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:

1 2	SECTION 1. IC 27-1-3-28, AS AMENDED BY P.L.100-2012, SECTION 65, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3	JULY 1, 2019]: Sec. 28. (a) The department of insurance fund is
4	established for the following purposes:
5	(1) To provide supplemental funding for the operations of the
6	department of insurance.
7	(2) To pay the costs of hiring and employing staff.
8	(3) To enable the department of insurance to maintain
9	accreditation by the National Association of Insurance
10	Commissioners.
11	(4) To carry out any other purpose determined necessary by the
12	department of insurance to carry out the department's duties under
13	this title.
14	(b) The fund shall be administered by the commissioner. The
15	following shall be deposited in the department of insurance fund:
16	(1) Audit fees remitted by insurers to the commissioner under
17	section 15(d) of this chapter.



1 (2) Filing fees remitted by insurers to the commissioner under 2 section 15(a) or 15(e) of this chapter. 3 (3) Any other amounts remitted to the commissioner or the 4 department that are required by rule or statute to be deposited into 5 the department of insurance fund. 6 (4) Money appropriated under section 36 of this chapter. 7 (c) The expenses of administering the fund shall be paid from 8 money in the fund. 9 (d) The treasurer of state shall invest the money in the fund not 10 currently needed to meet the obligations of the fund in the same 11 manner as other public funds may be invested. Interest that accrues 12 from these investments shall be deposited in the fund. 13 (e) Money in the fund at the end of a particular fiscal year does not 14 revert to the state general fund. 15 (f) There is annually appropriated to the department of insurance, 16 for the purposes set forth in subsection (a), the entire amount of money 17 deposited in the fund in each year. 18 SECTION 2. IC 27-1-3-36 IS ADDED TO THE INDIANA CODE 19 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 20 1, 2019]: Sec. 36. (a) There is annually appropriated from the state 21 general fund to the department of insurance fund established by 22 section 28 of this chapter two hundred ninety-seven thousand 23 dollars (\$297,000) in each state fiscal year beginning after June 30, 24 2019. Money appropriated under this subsection must be used to 25 fund payments to navigators and assisters to maintain 2017 levels 26 of effort for health care coverage consumer outreach, education, 27 and enrollment assistance. 28 (b) The commissioner shall, not later than December 31 of each 29 year, report the percentage of Indiana residents who lack health 30 insurance coverage to the legislative council in an electronic format 31 under IC 5-14-6. 32 SECTION 3. IC 27-8-5-2.5 IS REPEALED [EFFECTIVE JULY 1, 33 2019]. Sec. 2.5. (a) As used in this section, the term "policy of accident 34 and sickness insurance" does not include the following: 35 (1) Accident only, credit, dental, vision, Medicare supplement, 36 long term care, or disability income insurance. 37 (2) Coverage issued as a supplement to liability insurance. 38 (3) Automobile medical payment insurance. 39 (4) A specified disease policy. 40 (5) A short term insurance plan that: 41 (A) may not be renewed; and 42 (B) has a duration of not more than six (6) months.



1	(6) A policy that provides indemnity benefits not based on any
2	expense incurred requirement, including a plan that provides
$\frac{2}{3}$	coverage for:
4	(A) hospital confinement, critical illness, or intensive care; or
5	(B) gaps for deductibles or copayments.
6	(7) Worker's compensation or similar insurance.
7	(7) worker's compensation of similar insurance. (8) A student health plan.
8	(b) A student nearth plan. (9) A supplemental plan that always pays in addition to other
9	
10	coverage. (10) An employer sponsored health benefit plan that is:
10	(10) An employer sponsored nearth benefit plan that is. (A) provided to individuals who are eligible for Medicare; and
11	(B) not marketed as, or held out to be, a Medicare supplement
12	
13 14	policy.
14	(b) The benefits provided by: (1) on individual palicy of assident and sieleness incurrences on
15 16	(1) an individual policy of accident and sickness insurance; or
10	(2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance
17	to an individual who is a resident of Indiana;
18 19	
19 20	may not be excluded, limited, or denied for more than twelve (12)
20 21	months after the effective date of the coverage because of a preexisting condition of the individual.
21 22	
	(c) An individual policy of accident and sickness insurance or a
23	certificate of coverage described in subsection (b) may not define a
24	preexisting condition, a rider, or an endorsement more restrictively
25 26	than as:
26	(1) a condition that would have caused an ordinarily prudent
27	person to seek medical advice, diagnosis, care, or treatment
28	during the twelve (12) months immediately preceding the
29	effective date of the plan;
30	(2) a condition for which medical advice, diagnosis, care, or
31	treatment was recommended or received during the twelve (12)
32	months immediately preceding the effective date of the plan; or
33	(3) a pregnancy existing on the effective date of the plan.
34	(d) An insurer shall reduce the period allowed for a preexisting
35	condition exclusion described in subsection (b) by the amount of time
36	the individual has continuously served under a preexisting condition
37	clause for a policy of accident and sickness insurance issued under
38	IC 27-8-15 if the individual applies for a policy under this chapter not
39	more than thirty (30) days after coverage under a policy of accident and
40	sickness insurance issued under IC 27-8-15 expires.
41	SECTION 4. IC 27-8-5-19, AS AMENDED BY P.L.117-2015,
42	SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

