filed by the policyholder; or

(ii) in accordance with IC 27-8-5.7 if the claim is filed by the provider (as defined in IC 27-8-5.7-4); and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

~~(13)~~ **(11)** A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person

insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

~~(14)~~ **(12)** A provision that the insurer, at the insurer's expense, has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

~~(15)~~ **(13)** A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

~~(16)~~ **(14)** In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

~~(17)~~ **(15)** If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of a mental, intellectual, or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by

the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a child who has a mental, intellectual, or physical disability who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

~~(18)~~ **(16)** A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), **as in effect on January 1, 2019.**

(d) Subsection ~~(c)(5), (c)(8),~~ **(c)(6)** and ~~(c)(13)~~ **(c)(11)** do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection ~~(c)(8),~~ **(c)(6);** and

(2) request the certificate in paper form.

SECTION 5. IC 27-8-5.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

**Chapter 5.1. Health Status Related Requirements**

**Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a policy of accident and sickness insurance.**

**Sec. 2. As used in this chapter, "large group" has the meaning set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.**

**Sec. 3. As used in this chapter, "plan sponsor", with respect to**

**a group policy of accident and sickness insurance that is available to an employer only through an association, includes the employer.**

**Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.**

**Sec. 5. As used in this chapter, "preexisting condition exclusion" means a limitation or exclusion of benefits:**

**(1) related to a condition;**

**(2) based on the presence of the condition before the date on which an individual is enrolled in coverage under a policy of accident and sickness insurance; and**

**(3) regardless of whether medical advice, diagnosis, care, or treatment for the condition was recommended or received before the date described in subdivision (2).**

**Sec. 6. As used in this chapter, "small group" has the meaning set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.**

**Sec. 7. (a) This section applies to any of the following:**

**(1) An individual policy of accident and sickness insurance.**

**(2) A small group policy of accident and sickness insurance.**

**(3) A large group policy of accident and sickness insurance offered through an exchange as described in 42 U.S.C. 18032(f)(2)(B), as in effect on January 1, 2019.**

**(b) An insurer may vary the premium rate for coverage under an individual or small group policy of accident and sickness insurance based only on the following:**

**(1) Whether the policy covers an individual or a family.**

**(2) The rating area:**

**(A) established by the commissioner; and**

**(B) in which the policy is issued.**

**(3) The age of each covered individual, except that the premium rate may not vary under this subdivision by more than three (3) to one (1) for adults, in accordance with 42 U.S.C. 300gg-6(c), as in effect on January 1, 2019.**

**(4) Tobacco use, except that the premium rate may not vary under this subdivision by more than one and one-half (1.5) to one (1).**

**(c) The commissioner shall adopt rules under IC 4-22-2 to do the following for use under subsection (b):**

**(1) Establish at least one (1) rating area in Indiana.**

**(2) Establish permissible age bands.**

**(d) With respect to family coverage, a premium rate variation permitted under subsection (b)(3) or (b)(4) must be applied based on the part of the premium attributable to each family member**

**covered under the policy.**

**Sec. 8. (a) An insurer that issues a policy of accident and sickness insurance in Indiana shall accept every employer and individual in Indiana that applies for coverage under the policy. However, the following apply:**

**(1) The insurer may restrict enrollment in coverage under this section to open or special enrollment periods.**

**(2) The insurer shall establish special enrollment periods for qualifying events described in 29 U.S.C. 1163, as in effect on January 1, 2019, in accordance with rules adopted by the commissioner under IC 4-22-2.**

**(3) The insurer may do the following with respect to coverage provided through a preferred provider plan under IC 27-8-11:**

**(A) Limit the employers that may apply for the coverage to employers with employees who live, work, or reside in the service area of the preferred provider plan.**

**(B) Within the service area of the preferred provider plan, deny the coverage to employers and individuals if the insurer demonstrates to the commissioner that the insurer:**

**(i) does not have the capacity to deliver health care services through the preferred provider plan adequately to an additional individual or member of an additional group without compromising the insurer's current obligations to existing covered individuals and group members under the preferred provider plan; and**

**(ii) does not consider claim experience or health status related factors of individuals or group members in making the determination to deny coverage under this clause.**

