Citations Affected:  IC 4-1; IC 5-10; IC 27-1; IC 27-8; IC 27-13; noncode.

Synopsis:  Health coverage. Specifies that the preexisting condition requirements of the federal Patient Protection and Affordable Care Act (Continued next page)

Effective:  July 1, 2019.
Digest Continued

(ACA) as in effect on January 1, 2019, are in effect in Indiana, regardless of the legal status of the ACA. Prohibits preexisting condition exclusions in state employee health plans, policies of accident and sickness insurance, and health maintenance organization contracts. Permits premium rate variation based on certain factors. Specifies certain coverage and disclosures that must be provided with respect to a short term insurance plan, including renewal without underwriting, a term of not more than 364 days, and an annual limit of at least $2,000,000. Requires an insurer that makes a Medicare supplement policy available to an individual eligible for Medicare based on age to make at least one "Plan A" Medicare supplement policy available to an individual eligible for Medicare based on disability. Specifies enrollment and insurance producer compensation requirements that apply to the "Plan A" policy. Makes conforming amendments. Requires the legislative services agency to prepare conforming legislation for introduction during the 2020 legislative session.

ES 392—LS 6939/DI 97
ENGROSGS
SENATE BILL No. 392

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 4-1-12-1, AS ADDED BY P.L.160-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) Except as provided in subsection (b), as used in this chapter, "Patient Protection and Affordable Care Act" refers to 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 amended from time to time, and regulations or guidance issued under those acts.

(b) As used in section 5 of this chapter, "Patient Protection and Affordable Care Act" refers to 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), and regulations or guidance issued under those acts, all as in effect on January 1, 2019.

SECTION 2. IC 4-1-12-5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) As used in this section, "preexisting condition
"exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

(b) Notwithstanding any other law:
(1) 42 U.S.C. 300gg-3;
(2) 45 CFR 147.108; and
(3) all other provisions of the Patient Protection and Affordable Care Act concerning preexisting condition exclusions;

and the protections therein and in effect on January 1, 2019, are in effect and must be enforced in Indiana, regardless of the legal status of the Patient Protection and Affordable Care Act.

SECTION 3. 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" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.
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 state employee health plan may not impose a preexisting condition exclusion on state employee health plan coverage.
Sec. 6. (a) Except as provided in subsection (b), the premium rate for coverage under a state employee health plan may vary, by not more than five (5) to one (1), 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.

(b) The premium rate for coverage under a state employee health plan may vary based on tobacco use.

(c) 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.

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

SECTION 4. IC 27-1-37.3-5, AS ADDED BY P.L.55-2008, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Sec. 5. (a) As used in this chapter, "health plan" means a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes the following:
   (1) An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).
   (2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).
   (3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

(b) The term does not include the following:
   (1) Accident-only, credit, Medicare supplement, long term care, or disability income insurance.
   (2) Coverage issued as a supplement to liability insurance.
   (3) Worker's compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy issued as an individual policy.
   (6) A short term insurance plan that:
      (i) may not be renewed and for the greater of:
         (i) thirty-six (36) months; or
         (ii) the maximum term permitted under federal law;
      (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
      (C) has an annual limit of at least two million dollars ($2,000,000).
   (7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

SECTION 5. 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 6. IC 27-8-5-15.6, AS AMENDED BY P.L.173-2007, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a policy of accident and sickness insurance that:

1. is issued on an individual basis or a group basis;
2. is issued, entered into, or renewed after December 31, 1999; and
3. is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to the following:

1. A legal business entity that has obtained an exemption under section 15.7 of this chapter.
2. Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
3. Coverage issued as a supplement to liability insurance.
4. Worker's compensation or similar insurance.
5. Automobile medical payment insurance.
6. A specified disease policy.

(d) A short term insurance plan that:

1. may not be renewed and for the greater of: (i) thirty-six (36) months; or (ii) the maximum term permitted under federal law;
2. has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
3. has an annual limit of at least two million dollars ($2,000,000).

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

ES 392—LS 6939/DI 97
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.

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

(10) A student health plan.

(11) 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.

(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.

SECTION 7. 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) 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.

(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.

(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.

(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.

(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) 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) 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) 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.

(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.

(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.

(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.

(16) A provision that complies with the group portability and
guaranteed renewability provisions of the federal Health
Insurance Portability and Accountability Act of 1996

ES 392—LS 6939/DI 97
(P.L.104-191), as in effect on January 1, 2019.