1	JULY 1, 2019]: Sec. 19. (a) As used in this chapter, "late enrollee" has
2	the meaning set forth in 26 U.S.C. 9801(b)(3).
3	(b) A policy of group accident and sickness insurance may not be
4	issued to a group that has a legal situs in Indiana unless it contains in
5	substance:
6	(1) the provisions described in subsection (c); or
7	(2) provisions that, in the opinion of the commissioner, are:
8	(A) more favorable to the persons insured; or
9	(B) at least as favorable to the persons insured and more
10	favorable to the policyholder;
11	than the provisions set forth in subsection (c).
12	(c) The provisions referred to in subsection $(b)(1)$ are as follows:
13	(1) A provision that the policyholder is entitled to a grace period
14	of thirty-one (31) days for the payment of any premium due
15	except the first, during which grace period the policy will
16	continue in force, unless the policyholder has given the insurer
17	written notice of discontinuance in advance of the date of
18	discontinuance and in accordance with the terms of the policy.
19	The policy may provide that the policyholder is liable to the
20	insurer for the payment of a pro rata premium for the time the
$\frac{-3}{21}$	policy was in force during the grace period. A provision under
22	this subdivision may provide that the insurer is not obligated to
23	pay claims incurred during the grace period until the premium
24	due is received.
25	(2) A provision that the validity of the policy may not be
26	contested, except for nonpayment of premiums, after the policy
27	has been in force for two (2) years after its date of issue, and that
$\frac{27}{28}$	no statement made by a person covered under the policy relating
20 29	to the person's insurability may be used in contesting the validity
30	of the insurance with respect to which the statement was made,
31	unless:
32	(A) the insurance has not been in force for a period of two (2)
33	years or longer during the person's lifetime; or
33 34	(B) the statement is contained in a written instrument signed
35	by the insured person.
35 36	
30 37	However, a provision under this subdivision may not preclude the
	assertion at any time of defenses based upon a person's
38	ineligibility for coverage under the policy or based upon other
39 40	provisions in the policy.
40	(3) A provision that a copy of the application, if there is one, of
41	the policyholder must be attached to the policy when issued, that
42	all statements made by the policyholder or by the persons insured



1 are to be deemed representations and not warranties, and that no 2 statement made by any person insured may be used in any contest 3 unless a copy of the instrument containing the statement is or has 4 been furnished to the insured person or, in the event of death or 5 incapacity of the insured person, to the insured person's 6 beneficiary or personal representative. 7 (4) A provision setting forth the conditions, if any, under which 8 the insurer reserves the right to require a person eligible for 9 insurance to furnish evidence of individual insurability 10 satisfactory to the insurer as a condition to part or all of the person's coverage. 11 12 (5) A provision specifying any additional exclusions or limitations 13 applicable under the policy with respect to a disease or physical 14 condition of a person that existed before the effective date of the 15 person's coverage under the policy and that is not otherwise 16 excluded from the person's coverage by name or specific 17 description effective on the date of the person's loss. An exclusion 18 or limitation that must be specified in a provision under this 19 subdivision: 20(A) may apply only to a disease or physical condition for 21 which medical advice, diagnosis, care, or treatment was 22 received by the person or recommended to the person during 23 the six (6) months before the effective date of the person's 24 coverage; and 25 (B) may not apply to a loss incurred or disability beginning 26 after the earlier of: 27 (i) the end of a continuous period of twelve (12) months 28 beginning on or after the effective date of the person's 29 coverage; or 30 (ii) the end of a continuous period of eighteen (18) months 31 beginning on the effective date of the person's coverage if 32 the person is a late enrollee. 33 This subdivision applies only to group policies of accident and 34 sickness insurance other than those described in section 2.5(a)(1) 35 through 2.5(a)(8) and 2.5(b)(2) of this chapter. (6) A provision specifying any additional exclusions or limitations 36 37 applicable under the policy with respect to a disease or physical 38 condition of a person that existed before the effective date of the 39 person's coverage under the policy. An exclusion or limitation that 40 must be specified in a provision under this subdivision: 41 (A) may apply only to a disease or physical condition for 42 which medical advice or treatment was received by the person



1	during a period of three hundred sixty-five (365) days before
2	the effective date of the person's coverage; and
2 3	(B) may not apply to a loss incurred or disability beginning
4	after the earlier of the following:
5	(i) The end of a continuous period of three hundred
6	sixty-five (365) days, beginning on or after the effective date
7	of the person's coverage, during which the person did not
8	receive medical advice or treatment in connection with the
9	disease or physical condition.
10	(ii) The end of the two (2) year period beginning on the
11	effective date of the person's coverage.
12	This subdivision applies only to group policies of accident and
13	sickness insurance described in section 2.5(a)(1) through
14	2.5(a)(8) of this chapter.
15	(7) (5) If premiums or benefits under the policy vary according to
16	a person's age, a provision specifying an equitable adjustment of:
17	(A) premiums;
18	(B) benefits; or
19	(C) both premiums and benefits;
20	to be made if the age of a covered person has been misstated. A
21	provision under this subdivision must contain a clear statement of
22	the method of adjustment to be used.
23	(8) (6) A provision that the insurer will issue to the policyholder,
24	for delivery to each person insured, a certificate, in electronic or
25	paper form, setting forth a statement that:
26	(A) explains the insurance protection to which the person
27	insured is entitled;
28	(B) indicates to whom the insurance benefits are payable; and
29	(C) explains any family member's or dependent's coverage
30	under the policy.
31	The provision must specify that the certificate will be provided in
32	paper form upon the request of the insured.
33	(9) (7) A provision stating that written notice of a claim must be
34	given to the insurer within twenty (20) days after the occurrence
35	or commencement of any loss covered by the policy, but that a
36	failure to give notice within the twenty (20) day period does not
37	invalidate or reduce any claim if it can be shown that it was not
38	reasonably possible to give notice within that period and that
39	notice was given as soon as was reasonably possible.
40	(10) (8) A provision stating that:
41	(A) the insurer will furnish to the person making a claim, or to
42	the policyholder for delivery to the person making a claim,



