HOUSE BILL No. 1588

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15; IC 27-8; IC 34-30-2-116.

Synopsis: Insurance matters. Decreases, if approved by the federal Department of Health and Human Services, from 5% to 3%, the minimum daily benefit increase per year that must be included in a long term care insurance policy to qualify for the total asset disregard provision of the long term care program. Repeals the law concerning the small employer voluntary reinsurance program. Urges the legislative council to assign to an interim study committee for study during the 2019 interim of the general assembly the topic of insurance data security.

Effective: Upon passage; July 1, 2019.

Carbaugh

January 22, 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. 1588

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

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

SECTION 1. IC 12-15-1.3-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 19. (a) The office shall determine whether the asset disregard:**

(1) described in IC 12-15-39.6-10(a)(2); and

(2) permitted under the state plan in effect on January 1, 2019;

may be amended to change the daily benefit minimum percentage increase from five percent (5%) to three percent (3%), as provided in IC 12-15-39.6-10(a)(2)(A)(ii).

(b) If the office determines that the asset disregard definition may be amended as described in subsection (a), the office shall apply to the United States Department of Health and Human Services for a state plan amendment providing for the asset disregard definition amendment described in subsection (a).

(c) The office may not implement the amendment described in subsection (b) until the office files an affidavit with the governor

attesting that the amendment applied for under this section is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that the amendment is approved.

(d) If the office receives approval for the amendment under this section from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (c), the office shall implement the amendment not more than sixty (60) days after the governor receives the affidavit.

(e) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 2. IC 12-15-39.6-10, AS AMENDED BY P.L.146-2015, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 10. (a) As used in this section, "asset disregard" means one (1) of the following:

(1) A one dollar ($1) increase in the amount of assets an individual who:

(A) purchases a qualified long term care policy; and

(B) meets the requirements under section 8 of this chapter;

may retain under IC 12-15-3 for each one dollar ($1) of benefit paid out under the individual's long term care policy for long term care services.

(2) The total assets an individual owns and may retain under IC 12-15-3 and still qualify for benefits under IC 12-15 at the time the individual applies for benefits if the individual:

(A) is the beneficiary of a qualified long term care policy that provides maximum benefits at time of purchase of at least one hundred forty thousand dollars ($140,000) and includes a provision under which the daily benefit increases by at least:

(i) five percent (5%) **for a qualified long term care policy purchased before the date on which the office implements a state plan amendment as described in IC 12-15-1.3-19; or**

(ii) if a state plan amendment is approved by the United States Department of Health and Human Services, as described in IC 12-15-1.3-19, three percent (3%) for a qualified long term care policy purchased on or after the date on which the office implements the state plan amendment;

per year, compounded at least annually;

(B) meets the requirements under section 8 of this chapter; and

(C) has exhausted the benefits of the qualified long term care

policy.

(b) When the office determines whether an individual is eligible for Medicaid under IC 12-15-3, the office shall:

(1) make an asset disregard adjustment for any individual who purchases a qualified long term care policy; and

(2) if the assets owned by the individual's spouse are included in the individual's eligibility determination, include the assets of the individual's spouse in the asset disregard adjustment.

The asset disregard must be available after benefits of the long term care policy have been applied to the cost of long term care as required under this chapter.

(c) The qualified long term care policy an individual must purchase to be eligible for the asset disregard under subsection (a)(2) must have maximum benefits at time of purchase equal to at least one hundred forty thousand dollars ($140,000) plus:

(1) at least five percent (5%) **for a qualified long term care policy purchased before the date on which the office implements a state plan amendment as described in IC 12-15-1.3-19; or**

(2) if a state plan amendment is approved by the United States Department of Health and Human Services, as described in IC 12-15-1.3-19, three percent (3%) for a qualified long term care policy purchased on or after the date on which the office implements the state plan amendment;

interest compounded annually. ~~beginning January 1, 1999.~~

SECTION 3. IC 27-8-8-2, AS AMENDED BY P.L.208-2018, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 2. (a) The definitions in this section apply throughout this chapter.

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

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

(1) a guaranteed investment contract;

(2) a deposit administration contract;

(3) a structured settlement annuity;

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

(5) an immediate or a deferred annuity contract.

(d) "Assessment base year" means, for an impaired insurer or insolvent insurer, the most recent calendar year for which required premium information is available preceding the calendar year during

which the impaired insurer's or insolvent insurer's coverage date occurs.

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

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

(1) provides retirement income to employees; or

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

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

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

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

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

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

(1) The member insurer becomes an insolvent insurer.

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

(l) "Covered policy" means a:

(1) nongroup policy or contract;

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

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

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

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

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

(o) "Health benefit plan" means a hospital or medical expense policy or certificate, a health maintenance organization subscriber contract or certificate, or another similar health contract. The term does

not include the following:

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

(2) Coverage for:

(A) long term care;

(B) home health care;

(C) community based care; or

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

(3) Coverage for onsite medical clinics.

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

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

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

(1) not an insolvent insurer; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) "Owner" means the person:

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

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

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

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

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

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

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

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

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

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

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

(C) jointly by one (1) or more employers and one (1) or more

employee organizations;

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

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

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

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

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

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

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

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

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

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

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are employed in a single state, that state is considered to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subsection (x)(4), if more than fifty

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

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

(bb) "Resident" means the following:

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

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

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

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

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

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

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

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

except to the extent of any annuity benefits guaranteed to a natural person by an insurer under the contract or certificate. For purposes of this chapter, an unallocated annuity contract shall not be considered a group policy or group contract.

SECTION 4. IC 27-8-15.5 IS REPEALED [EFFECTIVE JULY 1, 2019]. (Small Employer Insurer Voluntary Reinsurance Program).

SECTION 5. IC 34-30-2-116, AS AMENDED BY P.L.86-2018, SECTION 297, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 116. ~~(a)~~ IC 27-8-10-8 (Concerning

persons for participation in the Indiana comprehensive health insurance association).

~~(b)~~ IC ~~27-8-15.5-29~~ ~~(Concerning persons for participation in the Indiana small employer health reinsurance program).~~

SECTION 6. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to an interim study committee for study during the 2019 interim of the general assembly the topic of insurance data security.**

(b) If the legislative council assigns the topic described in subsection (a), the interim study committee shall include the following in the study:

(1) Insurer risk assessment for cybersecurity risks involving information systems or nonpublic information stored on information systems.

(2) Insurer information security programs.

(3) Insurer internal and external party information system access.

(4) Insurer response to adverse cybersecurity events.

(5) Additional insurance data security items assigned by the legislative council.

(c) The interim study committee described in subsection (b) shall, not later than November 1, 2019, report to the legislative council in an electronic format under IC 5-14-6 the results of the study under this SECTION and any recommendations for legislation.

(d) This SECTION expires January 1, 2020.

SECTION 7. **An emergency is declared for this act.**