**An insurer that denies coverage under this clause may not offer individual or group coverage in the service area in which coverage was denied for at least one hundred eighty (180) days after the date on which the denial occurs.**

**(C) Deny coverage if the insurer demonstrates to the commissioner that the insurer:**

**(i) does not have the financial reserves necessary to underwrite additional coverage; and**

**(ii) does not consider claim experience or health status related factors of individuals or group members in making the determination to deny coverage under this clause.**

**An insurer that denies coverage under this clause may not offer individual or group coverage in the service area in which coverage was denied until the later of one hundred eighty (180) days after the date on which the denial occurs or the date on which the insurer demonstrates to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage.**

**(b) The commissioner may apply this section on a service area specific basis.**

**Sec. 9. (a) Subject to subsection (b), an insurer that issues an individual or group policy of accident and sickness insurance in Indiana shall renew or continue in force the policy at the option of the policyholder.**

**(b) An insurer described in subsection (a) may terminate or refuse to renew a policy described in subsection (a) based only on one (1) or more of the following:**

**(1) The policyholder fails to pay premiums in accordance with the terms of the policy.**

**(2) The policyholder has performed an act that constitutes fraud or intentional misrepresentation of a material fact under the terms of the policy.**

**(3) The plan sponsor of a group policy fails to comply with a material policy provision related to employer contribution or group participation rules in accordance with state law.**

**(4) The insurer ceases to offer the policy in Indiana in accordance with subsection (c) or (d), as applicable, and other state law.**

**(5) If the policy provides coverage through a preferred provider plan described in IC 27-8-11, there is no longer a covered individual covered under the preferred provider plan who lives, resides, or works in the service area of the preferred provider plan.**

**(6) If the policy is available only through membership in a bona fide association:**

**(A) membership of the plan sponsor in the association ceases; and**

**(B) the policy is terminated uniformly without regard to any health status related factor relating to a covered individual.**

**(c) An insurer may discontinue offering an individual or a group policy of accident and sickness insurance only in accordance with all of the following and other applicable state law:**

**(1) The insurer notifies each policyholder and covered individual of the discontinuation at least ninety (90) days before the date on which the policy is discontinued.**

**(2) The insurer offers to each policyholder the option to purchase all (or, in the case of a large group, any) other individual or group policy of accident and sickness insurance that is currently offered by the insurer in Indiana.**

**(3) The insurer acts uniformly without regard to any:**

**(A) claim experience of; or**

**(B) health status related factor relating to;**

**any covered individual or prospective covered individual.**

**(d) An insurer may discontinue all individual, group, or both individual and group policies of accident and sickness insurance in Indiana only in accordance with state law and all of the following:**

**(1) The insurer notifies the commissioner and each policyholder and covered individual of the discontinuation at least one hundred eighty (180) days before the date on which the policies are discontinued.**

**(2) All individual, group, or individual and group policies of accident and sickness insurance issued or delivered in Indiana are discontinued and coverage under the policies is not renewed.**

**(3) The insurer does not issue any individual or group policy of accident and sickness insurance in Indiana for at least five (5) years after the date on which the last policy is discontinued under this subsection.**

**(e) An insurer may modify coverage under a group policy of accident and sickness insurance at the time of policy renewal. However, in the case of a small group policy of accident and sickness insurance that is available other than through a bona fide association, the modification must be:**

**(1) consistent with Indiana law; and**

**(2) effective on a uniform basis among all small groups covered under the small group policy.**

**Sec. 10. An insurer that issues a policy of accident and sickness insurance in Indiana may not impose a preexisting condition exclusion on the policy or coverage under the policy.**

**Sec. 11. An insurer that issues an individual or group policy of accident and sickness insurance in Indiana may not establish rules for eligibility of an individual to enroll or to continue enrollment under the terms of the policy based on any of the following health status related factors in relation to the individual or a dependent**