1	forms usually furnished by the insurer for filing proof of loss;
2	and
3	(B) if the forms are not furnished within fifteen (15) days after
4	the insurer received notice of a claim, the person making the
5	
	claim will be deemed to have complied with the requirements
6	of the policy as to proof of loss upon submitting, within the
7	time fixed in the policy for filing proof of loss, written proof
8	covering the occurrence, character, and extent of the loss for
9	which the claim is made.
10	(11) (9) A provision stating that:
11	(A) in the case of a claim for loss of time for disability, written
12	proof of the loss must be furnished to the insurer within ninety
13	(90) days after the commencement of the period for which the
14	insurer is liable, and that subsequent written proofs of the
15	continuance of the disability must be furnished to the insurer
16	at reasonable intervals as may be required by the insurer;
10	(B) in the case of a claim for any other loss, written proof of
18	the loss must be furnished to the insurer within ninety (90)
19	days after the date of the loss; and
20	•
20	(C) the failure to furnish proof within the time required under $(A) = (A)$
	clause (A) or (B) does not invalidate or reduce any claim if it
22	was not reasonably possible to furnish proof within that time,
23	and if proof is furnished as soon as reasonably possible but
24	(except in case of the absence of legal capacity of the
25	claimant) no later than one (1) year from the time proof is
26	otherwise required under the policy.
27	(12) (10) A provision that:
28	(A) all benefits payable under the policy (other than benefits
29	for loss of time) will be paid:
30	(i) not more than forty-five (45) days after the insurer's (as
31	defined in IC 27-8-5.7-3) receipt of written proof of loss if
32	the claim is filed by the policyholder; or
33	(ii) in accordance with IC 27-8-5.7 if the claim is filed by
34	the provider (as defined in IC 27-8-5.7-4); and
35	(B) subject to due proof of loss, all accrued benefits under the
36	policy for loss of time will be paid not less frequently than
37	monthly during the continuance of the period for which the
38	insurer is liable, and any balance remaining unpaid at the
39	termination of the period for which the insurer is liable will be
40	-
40 41	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
42	insured are payable to the beneficiary designated by the person



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1	insured. However, if the policy contains conditions pertaining to
2	family status, the beneficiary may be the family member specified
3	by the policy terms. In either case, payment of benefits for loss of
4	life is subject to the provisions of the policy if no designated or
5	specified beneficiary is living at the death of the person insured.
6	All other benefits of the policy are payable to the person insured.
7	The policy may also provide that if any benefit is payable to the
8	estate of a person or to a person who is a minor or otherwise not
9	competent to give a valid release, the insurer may pay the benefit,
10	up to an amount of five thousand dollars (\$5,000), to any relative
11	by blood or connection by marriage of the person who is deemed
12	by the insurer to be equitably entitled to the benefit.
13	(14) (12) A provision that the insurer, at the insurer's expense, has
14	the right and must be allowed the opportunity to:
15	(A) examine the person of the individual for whom a claim is
16	made under the policy when and as often as the insurer
17	reasonably requires during the pendency of the claim; and
18	(B) conduct an autopsy in case of death if it is not prohibited
19	by law.
20	(15) (13) A provision that no action at law or in equity may be
21	brought to recover on the policy less than sixty (60) days after
22	proof of loss is filed in accordance with the requirements of the
23	policy and that no action may be brought at all more than three (3)
24	years after the expiration of the time within which proof of loss is
25	required by the policy.
26	(16) (14) In the case of a policy insuring debtors, a provision that
27	the insurer will furnish to the policyholder, for delivery to each
28	debtor insured under the policy, a certificate of insurance
29	describing the coverage and specifying that the benefits payable
30	will first be applied to reduce or extinguish the indebtedness.
31	(17) (15) If the policy provides that hospital or medical expense
32	coverage of a dependent child of a group member terminates upon
33	the child's attainment of the limiting age for dependent children
34	set forth in the policy, a provision that the child's attainment of the
35	limiting age does not terminate the hospital and medical coverage
36	of the child while the child is:
37	(A) incapable of self-sustaining employment because of a
38	mental, intellectual, or physical disability; and
39	(B) chiefly dependent upon the group member for support and
40	maintenance.
41	A provision under this subdivision may require that proof of the
42	child's incapacity and dependency be furnished to the insurer by