(d) Subsection (c)(5), (c)(8), (c)(6) and (c)(13) 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 8. IC 27-8-5-27, AS AMENDED BY P.L.173-2007, SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term 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 for the greater of:

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and

(C) has an annual limit of at least two million dollars ($2,000,000).

(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.

ES 392—LS 6939/DI 97
(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) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.
(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.
(d) As used in this section, "individual with a disability" means an individual:
(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and
(2) who:
(A) has a record of; or
(B) is regarded as;
having an impairment described in subdivision (1).
(e) A policy of accident and sickness insurance must include coverage for anesthesia and hospital charges for dental care for an insured if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.
(f) An insurer that issues a policy of accident and sickness insurance may:
(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and
(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.
(g) This section does not apply to treatment rendered for temporal mandibular joint disorders (TMJ).
SECTION 9. 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, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 3. As used in this chapter, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

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. 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. 6. (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.

(b) Except as provided in subsection (c), an insurer may vary, by not more than five (5) to one (1), 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.

(c) An insurer may vary the premium rate for coverage under an individual or small group policy of accident and sickness insurance based on tobacco use.

(d) 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.

(e) With respect to family coverage, a premium rate variation permitted under subsection (b)(3) must be applied based on the part of the premium attributable to each family member covered under the policy.

SECTION 10. IC 27-8-5.6-1, AS AMENDED BY P.L.86-2018, SECTION 207, IS AMENDED TO READ AS FOLLOWS
[EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, the term "accident and sickness insurance" means any policy or contract covering one (1) or more of the kinds of insurance described in classes 1(b) or 2(a) of IC 27-1-5-1, as governed by IC 27-8-5.

(b) The term 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. Worker's compensation or similar insurance.
4. Automobile medical payment insurance.
5. A specified disease policy.
6. A short term insurance plan that:
   (A) may not be renewed and for the greater of:
   (i) thirty-six (36) months; or
   (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars ($2,000,000).
7. 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.
8. 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.

SECTION 11. IC 27-8-5.8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

1. Accident only, credit, dental, vision, Medicare, 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.

ES 392—LS 6939/DI 97
(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may not be renewed and for the greater of:

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a duration term of not more than six (6) months; three

hundred sixty-four (364) days; and

(C) has an annual limit of at least two million dollars

($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly
payment to an insured during hospital confinement, without
regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

SECTION 12. IC 27-8-5.9 IS ADDED TO THE INDIANA CODE
AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2019]:

Chapter 5.9. Short Term Insurance Plan

Sec. 1. As used in this chapter, "covered individual" means an
individual entitled to coverage under a short term insurance plan.

Sec. 2. As used in this chapter, "PPACA" has the meaning set

Sec. 3. As used in this chapter, "short term insurance plan"
means a policy of accident and sickness insurance (as defined in
IC 27-8-5-1) that:

(1) may be renewed for the greater of:

(A) thirty-six (36) months; or

(B) the maximum term permitted under federal law;

(2) has a term of not more than three hundred sixty-four (364)
days; and

(3) has an annual limit of at least two million dollars

($2,000,000).

Sec. 4. An insurer shall not require underwriting of an existing
insured upon renewal of a short term insurance plan.

Sec. 5. A short term insurance plan shall include coverage for
the following, as provided under PPACA:

(1) Ambulatory patient services.

(2) Hospitalization.

(3) Emergency services.

(4) Laboratory services.

Sec. 6. (a) An insurer that issues a short term insurance plan
shall disclose to an applicant, in bold, 10 point type, the following:
(1) That the short term insurance plan does not include coverage for the essential health benefits required under PPACA, other than the essential health benefits specified in section 5 of this chapter.
(2) That the short term insurance plan does not provide the coverage that is required under PPACA.
(3) That enrollment in health coverage that provides the coverage that is required under PPACA may be done during the next PPACA open enrollment period.
(4) The dates of the next PPACA open enrollment period during which the applicant may enroll in coverage described in subdivision (3).

(b) An insurer shall obtain the signature of an applicant to whom the disclosures required by subsection (a) are made.

Sec. 7. An insurer shall not, as a condition of enrollment or continued enrollment in a short term insurance plan, require an individual to pay a premium or contribution greater than the premium or contribution for a similarly situated individual enrolled in the short term insurance plan on the basis of a health status related factor in relation to the individual or a dependent of the individual.

Sec. 8. This chapter does not prevent an insurer from establishing a premium discount, a rebate, or out-of-pocket payment modifications in return for adherence to programs of health promotion and disease prevention.