**of the individual:**

**(1) Health status.**

**(2) Medical condition (including both physical and mental illness).**

**(3) Claim experience.**

**(4) Receipt of health care.**

**(5) Medical history.**

**(6) Genetic information.**

**(7) Evidence of insurability (including conditions arising out of acts of domestic violence).**

**(8) Disability.**

**(9) Any other health status related factor determined appropriate by the commissioner.**

SECTION 6. IC 27-8-15-27, AS AMENDED BY P.L.160-2011, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 27. (a) This section shall be applied in conformity with the requirements 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), as in effect on September 23, 2010, **IC 27-8-5.1, and IC 27-13-7.1.**

(b) A health insurance plan provided by a small employer insurer to a small employer must comply with the following:

(1) The benefits provided by a plan to an eligible employee enrolled in the plan may not be excluded, limited, or denied for more than nine (9) months after the effective date of the coverage because of a preexisting condition of the eligible employee, the eligible employee's spouse, or the eligible employee's dependent.

(2) The plan may not define a preexisting condition, rider, or endorsement more restrictively than as a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the effective date of enrollment in the plan.

SECTION 7. IC 27-8-15-29, AS AMENDED BY P.L.160-2011, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 29. (a) This section shall be applied in conformity with the requirements 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), as in effect on September 23, 2010, **IC 27-8-5.1, and IC 27-13-7.1.**

(b) A plan may exclude coverage for a late enrollee or the late enrollee's covered spouse or dependent for not more than fifteen (15) months.

(c) If a late enrollee or the late enrollee's covered spouse or dependent has a preexisting condition, a plan may exclude coverage for the preexisting condition for not more than fifteen (15) months.

(d) If a period of exclusion from coverage under subsection (b) and a preexisting condition exclusion under subsection (c) are applicable to the late enrollee, the combined period of exclusion may not exceed fifteen (15) months from the date that the eligible employee enrolls for coverage under the health insurance plan.

SECTION 8. IC 27-13-7.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

**Chapter 7.1. Health Status Related Requirements**

**Sec. 1. As used in this chapter, "large group" has the meaning set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.**

**Sec. 2. As used in this chapter, "plan sponsor", with respect to a group contract that is available to an employer only through an association, includes the employer.**

**Sec. 3. As used in this chapter, "preexisting condition exclusion" means a limitation or exclusion of benefits:**

**(1) related to a condition;**

**(2) based on the presence of the condition before the date on which an individual is enrolled in coverage under an individual contract or a group contract; and**

**(3) regardless of whether medical advice, diagnosis, care, or treatment for the condition was recommended or received before the date described in subdivision (2).**

**Sec. 4. As used in this chapter, "small group" has the meaning set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.**

**Sec. 5. (a) This section applies to any of the following:**

**(1) An individual contract.**

**(2) A small group contract.**

**(3) A large group contract offered through an exchange as described in 42 U.S.C. 18032(f)(2)(B), as in effect on January 1, 2019.**

**(b) A health maintenance organization may vary the premium rate for coverage under an individual contract, or a small group contract, based only on the following:**

**(1) Whether the individual contract or small group contract covers an individual or a family.**

**(2) The rating area:**

**(A) established by the commissioner; and**

**(B) in which the individual contract or small group**

**contract is issued.**

**(3) The age of each enrollee, except that the premium rate may not vary under this subdivision by more than three (3) to one (1) for adults, in accordance with 42 U.S.C. 300gg-6(c), as in effect on January 1, 2019.**

**(4) Tobacco use, except that the premium rate may not vary under this subdivision by more than one and one-half (1.5) to one (1).**

**(c) The commissioner shall adopt rules under IC 4-22-2 to do the following for use under subsection (b):**

**(1) Establish at least one (1) rating area in Indiana.**

**(2) Establish permissible age bands.**

**(d) With respect to family coverage, a premium rate variation permitted under subsection (b)(3) or (b)(4) must be applied based on the part of the premium attributable to each family member covered under the individual contract or small group contract.**

**Sec. 6. (a) A health maintenance organization that enters into an individual contract or a group contract in Indiana shall accept every employer and individual in Indiana that applies for coverage under the individual contract or group contract. However, the following apply:**

**(1) The health maintenance organization may restrict enrollment in coverage under this section to open or special enrollment periods.**

**(2) The health maintenance organization shall establish special enrollment periods for qualifying events described in 29 U.S.C. 1163, as in effect on January 1, 2019, in accordance with rules adopted by the commissioner under IC 4-22-2.**