1 the group member within one hundred twenty (120) days of the 2 child's attainment of the limiting age and, subsequently, at 3 reasonable intervals during the two (2) years following the child's 4 attainment of the limiting age. The policy may not require proof 5 more than once per year in the time more than two (2) years after 6 the child's attainment of the limiting age. This subdivision does 7 not require an insurer to provide coverage to a child who has a 8 mental, intellectual, or physical disability who does not satisfy the 9 requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In 10 any case, the terms of the policy apply with regard to the coverage 11 12 or exclusion from coverage of the child. 13 (18) (16) A provision that complies with the group portability and 14 guaranteed renewability provisions of the federal Health 15 Insurance Portability and Accountability Act of 1996 16 (P.L.104-191), as in effect on January 1, 2019. 17 (d) Subsection $\frac{(c)(5)}{(c)(8)}$, $\frac{(c)(6)}{(c)(13)}$ (c)(11) do not apply 18 to policies insuring the lives of debtors. The standard provisions 19 required under section 3(a) of this chapter for individual accident and 20 sickness insurance policies do not apply to group accident and sickness 21 insurance policies. 22 (e) If any policy provision required under subsection (c) is in whole 23 or in part inapplicable to or inconsistent with the coverage provided by 24 an insurer under a particular form of policy, the insurer, with the 25 approval of the commissioner, shall delete the provision from the 26 policy or modify the provision in such a manner as to make it 27 consistent with the coverage provided by the policy. 28 (f) An insurer that issues a policy described in this section shall 29 include in the insurer's enrollment materials information concerning the 30 manner in which an individual insured under the policy may: 31 (1) obtain a certificate described in subsection (c)(8); (c)(6); and 32 (2) request the certificate in paper form. 33 SECTION 5. IC 27-8-5.1 IS ADDED TO THE INDIANA CODE 34 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: 35 36 **Chapter 5.1. Health Status Related Requirements** 37 Sec. 1. As used in this chapter, "covered individual" means an 38 individual who is entitled to coverage under a policy of accident 39 and sickness insurance. 40 Sec. 2. As used in this chapter, "large group" has the meaning 41 set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019. 42 Sec. 3. As used in this chapter, "plan sponsor", with respect to



2019

1	a group policy of accident and sickness insurance that is available
2	to an employer only through an association, includes the employer.
3	Sec. 4. As used in this chapter, "policy of accident and sickness
4	insurance" has the meaning set forth in IC 27-8-5-1.
5	Sec. 5. As used in this chapter, "preexisting condition exclusion"
6	means a limitation or exclusion of benefits:
7	(1) related to a condition;
8	(2) based on the presence of the condition before the date on
9	which an individual is enrolled in coverage under a policy of
10	accident and sickness insurance; and
11	(3) regardless of whether medical advice, diagnosis, care, or
12	treatment for the condition was recommended or received
13	before the date described in subdivision (2).
14	Sec. 6. As used in this chapter, "small group" has the meaning
15	set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019.
16	Sec. 7. (a) This section applies to any of the following:
17	(1) An individual policy of accident and sickness insurance.
18	(2) A small group policy of accident and sickness insurance.
19	(3) A large group policy of accident and sickness insurance
20	offered through an exchange as described in 42 U.S.C.
21	18032(f)(2)(B), as in effect on January 1, 2019.
22	(b) An insurer may vary the premium rate for coverage under
23	an individual or small group policy of accident and sickness
24	insurance based only on the following:
25	(1) Whether the policy covers an individual or a family.
26	(2) The rating area:
27	(A) established by the commissioner; and
28	(B) in which the policy is issued.
29	(3) The age of each covered individual, except that the
30	premium rate may not vary under this subdivision by more
31	than three (3) to one (1) for adults, in accordance with 42
32	U.S.C. 300gg-6(c), as in effect on January 1, 2019.
33	(4) Tobacco use, except that the premium rate may not vary
34	under this subdivision by more than one and one-half (1.5) to
35	one (1).
36	(c) The commissioner shall adopt rules under IC 4-22-2 to do the
37	following for use under subsection (b):
38	(1) Establish at least one (1) rating area in Indiana.
39	(2) Establish permissible age bands.
40	(d) With respect to family coverage, a premium rate variation
41	permitted under subsection (b)(3) or (b)(4) must be applied based
42	on the part of the premium attributable to each family member



1 covered under the policy.

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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.

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

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

15(A) Limit the employers that may apply for the coverage16to employers with employees who live, work, or reside in17the service area of the preferred provider plan.

18(B) Within the service area of the preferred provider plan,19deny the coverage to employers and individuals if the20insurer demonstrates to the commissioner that the insurer:

21(i) does not have the capacity to deliver health care22services through the preferred provider plan adequately23to an additional individual or member of an additional24group without compromising the insurer's current25obligations to existing covered individuals and group26members under the preferred provider plan; and

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

31An insurer that denies coverage under this clause may not32offer individual or group coverage in the service area in33which coverage was denied for at least one hundred eighty34(180) days after the date on which the denial occurs.

35(C) Deny coverage if the insurer demonstrates to the36commissioner that the insurer:

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

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

1	An insurer that denies coverage under this clause may not
2	offer individual or group coverage in the service area in
$\frac{2}{3}$	which coverage was denied until the later of one hundred
4	eighty (180) days after the date on which the denial occurs
5	or the date on which the insurer demonstrates to the
6	commissioner that the insurer has sufficient financial
7	
8	reserves to underwrite additional coverage.
8 9	(b) The commissioner may apply this section on a service area specific basis.
10	Sec. 9. (a) Subject to subsection (b), an insurer that issues an
10	individual or group policy of accident and sickness insurance in
11	
12	Indiana shall renew or continue in force the policy at the option of the policyholder.
13	(b) An insurer described in subsection (a) may terminate or
14	refuse to renew a policy described in subsection (a) may terminate of
15	one (1) or more of the following:
17	(1) The policyholder fails to pay premiums in accordance with
17	(1) The policyholder rans to pay premiums in accordance with the terms of the policy.
18	
20	(2) The policyholder has performed an act that constitutes fraud or intentional misrepresentation of a material fact
20	under the terms of the policy.
21	(3) The plan sponsor of a group policy fails to comply with a
23	material policy provision related to employer contribution or
23	group participation rules in accordance with state law.
25	(4) The insurer ceases to offer the policy in Indiana in
26	accordance with subsection (c) or (d), as applicable, and other
20 27	state law.
28	(5) If the policy provides coverage through a preferred
29	provider plan described in IC 27-8-11, there is no longer a
30	covered individual covered under the preferred provider plan
31	who lives, resides, or works in the service area of the
32	preferred provider plan.
33	(6) If the policy is available only through membership in a
34	bona fide association:
35	(A) membership of the plan sponsor in the association
36	ceases; and
37	(B) the policy is terminated uniformly without regard to
38	any health status related factor relating to a covered
39	individual.
40	(c) An insurer may discontinue offering an individual or a group
41	policy of accident and sickness insurance only in accordance with
42	all of the following and other applicable state law:
	6 1 1