SECTION 13. IC 27-8-6-6, AS ADDED BY P.L.133-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 6. (a) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. However, the term 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 for the greater of:
   (i) thirty-six (36) months; or
   (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars
(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) A supplemental plan that always pays in addition to other coverage.
(b) A policy of accident and sickness insurance that provides coverage for physical medicine and rehabilitative services shall provide the coverage for physical medicine and rehabilitative services that are:
   (1) rendered by an athletic trainer who is licensed under IC 25-5.1; and
   (2) within the athletic trainer's scope of practice.
(c) This section does not require a policy of accident and sickness insurance to provide coverage for physical medicine or rehabilitative services generally.

SECTION 14. IC 27-8-13-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9. (a) A Medicare supplement policy, contract, or certificate in force in Indiana may not contain benefits that duplicate benefits provided by Medicare. However, a change in Medicare coverage that becomes effective after a Medicare supplement policy, contract, or certificate is in force in Indiana and that causes a duplication of benefits does not void the policy, contract, or certificate.
(b) The commissioner shall adopt rules under IC 4-22-2 to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with Indiana law. No requirement of IC 27 relating to minimum required policy benefits other than the minimum standards contained in this chapter apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:
   (1) terms of renewability;
   (2) initial and subsequent conditions of eligibility;
   (3) nonduplication of coverage;
   (4) probationary periods;
   (5) benefit limitations, exceptions, and reductions;
   (6) elimination periods;
   (7) requirements for replacement;
   (8) recurrent conditions; and
   (9) definitions of terms.
(c) The commissioner may adopt rules under IC 4-22-2 that specify...
prohibited policy provisions not specifically authorized by statute that,
in the opinion of the commissioner, are unjust, unfair, or unfairly
discriminatory to a person insured or proposed to be insured under a
Medicare supplement policy or certificate.

(d) Notwithstanding any other law, a Medicare supplement policy
or certificate shall not exclude or limit benefits for a loss incurred more
than six (6) months after the effective date of the policy because the
loss involves a preexisting condition. The policy or certificate shall not
define a preexisting condition more restrictively than a condition for
which medical advice was given or treatment was recommended by or
received from a physician within six (6) months before the effective
date of coverage.

(e) After June 30, 2020, an issuer that makes a Medicare
supplement policy or certificate available to a person who is at
least sixty-five (65) years of age and eligible for Medicare benefits
as described in 42 U.S.C. 1395c(1) shall make at least one (1)
Medicare supplement policy or certificate that meets the
requirements of section 9.5 of this chapter available to an
individual who is eligible for and enrolled in Medicare by reason
of disability as described in 42 U.S.C. 1395c(2).

SECTION 15. IC 27-8-13-9.5 IS ADDED TO THE INDIANA
CODE AS A NEW SECTION TO READ AS FOLLOWS
[EFFECTIVE JULY 1, 2019]: Sec. 9.5. (a) This section applies:
(1) after June 30, 2020; and
(2) to a Medicare supplement policy or certificate made
available under section 9(e) of this chapter to an individual
who is eligible for and enrolled in Medicare by reason of
disability as described in 42 U.S.C. 1395c(2).

(b) A Medicare supplement policy or certificate described in
subsection (a) must meet the following requirements:
(1) Except as provided in this section, meet all requirements
of this chapter that apply to a Medicare supplement policy or
certificate made available to a person who is at least sixty-five
(65) years of age and eligible for Medicare as described in 42
U.S.C. 1395c(1).
(2) Be standardized as Plan A by the federal Centers for
Medicare and Medicaid Services.
(c) An individual may enroll in a Medicare supplement policy or
certificate under this section as follows:
(1) At any time the individual is authorized or required to
enroll under federal law.
(2) On:
(A) July 1, 2020; or
(B) six (6) months after enrolling in Medicare Part B;
whichever is later.
(3) Within six (6) months after receiving notice that the
individual has been retroactively enrolled in Medicare Part B
due to a retroactive eligibility decision under 42 U.S.C. 1395.
(4) Within six (6) months after experiencing a qualifying event
under 42 U.S.C. 1395.
(d) Notwithstanding any other law, an issuer or another entity
may provide to an insurance producer or another agent of the
issuer or other entity a commission or other compensation of not
more than two percent (2%) of the premium for the sale of a
Medicare supplement policy or certificate described in subsection
(a).
SECTION 16. IC 27-8-13.4-1, AS ADDED BY P.L.124-2014,
SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and
sickness insurance policy" means an insurance policy that:
(1) provides one (1) or more of the types of insurance described
in IC 27-1-5-1, Class 1(b) and Class 2(a); and
(2) is issued on a group or individual basis.
(b) As used in this chapter, "accident and sickness insurance policy"
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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three
   hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars
   ($2,000,000).
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.