**(3) The health maintenance organization may do the following:**

**(A) Limit the employers that may apply for the coverage to employers with employees who live, work, or reside in the service area of the individual contract or group contract.**

**(B) Within the service area of the individual contract or group contract, deny the coverage to employers and individuals if the health maintenance organization demonstrates to the commissioner that the health maintenance organization:**

**(i) does not have the capacity to deliver health care services adequately to an additional individual or member of an additional group without compromising**

**the health maintenance organization's current obligations to existing enrollees and group members; and**

**(ii) does not consider claim experience or health status related factors of individuals or group members in making the determination to deny coverage under this clause.**

**A health maintenance organization that denies coverage under this clause may not offer individual or group coverage in the service area in which coverage was denied for at least one hundred eighty (180) days after the date on which the denial occurs.**

**(C) Deny coverage if the health maintenance organization demonstrates to the commissioner that the health maintenance organization:**

**(i) does not have the financial reserves necessary to underwrite additional coverage; and**

**(ii) does not consider claim experience or health status related factors of individuals or group members in making the determination to deny coverage under this clause.**

**A health maintenance organization that denies coverage under this clause may not offer individual or group coverage in the service area in which coverage was denied until the later of one hundred eighty (180) days after the date on which the denial occurs or the date on which the health maintenance organization demonstrates to the commissioner that the health maintenance organization has sufficient financial reserves to underwrite additional coverage.**

**(b) The commissioner may apply this section on a service area specific basis.**

**Sec. 7. (a) Subject to subsection (b), a health maintenance organization that enters into an individual contract or a group contract in Indiana shall renew or continue in force the:**

**(1) individual contract at the option of the subscriber; or**

**(2) group contract at the option of the group contract holder.**

**(b) A health maintenance organization described in subsection (a) may terminate or refuse to renew an individual contract or a group contract described in subsection (a) based only on one (1) or more of the following:**

**(1) The subscriber or group contract holder fails to pay premiums in accordance with the terms of the individual**

**contract or group contract.**

**(2) The subscriber or group contract holder has performed an act that constitutes fraud or intentional misrepresentation of a material fact under the terms of the individual contract or group contract.**

**(3) The group contract holder of a group contract fails to comply with a material contract provision related to employer contribution or group participation rules in accordance with state law.**

**(4) The health maintenance organization ceases to offer the individual contract or group contract in Indiana in accordance with subsection (c) or (d), as applicable, and other state law.**

**(5) There is no longer an enrollee covered under the individual contract or group contract who lives, resides, or works in the service area of the individual contract or group contract.**

**(6) If the individual contract or group contract is available only through membership in a bona fide association:**

**(A) membership of the plan sponsor in the association ceases; and**

**(B) the individual contract or group contract is terminated uniformly without regard to any health status related factor relating to an enrollee.**

**(c) A health maintenance organization may discontinue offering an individual contract or a group contract only in accordance with all of the following and other applicable state law:**

**(1) The health maintenance organization notifies each contract holder and enrollee of the discontinuation at least ninety (90) days before the date on which the individual contract or group contract is discontinued.**

**(2) The health maintenance organization offers to each subscriber or group contract holder the option to purchase any other individual contract or group contract that is currently offered by the health maintenance organization in Indiana.**

**(3) The health maintenance organization acts uniformly without regard to any:**

**(A) claim experience of; or**

**(B) health status related factor relating to;**

**any enrollee or prospective enrollee.**

**(d) A health maintenance organization may discontinue all**

**individual contracts, group contracts, or both individual and group contracts in Indiana only in accordance with state law and all of the following:**

**(1) The health maintenance organization notifies the commissioner and each subscriber or group contract holder and enrollee of the discontinuation at least one hundred eighty (180) days before the date on which the individual contracts or group contracts are discontinued.**

**(2) All individual contracts, group contracts, or both individual and group contracts entered into in Indiana are discontinued and coverage under the individual contracts, group contracts, or both individual and group contracts is not renewed.**

**(3) The health maintenance organization does not enter into an individual contract or a group contract in Indiana for at least five (5) years after the date on which the last individual contract or group contract is discontinued under this subsection.**