1 (1) The insurer notifies each policyholder and covered 2 individual of the discontinuation at least ninety (90) days 3 before the date on which the policy is discontinued. 4 (2) The insurer offers to each policyholder the option to 5 purchase all (or, in the case of a large group, any) other 6 individual or group policy of accident and sickness insurance 7 that is currently offered by the insurer in Indiana. 8 (3) The insurer acts uniformly without regard to any: 9 (A) claim experience of; or 10 (B) health status related factor relating to; 11 any covered individual or prospective covered individual. 12 (d) An insurer may discontinue all individual, group, or both 13 individual and group policies of accident and sickness insurance in 14 Indiana only in accordance with state law and all of the following: 15 (1) The insurer notifies the commissioner and each 16 policyholder and covered individual of the discontinuation at 17 least one hundred eighty (180) days before the date on which 18 the policies are discontinued. 19 (2) All individual, group, or individual and group policies of 20 accident and sickness insurance issued or delivered in Indiana 21 are discontinued and coverage under the policies is not 22 renewed. 23 (3) The insurer does not issue any individual or group policy 24 of accident and sickness insurance in Indiana for at least five 25 (5) years after the date on which the last policy is discontinued 26 under this subsection. 27 (e) An insurer may modify coverage under a group policy of 28 accident and sickness insurance at the time of policy renewal. 29 However, in the case of a small group policy of accident and 30 sickness insurance that is available other than through a bona fide 31 association, the modification must be: 32 (1) consistent with Indiana law; and 33 (2) effective on a uniform basis among all small groups 34 covered under the small group policy. 35 Sec. 10. An insurer that issues a policy of accident and sickness 36 insurance in Indiana may not impose a preexisting condition 37 exclusion on the policy or coverage under the policy. 38 Sec. 11. An insurer that issues an individual or group policy of 39 accident and sickness insurance in Indiana may not establish rules 40 for eligibility of an individual to enroll or to continue enrollment 41 under the terms of the policy based on any of the following health 42 status related factors in relation to the individual or a dependent



1 of the individual: 2 (1) Health status. 3 (2) Medical condition (including both physical and mental 4 illness). 5 (3) Claim experience. 6 (4) Receipt of health care. 7 (5) Medical history. 8 (6) Genetic information. 9 (7) Evidence of insurability (including conditions arising out 10 of acts of domestic violence). 11 (8) Disability. 12 (9) Any other health status related factor determined 13 appropriate by the commissioner. 14 SECTION 6. IC 27-8-15-27, AS AMENDED BY P.L.160-2011, 15 SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 27. (a) This section shall be applied in conformity 16 17 with the requirements of the federal Patient Protection and Affordable 18 Care Act (P.L. 111-148), as amended by the federal Health Care and 19 Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on 20 September 23, 2010, IC 27-8-5.1, and IC 27-13-7.1. 21 (b) A health insurance plan provided by a small employer insurer to 22 a small employer must comply with the following: 23 (1) The benefits provided by a plan to an eligible employee 24 enrolled in the plan may not be excluded, limited, or denied for 25 more than nine (9) months after the effective date of the coverage 26 because of a preexisting condition of the eligible employee, the 27 eligible employee's spouse, or the eligible employee's dependent. 28 (2) The plan may not define a preexisting condition, rider, or 29 endorsement more restrictively than as a condition for which 30 medical advice, diagnosis, care, or treatment was recommended 31 or received during the six (6) months immediately preceding the 32 effective date of enrollment in the plan. 33 SECTION 7. IC 27-8-15-29, AS AMENDED BY P.L.160-2011, 34 SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE 35 JULY 1, 2019]: Sec. 29. (a) This section shall be applied in conformity with the requirements of the federal Patient Protection and Affordable 36 37 Care Act (P.L. 111-148), as amended by the federal Health Care and 38 Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on 39 September 23, 2010, IC 27-8-5.1, and IC 27-13-7.1. 40 (b) A plan may exclude coverage for a late enrollee or the late 41 enrollee's covered spouse or dependent for not more than fifteen (15) 42 months.