(9) 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.

SECTION 17. IC 27-8-13.5-4, AS ADDED BY P.L.126-2013, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term 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 for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars ($2,000,000).

(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.

SECTION 18. IC 27-8-14-1, AS AMENDED BY P.L.173-2007, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described
in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.
(b) The term 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three
      hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars
      ($2,000,000).
(7) 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.
(8) A supplemental plan that always pays in addition to other
coverage.
(9) A student health plan.
(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.

SECTION 19. IC 27-8-14.1-1, AS AMENDED BY P.L.173-2007,
SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and
sickness insurance policy" means an insurance policy that:
(1) provides one (1) or more of the types of insurance described
in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.
(b) As used in this chapter, "accident and sickness insurance policy"
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) Worker's compensation or similar insurance.

ES 392—LS 6939/DI 97
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars ($2,000,000).
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

SECTION 20. IC 27-8-14.2-1, AS AMENDED BY P.L.173-2007, SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).
(b) The term 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) Worker's compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy.
   (6) A short term insurance plan that:
      (A) may not be renewed and for the greater of:
         (i) thirty-six (36) months; or
         (ii) the maximum term permitted under federal law;
      (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
      (C) has an annual limit of at least two million dollars
(S$2,000,000).

(7) 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.

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

(9) A student health plan.

(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.

SECTION 21. IC 27-8-14.5-1, AS AMENDED BY P.L.173-2007, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "health insurance plan" means any:
   (1) hospital or medical expense incurred policy or certificate;
   (2) hospital or medical service plan contract; or
   (3) health maintenance organization subscriber contract; provided to an insured.
   (b) The term 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) Worker's compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy.
   (6) A short term insurance plan that:
      (A) may not be renewed and for the greater of:
         (i) thirty-six (36) months; or
         (ii) the maximum term permitted under federal law;
      (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
      (C) has an annual limit of at least two million dollars ($2,000,000).
   (7) 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.
   (8) A supplemental plan that always pays in addition to other
(9) A student health plan.
(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.

SECTION 22. IC 27-8-14.7-1, AS AMENDED BY P.L.173-2007, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
    (1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
    (2) is issued on a group basis.
(b) "Accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
    (4) Automobile medical payment insurance.
    (5) A specified disease policy.
    (6) A short term insurance plan that:
       (A) may not be renewed and for the greater of:
          (i) thirty-six (36) months; or
          (ii) the maximum term permitted under federal law;
       (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
       (C) has an annual limit of at least two million dollars ($2,000,000).
    (7) 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.
    (8) A supplemental plan that always pays in addition to other coverage.
    (9) A student health plan.
    (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.

SECTION 23. IC 27-8-14.8-1, AS AMENDED BY P.L.173-2007,
SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
(2) is issued on a group basis.
(b) "Accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
       (i) thirty-six (36) months; or
       (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars ($2,000,000).
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

SECTION 24. IC 27-8-15-9, AS AMENDED BY P.L.11-2011, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9. (a) Except as provided in section 28 of this chapter, as used in this chapter, "health insurance plan" or "plan" means any:
(1) hospital or medical expense incurred policy or certificate;
(2) hospital or medical service plan contract; or
(3) health maintenance organization subscriber contract;
(b) The term 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. Worker's compensation or similar insurance.
4. Automobile medical payment insurance.
5. A specified disease policy.
6. A short term insurance plan that:
   - (A) may not be renewed and for the greater of:
     1. thirty-six (36) months; or
     2. the maximum term permitted under federal law;
   - (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   - (C) has an annual limit of at least two million dollars ($2,000,000).
7. 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.
8. 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.

SECTION 25. 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 26. 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 27. IC 27-8-24.1-1, AS AMENDED BY P.L.173-2007, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis.

(b) The term 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) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed and for the greater of:

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

(7) 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.

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

(9) A student health plan.

(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.

SECTION 28. IC 27-8-24.2-3, AS ADDED BY P.L.109-2008, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Sec. 3. (a) As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare, 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 limited benefit health insurance policy.