**(e) A health maintenance organization may modify coverage under a group contract at the time of group contract renewal. However, in the case of a small group contract that is available other than through a bona fide association, the modification must be:**

**(1) consistent with Indiana law; and**

**(2) effective on a uniform basis among all small groups covered under the small group contract.**

**Sec. 8. A health maintenance organization that issues an individual contract or a group contract in Indiana may not impose a preexisting condition exclusion on the individual contract or group contract or coverage under the individual contract or group contract.**

**Sec. 9. A health maintenance organization that enters into an individual contract or a group contract in Indiana may not establish rules for eligibility of an individual to enroll or to continue enrollment under the terms of the individual contract or group contract based on any of the following health status related factors in relation to the individual or a dependent of the individual:**

**(1) Health status.**

**(2) Medical condition (including both physical and mental illness).**

**(3) Claim experience.**

**(4) Receipt of health care.**

**(5) Medical history.**

**(6) Genetic information.**

**(7) Evidence of insurability (including conditions arising out of acts of domestic violence).**

**(8) Disability.**

**(9) Any other health status related factor determined appropriate by the commissioner.**

SECTION 9. IC 5-10-8.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

**Chapter 8.2. Health Status Related Requirements**

**Sec. 1. As used in this chapter, "commissioner" refers to the commissioner of insurance appointed under IC 27-1-1-2.**

**Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a state employee health plan.**

**Sec. 3. As used in this chapter, "preexisting condition exclusion" means a limitation or exclusion of benefits:**

**(1) related to a condition;**

**(2) based on the presence of the condition before the date on which an individual is enrolled in coverage under a state employee health plan; and**

**(3) regardless of whether medical advice, diagnosis, care, or treatment for the condition was recommended or received before the date described in subdivision (2).**

**Sec. 4. As used in this chapter, "state employee health plan" refers to a:**

**(1) self-insurance program established under IC 5-10-8-7(b) to provide group health coverage; or**

**(2) contract with a prepaid health care delivery plan that is entered into or renewed under IC 5-10-8-7(c).**

**The term includes a person that administers benefits under a state employee health plan described in subdivision (1) or (2).**

**Sec. 5. (a) The premium rate for coverage under a state employee health plan may vary based only on the following:**

**(1) Whether the state employee health plan covers an individual or a family.**

**(2) The rating area:**

**(A) established by the commissioner; and**

**(B) in which the state employee health plan is issued.**

**(3) The age of each covered individual, except that the**

**premium rate may not vary under this subdivision by more than three (3) to one (1) for adults, in accordance with 42 U.S.C. 300gg-6(c), as in effect on January 1, 2019.**

**(4) Tobacco use, except that the premium rate may not vary under this subdivision by more than one and one-half (1.5) to one (1).**

**(b) The commissioner shall adopt rules under IC 4-22-2 to do the following for use under subsection (a):**

**(1) Establish at least one (1) rating area in Indiana.**

**(2) Establish permissible age bands.**

**(c) With respect to family coverage, a premium rate variation permitted under subsection (a)(3) or (a)(4) must be applied based on the part of the premium attributable to each family member covered under the state employee health plan.**

**Sec. 6. (a) A state employee health plan shall accept every state employee who applies for coverage under the state employee health plan. However, the following apply:**

**(1) The state employee health plan may restrict enrollment in coverage under this section to open or special enrollment periods.**

**(2) The state employee health plan shall establish special enrollment periods for qualifying events described in 29 U.S.C. 1163, as in effect on January 1, 2019, in accordance with rules adopted by the commissioner under IC 4-22-2.**

**(3) The state employee health plan may do the following with respect to coverage provided through a preferred provider plan described in IC 27-8-11 or a health maintenance organization granted a certificate of authority under IC 27-13:**

**(A) Limit the state employees who may apply for the coverage to state employees who live, work, or reside in the service area of the preferred provider plan or health maintenance organization.**

**(B) Within the service area of the preferred provider plan or health maintenance organization, deny the coverage to state employees if the state employee health plan demonstrates to the commissioner that the state employee health plan:**

**(i) does not have the capacity to deliver health care services through the preferred provider plan or health maintenance organization adequately to an additional individual without compromising the state employee**