1 (c) If a late enrollee or the late enrollee's covered spouse or 2 dependent has a preexisting condition, a plan may exclude coverage for 3 the preexisting condition for not more than fifteen (15) months. 4 (d) If a period of exclusion from coverage under subsection (b) and 5 a preexisting condition exclusion under subsection (c) are applicable 6 to the late enrollee, the combined period of exclusion may not exceed 7 fifteen (15) months from the date that the eligible employee enrolls for 8 coverage under the health insurance plan. 9 SECTION 8. IC 27-13-7.1 IS ADDED TO THE INDIANA CODE 10 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE 11 JULY 1, 2019]: 12 **Chapter 7.1. Health Status Related Requirements** 13 Sec. 1. As used in this chapter, "large group" has the meaning 14 set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019. 15 Sec. 2. As used in this chapter, "plan sponsor", with respect to a group contract that is available to an employer only through an 16 17 association, includes the employer. 18 Sec. 3. As used in this chapter, "preexisting condition exclusion" 19 means a limitation or exclusion of benefits: 20 (1) related to a condition: 21 (2) based on the presence of the condition before the date on 22 which an individual is enrolled in coverage under an 23 individual contract or a group contract; and 24 (3) regardless of whether medical advice, diagnosis, care, or 25 treatment for the condition was recommended or received 26 before the date described in subdivision (2). 27 Sec. 4. As used in this chapter, "small group" has the meaning 28 set forth in 42 U.S.C. 300gg-91, as in effect on January 1, 2019. 29 Sec. 5. (a) This section applies to any of the following: 30 (1) An individual contract. 31 (2) A small group contract. 32 (3) A large group contract offered through an exchange as 33 described in 42 U.S.C. 18032(f)(2)(B), as in effect on January 34 1, 2019. 35 (b) A health maintenance organization may vary the premium 36 rate for coverage under an individual contract, or a small group 37 contract, based only on the following: 38 (1) Whether the individual contract or small group contract 39 covers an individual or a family. 40 (2) The rating area: 41 (A) established by the commissioner; and 42 (B) in which the individual contract or small group



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1 contract is issued. 2 (3) The age of each enrollee, except that the premium rate 3 may not vary under this subdivision by more than three (3) to 4 one (1) for adults, in accordance with 42 U.S.C. 300gg-6(c), as 5 in effect on January 1, 2019. 6 (4) Tobacco use, except that the premium rate may not vary 7 under this subdivision by more than one and one-half (1.5) to 8 one (1). 9 (c) The commissioner shall adopt rules under IC 4-22-2 to do the 10 following for use under subsection (b): 11 (1) Establish at least one (1) rating area in Indiana. 12 (2) Establish permissible age bands. 13 (d) With respect to family coverage, a premium rate variation 14 permitted under subsection (b)(3) or (b)(4) must be applied based 15 on the part of the premium attributable to each family member 16 covered under the individual contract or small group contract. 17 Sec. 6. (a) A health maintenance organization that enters into an 18 individual contract or a group contract in Indiana shall accept 19 every employer and individual in Indiana that applies for coverage 20 under the individual contract or group contract. However, the 21 following apply: 22 (1) The health maintenance organization may restrict 23 enrollment in coverage under this section to open or special 24 enrollment periods. 25 (2) The health maintenance organization shall establish 26 special enrollment periods for qualifying events described in 27 29 U.S.C. 1163, as in effect on January 1, 2019, in accordance 28 with rules adopted by the commissioner under IC 4-22-2. 29 (3) The health maintenance organization may do the 30 following: 31 (A) Limit the employers that may apply for the coverage 32 to employers with employees who live, work, or reside in 33 the service area of the individual contract or group 34 contract. 35 (B) Within the service area of the individual contract or 36 group contract, deny the coverage to employers and 37 individuals if the health maintenance organization 38 demonstrates to the commissioner that the health 39 maintenance organization: 40 (i) does not have the capacity to deliver health care 41 services adequately to an additional individual or 42 member of an additional group without compromising



1	the health maintenance organization's current
2	obligations to existing enrollees and group members; and
$\frac{2}{3}$	(ii) does not consider claim experience or health status
4	related factors of individuals or group members in
5	making the determination to deny coverage under this
6	clause.
7	A health maintenance organization that denies coverage
8	under this clause may not offer individual or group
9	coverage in the service area in which coverage was denied
10	for at least one hundred eighty (180) days after the date on
11	which the denial occurs.
12	(C) Deny coverage if the health maintenance organization
13	demonstrates to the commissioner that the health
14	maintenance organization:
15	(i) does not have the financial reserves necessary to
16	underwrite additional coverage; and
17	(ii) does not consider claim experience or health status
18	related factors of individuals or group members in
19	making the determination to deny coverage under this
20	clause.
21	A health maintenance organization that denies coverage
22	under this clause may not offer individual or group
23	coverage in the service area in which coverage was denied
24	until the later of one hundred eighty (180) days after the
25	date on which the denial occurs or the date on which the
26	health maintenance organization demonstrates to the
27	commissioner that the health maintenance organization
28	has sufficient financial reserves to underwrite additional
29	coverage.
30	(b) The commissioner may apply this section on a service area
31	specific basis.
32	Sec. 7. (a) Subject to subsection (b), a health maintenance
33	organization that enters into an individual contract or a group
34	contract in Indiana shall renew or continue in force the:
35	(1) individual contract at the option of the subscriber; or
36	(2) group contract at the option of the group contract holder.
37	(b) A health maintenance organization described in subsection
38	(a) may terminate or refuse to renew an individual contract or a
39 40	group contract described in subsection (a) based only on one (1) or
40	more of the following:
41	(1) The subscriber or group contract holder fails to pay
42	premiums in accordance with the terms of the individual