(6) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

SECTION 29. IC 27-8-27-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. (a) For purposes of this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;
(2) hospital or medical service plan contract; or
(3) health maintenance organization subscriber contract;
provided to an insured.
(b) The term does not include the following:
(1) Accident-only, credit, dental, Medicare supplement, long term
care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy issued as an individual policy.
(6) A limited benefit health insurance plan issued as an individual
policy.
(7) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
      (B) has a duration term of not more than six (6) months; three
      hundred sixty-four (364) days; and
      (C) has an annual limit of at least two million dollars
      ($2,000,000).
(8) A policy that provides a stipulated daily, weekly, or monthly
payment to an insured during hospital confinement, without
regard to the actual expense of the confinement.

SECTION 30. IC 27-8-28-1 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this
chapter, "accident and sickness insurance policy" means an insurance
policy that provides one (1) or more of the kinds of insurance described
in Class 1(b) and 2(a) of IC 27-1-5-1.
(b) The term 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 issued as an individual policy.
(5) A limited benefit health insurance policy issued as an
individual policy.
(6) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
      (B) has a duration term of not more than six (6) months; three
      hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

SECTION 31. 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, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

Sec. 2. 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. 3. 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. 4. (a) This section applies to any of the following:

(1) An individual contract.

(2) A small group contract.

(b) Except as provided in subsection (c), a health maintenance organization may vary, by not more than five (5) to one (1), 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.

(c) A health maintenance organization may vary the premium rate for coverage under an individual contract or a small group contract based on tobacco use.

(d) 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.

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

SECTION 32. [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.
COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred Senate Bill No. 392, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, line 21, delete "An" and insert "After June 30, 2020, an".
Page 2, line 21, after "policy" insert "or certificate".
Page 2, line 22, after "is" insert "at least sixty-five (65) years of age and".
Page 2, line 24, after "policy" insert "or certificate that meets the requirements of section 9.5 of this chapter".
Page 2, line 24, after "for" insert "and enrolled in".
Page 2, line 24, after "Medicare" insert "by reason of disability".
Page 2, after line 25, begin a new paragraph and insert:

"SECTION 2. IC 27-8-13-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9.5. (a) This section applies:

(1) after June 30, 2020; and
(2) to a Medicare supplement policy or certificate made available under section 9(e) of this chapter to an individual who is eligible for and enrolled in Medicare by reason of disability as described in 42 U.S.C. 1395c(2).

(b) A Medicare supplement policy or certificate described in subsection (a) must meet the following requirements:

(1) Except as provided in this section, meet all requirements of this chapter that apply to a Medicare supplement policy or certificate made available to a person who is at least sixty-five (65) years of age and eligible for Medicare as described in 42 U.S.C. 1395c(1).

(2) Be standardized as Plan A by the federal Centers for Medicare and Medicaid Services.

(c) An individual may enroll in a Medicare supplement policy or certificate under this section as follows:

(1) At any time the individual is authorized or required to enroll under federal law.
(2) On:
   (A) July 1, 2020; or
   (B) six (6) months after enrolling in Medicare Part B; whichever is later.
(3) Within six (6) months after receiving notice that the individual has been retroactively enrolled in Medicare Part B
due to a retroactive eligibility decision under 42 U.S.C. 1395.
(4) Within six (6) months after experiencing a qualifying event
under 42 U.S.C. 1395.
(d) Notwithstanding any other law, an issuer or another entity
may provide to an insurance producer or another agent of the
issuer or other entity a commission or other compensation of not
more than two percent (2%) of the premium for the sale of a
Medicare supplement policy or certificate described in subsection
(a)."

and when so amended that said bill do pass.

(Reference is to SB 392 as introduced.)

BASSLER, Chairperson

Committee Vote: Yeas 8, Nays 1.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred
Senate Bill 392, has had the same under consideration and begs leave
to report the same back to the House with the recommendation that said
bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new
paragraph and insert:

"SECTION 1. IC 4-1-12-1, AS ADDED BY P.L.160-2011,
SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2019]: Sec. 1. (a) Except as provided in subsection (b), as
used in this chapter, "Patient Protection and Affordable Care Act"
refers to 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 amended from time to
time, and regulations or guidance issued under those acts.
(b) As used in section 5 of this chapter, "Patient Protection and
Affordable Care Act" refers to 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), and regulations or guidance issued under those acts, all
as in effect on January 1, 2019.

SECTION 2. IC 4-1-12-5 IS ADDED TO THE INDIANA CODE
AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

ES 392—LS 6939/DI 97
Sec. 5. (a) As used in this section, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

(b) Notwithstanding any other law:
   (1) 42 U.S.C. 300gg-3;
   (2) 45 CFR 147.108; and
   (3) all other provisions of the Patient Protection and Affordable Care Act concerning preexisting condition exclusions;

and the protections therein and in effect on January 1, 2019, are in effect and must be enforced in Indiana, regardless of the legal status of the Patient Protection and Affordable Care Act.