**health plan's current obligations to existing covered individuals under the preferred provider plan or health maintenance organization; and**

**(ii) does not consider claim experience or health status related factors of individuals in making the determination to deny coverage under this clause.**

**A state employee health plan that denies coverage under this clause may not offer coverage in the service area in which coverage was denied for at least one hundred eighty (180) days after the date on which the denial occurs.**

**(C) Deny coverage if the state employee health plan demonstrates to the commissioner that the state employee health plan:**

**(i) does not have the financial reserves necessary to underwrite additional coverage; and**

**(ii) does not consider claim experience or health status related factors of individuals in making the determination to deny coverage under this clause.**

**A state employee health plan that denies coverage under this clause may not offer coverage in the service area in which coverage was denied until the later of one hundred eighty (180) days after the date on which the denial occurs or the date on which the state employee health plan demonstrates to the commissioner that the state employee health plan has sufficient financial reserves to underwrite additional coverage.**

**(b) The commissioner may apply this section on a service area specific basis.**

**Sec. 7. (a) Subject to subsection (b), a state employee health plan shall renew or continue in force the coverage under the state employee health plan at the option of the state employee.**

**(b) A state employee health plan may terminate or refuse to renew coverage under a state employee health plan based only on one (1) or more of the following:**

**(1) The covered individual fails to pay premiums in accordance with the terms of the state employee health plan.**

**(2) The covered individual has performed an act that constitutes fraud or intentional misrepresentation of a material fact under the terms of the state employee health plan.**

**(3) The state employee health plan ceases to offer the coverage in accordance with subsection (c) or (d), as applicable, and**

**other state law.**

**(4) If the state employee health plan provides coverage through a preferred provider plan described in IC 27-8-11 or a health maintenance organization granted a certificate of authority under IC 27-13, there is no longer an individual covered under the preferred provider plan or health maintenance organization who lives, resides, or works in the service area of the preferred provider plan or health maintenance organization.**

**(c) A state employee health plan may discontinue offering coverage under a particular state employee health plan only in accordance with all of the following and other applicable state law:**

**(1) The state employee health plan notifies each covered individual of the discontinuation at least ninety (90) days before the date on which the state employee health plan is discontinued.**

**(2) The state employee health plan offers to each covered individual the option to purchase any other state employee health plan coverage that is currently offered by the state employee health plan in Indiana.**

**(3) The state employee health plan acts uniformly without regard to any:**

**(A) claim experience of; or**

**(B) health status related factor relating to;**

**a covered individual or prospective covered individual.**

**(d) A state employee health plan may discontinue all state employee health plan coverage only in accordance with state law and all of the following:**

**(1) The state employee health plan notifies the commissioner and each covered individual of the discontinuation at least one hundred eighty (180) days before the date on which the state employee health plan coverage is discontinued.**

**(2) All state employee health plans are discontinued and state employee health plan coverage is not renewed.**

**(3) The state employee health plan does not provide any coverage for at least five (5) years after the date on which all employee health plan coverage is discontinued under this subsection.**

**(e) A state employee health plan may modify state employee health plan coverage at the time of renewal.**

**Sec. 8. A state employee health plan may not impose a preexisting condition exclusion on state employee health plan**

**coverage.**

**Sec. 9. A state employee health plan may not establish rules for eligibility of an individual to enroll or to continue enrollment under the terms of the state employee health plan based on any of the following health status related factors in relation to the individual or a dependent of the individual:**

**(1) Health status.**

**(2) Medical condition (including both physical and mental illness).**

**(3) Claim experience.**

**(4) Receipt of health care.**

**(5) Medical history.**

**(6) Genetic information.**

**(7) Evidence of insurability (including conditions arising out of acts of domestic violence).**

**(8) Disability.**

**(9) Any other health status related factor determined appropriate by the commissioner.**

SECTION 10. [EFFECTIVE JULY 1, 2019] **(a) The legislative services agency shall prepare legislation for introduction during the 2020 session of the general assembly to conform the Indiana Code to amendments made by this act.**

**(b) To the extent that a provision of this act is inconsistent with another provision of the Indiana Code, the provision of this act prevails.**

**(c) This SECTION expires July 1, 2020.**