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1	contract or group contract.
	(2) The subscriber or group contract holder has performed an
2 3	act that constitutes fraud or intentional misrepresentation of
4	a material fact under the terms of the individual contract or
5	group contract.
6	(3) The group contract holder of a group contract fails to
7	comply with a material contract provision related to employer
8	contribution or group participation rules in accordance with
9	state law.
10	(4) The health maintenance organization ceases to offer the
11	individual contract or group contract in Indiana in
12	accordance with subsection (c) or (d), as applicable, and other
13	state law.
14	(5) There is no longer an enrollee covered under the
15	individual contract or group contract who lives, resides, or
16	works in the service area of the individual contract or group
17	contract.
18	(6) If the individual contract or group contract is available
19	only through membership in a bona fide association:
20	(A) membership of the plan sponsor in the association
21	ceases; and
22	(B) the individual contract or group contract is terminated
23	uniformly without regard to any health status related
24	factor relating to an enrollee.
25	(c) A health maintenance organization may discontinue offering
26	an individual contract or a group contract only in accordance with
27	all of the following and other applicable state law:
28	(1) The health maintenance organization notifies each
29	contract holder and enrollee of the discontinuation at least
30	ninety (90) days before the date on which the individual
31	contract or group contract is discontinued.
32	(2) The health maintenance organization offers to each
33	subscriber or group contract holder the option to purchase
34	any other individual contract or group contract that is
35	currently offered by the health maintenance organization in
36 37	Indiana.
37 38	(3) The health maintenance organization acts uniformly without regard to any:
30 39	without regard to any: (A) claim experience of; or
39 40	(A) claim experience of; or (B) health status related factor relating to;
40 41	any enrollee or prospective enrollee.
42	(d) A health maintenance organization may discontinue all
14	(a) is nearth manifoliance organization may unscontinue an



1 individual contracts, group contracts, or both individual and group 2 contracts in Indiana only in accordance with state law and all of 3 the following: 4 (1) The health maintenance organization notifies the 5 commissioner and each subscriber or group contract holder 6 and enrollee of the discontinuation at least one hundred eighty 7 (180) days before the date on which the individual contracts 8 or group contracts are discontinued. 9 (2) All individual contracts, group contracts, or both 10 individual and group contracts entered into in Indiana are 11 discontinued and coverage under the individual contracts, 12 group contracts, or both individual and group contracts is not 13 renewed. 14 (3) The health maintenance organization does not enter into 15 an individual contract or a group contract in Indiana for at 16 least five (5) years after the date on which the last individual 17 contract or group contract is discontinued under this 18 subsection. 19 (e) A health maintenance organization may modify coverage 20 under a group contract at the time of group contract renewal. 21 However, in the case of a small group contract that is available 22 other than through a bona fide association, the modification must 23 be: 24 (1) consistent with Indiana law; and 25 (2) effective on a uniform basis among all small groups 26 covered under the small group contract. 27 Sec. 8. A health maintenance organization that issues an 28 individual contract or a group contract in Indiana may not impose 29 a preexisting condition exclusion on the individual contract or 30 group contract or coverage under the individual contract or group 31 contract. 32 Sec. 9. A health maintenance organization that enters into an 33 individual contract or a group contract in Indiana may not 34 establish rules for eligibility of an individual to enroll or to 35 continue enrollment under the terms of the individual contract or 36 group contract based on any of the following health status related 37 factors in relation to the individual or a dependent of the 38 individual: 39 (1) Health status. 40 (2) Medical condition (including both physical and mental 41 illness). 42 (3) Claim experience.



1	(4) Receipt of health care.
2	(5) Medical history.
3	(6) Genetic information.
4	(7) Evidence of insurability (including conditions arising out
5	of acts of domestic violence).
6	(8) Disability.
7	(9) Any other health status related factor determined
8	appropriate by the commissioner.
9	SECTION 9. IC 5-10-8.2 IS ADDED TO THE INDIANA CODE
10	AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
11	JULY 1, 2019]:
12	Chapter 8.2. Health Status Related Requirements
13	Sec. 1. As used in this chapter, "commissioner" refers to the
14	commissioner of insurance appointed under IC 27-1-1-2.
15	Sec. 2. As used in this chapter, "covered individual" means an
16	individual who is entitled to coverage under a state employee
17	health plan.
18	Sec. 3. As used in this chapter, "preexisting condition exclusion"
19	means a limitation or exclusion of benefits:
20	(1) related to a condition;
21	(2) based on the presence of the condition before the date on
22	which an individual is enrolled in coverage under a state
23	employee health plan; and
24	(3) regardless of whether medical advice, diagnosis, care, or
25	treatment for the condition was recommended or received
26	before the date described in subdivision (2).
27	Sec. 4. As used in this chapter, "state employee health plan"
28	refers to a:
29	(1) self-insurance program established under IC 5-10-8-7(b)
30	to provide group health coverage; or
31	(2) contract with a prepaid health care delivery plan that is
32	entered into or renewed under IC 5-10-8-7(c).
33	The term includes a person that administers benefits under a state
34	employee health plan described in subdivision (1) or (2).
35	Sec. 5. (a) The premium rate for coverage under a state
36	employee health plan may vary based only on the following:
37	(1) Whether the state employee health plan covers an
38	individual or a family.
39	(2) The rating area:
40	(A) established by the commissioner; and
41	(B) in which the state employee health plan is issued.
42	(3) The age of each covered individual, except that the



1	premium rate may not vary under this subdivision by more
2	than three (3) to one (1) for adults, in accordance with 42
3	U.S.C. 300gg-6(c), as in effect on January 1, 2019.
4	(4) Tobacco use, except that the premium rate may not vary
5	under this subdivision by more than one and one-half (1.5) to
6	one (1).
7	(b) The commissioner shall adopt rules under IC 4-22-2 to do
8	the following for use under subsection (a):
9	(1) Establish at least one (1) rating area in Indiana.
10	(2) Establish permissible age bands.
11	(c) With respect to family coverage, a premium rate variation
12	permitted under subsection (a)(3) or (a)(4) must be applied based
13	on the part of the premium attributable to each family member
14	covered under the state employee health plan.
15	Sec. 6. (a) A state employee health plan shall accept every state
16	employee who applies for coverage under the state employee health
17	plan. However, the following apply:
18	(1) The state employee health plan may restrict enrollment in
19	coverage under this section to open or special enrollment
20	periods.
21	(2) The state employee health plan shall establish special
22	enrollment periods for qualifying events described in 29
23	U.S.C. 1163, as in effect on January 1, 2019, in accordance
24	with rules adopted by the commissioner under IC 4-22-2.
25	(3) The state employee health plan may do the following with
26	respect to coverage provided through a preferred provider
27	plan described in IC 27-8-11 or a health maintenance
28	organization granted a certificate of authority under
29	IC 27-13:
30	(A) Limit the state employees who may apply for the
31	coverage to state employees who live, work, or reside in the
32	service area of the preferred provider plan or health
33	maintenance organization.
34	(B) Within the service area of the preferred provider plan
35	or health maintenance organization, deny the coverage to
36	state employees if the state employee health plan
37	demonstrates to the commissioner that the state employee
38	health plan:
39 40	(i) does not have the capacity to deliver health care
40	services through the preferred provider plan or health
41 42	maintenance organization adequately to an additional
42	individual without compromising the state employee



1	health plan's current obligations to existing covered
2	individuals under the preferred provider plan or health
3	maintenance organization; and
4	(ii) does not consider claim experience or health status
5	related factors of individuals in making the
6	determination to deny coverage under this clause.
7	A state employee health plan that denies coverage under
8	this clause may not offer coverage in the service area in
9	which coverage was denied for at least one hundred eighty
10	(180) days after the date on which the denial occurs.
11	(C) Deny coverage if the state employee health plan
12	demonstrates to the commissioner that the state employee
13	health plan:
14	(i) does not have the financial reserves necessary to
15	underwrite additional coverage; and
16	(ii) does not consider claim experience or health status
17	related factors of individuals in making the
18	determination to deny coverage under this clause.
19	A state employee health plan that denies coverage under
20	this clause may not offer coverage in the service area in
21	which coverage was denied until the later of one hundred
22	eighty (180) days after the date on which the denial occurs
23	or the date on which the state employee health plan
24	demonstrates to the commissioner that the state employee
25	health plan has sufficient financial reserves to underwrite
26	additional coverage.
27	(b) The commissioner may apply this section on a service area
28	specific basis.
29	Sec. 7. (a) Subject to subsection (b), a state employee health plan
30	shall renew or continue in force the coverage under the state
31	employee health plan at the option of the state employee.
32	(b) A state employee health plan may terminate or refuse to
33	renew coverage under a state employee health plan based only on
34	one (1) or more of the following:
35	(1) The covered individual fails to pay premiums in
36	accordance with the terms of the state employee health plan.
37	(2) The covered individual has performed an act that
38	constitutes fraud or intentional misrepresentation of a
39 40	material fact under the terms of the state employee health
40	plan. (2) The state employee health plan access to effect the coverage
41	(3) The state employee health plan ceases to offer the coverage in successful and the successful $(x) = x^{-1} (x)^{-1} (x)^{-1}$
42	in accordance with subsection (c) or (d), as applicable, and



1	
1	other state law.
2 3	(4) If the state employee health plan provides coverage
3 4	through a preferred provider plan described in IC 27-8-11 or
	a health maintenance organization granted a certificate of
5	authority under IC 27-13, there is no longer an individual
6	covered under the preferred provider plan or health
7	maintenance organization who lives, resides, or works in the
8	service area of the preferred provider plan or health
9	maintenance organization.
10	(c) A state employee health plan may discontinue offering
11	coverage under a particular state employee health plan only in
12	accordance with all of the following and other applicable state law:
13	(1) The state employee health plan notifies each covered
14	individual of the discontinuation at least ninety (90) days
15	before the date on which the state employee health plan is
16	discontinued.
17	(2) The state employee health plan offers to each covered
18	individual the option to purchase any other state employee
19	health plan coverage that is currently offered by the state
20	employee health plan in Indiana.
21	(3) The state employee health plan acts uniformly without
22	regard to any:
23	(A) claim experience of; or
24	(B) health status related factor relating to;
25	a covered individual or prospective covered individual.
26	(d) A state employee health plan may discontinue all state
27	employee health plan coverage only in accordance with state law
28	and all of the following:
29	(1) The state employee health plan notifies the commissioner
30	and each covered individual of the discontinuation at least one
31	hundred eighty (180) days before the date on which the state
32	employee health plan coverage is discontinued.
33	(2) All state employee health plans are discontinued and state
34	employee health plan coverage is not renewed.
35	(3) The state employee health plan does not provide any
36	coverage for at least five (5) years after the date on which all
37	employee health plan coverage is discontinued under this
38	subsection.
39	(e) A state employee health plan may modify state employee
40	health plan coverage at the time of renewal.
41	Sec. 8. A state employee health plan may not impose a
42	preexisting condition exclusion on state employee health plan

1 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.
- 8 (2) Medical condition (including both physical and mental 9 illness).
- 10 (3) Claim experience.
- 11 (4) Receipt of health care.
- 12 (5) Medical history.
- 13 **(6)** Genetic information.
- 14 (7) Evidence of insurability (including conditions arising out
- 15 of acts of domestic violence).
- 16 **(8) Disability.**
- 17 (9) Any other health status related factor determined18 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.
- 26 (c) This SECTION expires July 1, 2020.