SECTION 3. 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" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

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(e).

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

Sec. 5. A state employee health plan may not impose a preexisting condition exclusion on state employee health plan coverage.

Sec. 6. (a) Except as provided in subsection (b), the premium rate for coverage under a state employee health plan may vary, by not more than five (5) to one (1), 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.

(b) The premium rate for coverage under a state employee health plan may vary based on tobacco use.

(c) 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.

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

SECTION 4. IC 27-1-37.3-5, AS ADDED BY P.L.55-2008, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Sec. 5. (a) As used in this chapter, "health plan" means a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes the following:

(1) An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

(b) The term does not include the following:

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

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

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed and for the greater of:

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

ES 392—LS 6939/DI 97
SECTION 5. 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
(2) 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 6. IC 27-8-5-15.6, AS AMENDED BY P.L.173-2007, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a policy of accident and sickness insurance that:

(1) is issued on an individual basis or a group basis;
(2) is issued, entered into, or renewed after December 31, 1999; and
(3) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to the following:

(1) A legal business entity that has obtained an exemption under section 15.7 of this chapter.
(2) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(3) Coverage issued as a supplement to liability insurance.
(4) Worker's compensation or similar insurance.
(5) Automobile medical payment insurance.
(6) A specified disease policy.
(7) A short term insurance plan that:

(A) may not be renewed and for the greater of:

(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

(8) 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.
(9) A supplemental plan that always pays in addition to other
coverage.
(10) A student health plan.
(11) 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.

(d) A group or individual insurance policy or agreement may not
permit treatment limitations or financial requirements on the coverage
of services for a mental illness if similar limitations or requirements are
not imposed on the coverage of services for other medical or surgical
conditions.
(e) An insurer that issues a policy of accident and sickness
insurance that provides coverage of services for the treatment of
substance abuse and chemical dependency when the services are
required in the treatment of a mental illness shall offer to provide the
coverage without treatment limitations or financial requirements if
similar limitations or requirements are not imposed on the coverage of
services for other medical or surgical conditions.
(f) This section does not require a group or individual insurance
policy or agreement to offer mental health benefits.
(g) The benefits delivered under this section may be delivered under
a managed care system.

SECTION 7. 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:

(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.
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.

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.

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.

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.

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) 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) 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) 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) 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) 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) 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) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health...

(d) Subsection (c)(5), (c)(8), (c)(6) and (e)(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 8. IC 27-8-5-27, AS AMENDED BY P.L.173-2007, SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term 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 for the greater of:
      i. thirty-six (36) months; or
      ii. the maximum term permitted under federal law;
   B. has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   C. has an annual limit of at least two million dollars ($2,000,000).
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) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.

(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(d) As used in this section, "individual with a disability" means an individual:

(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and

(2) who:

(A) has a record of; or

(B) is regarded as;

having an impairment described in subdivision (1).

(e) A policy of accident and sickness insurance must include coverage for anesthesia and hospital charges for dental care for an insured if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.

(f) An insurer that issues a policy of accident and sickness insurance may:

(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and

(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.

(g) This section does not apply to treatment rendered for temporal
mandibular joint disorders (TMJ).

SECTION 9. 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, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 3. As used in this chapter, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

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. 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. 6. (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.
(b) Except as provided in subsection (c), an insurer may vary, by not more than five (5) to one (1), 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.
(c) An insurer may vary the premium rate for coverage under an individual or small group policy of accident and sickness insurance based on tobacco use.
(d) 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.
(e) With respect to family coverage, a premium rate variation permitted under subsection (b)(3) must be applied based on the part of the premium attributable to each family member covered under the policy.

SECTION 10. IC 27-8-5.6-1, AS AMENDED BY P.L.86-2018, ES 392—LS 6939/DI 97
SECTION 207. IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, the term "accident and sickness insurance" means any policy or contract covering one (1) or more of the kinds of insurance described in classes 1(b) or 2(a) of IC 27-1-5-1, as governed by IC 27-8-5.

(b) The term 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) Worker's compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy.
   (6) A short term insurance plan that:
       (A) may not be renewed and for the greater of:
           (i) thirty-six (36) months; or
           (ii) the maximum term permitted under federal law;
       (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
       (C) has an annual limit of at least two million dollars ($2,000,000).
   (7) 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.
   (8) A supplemental plan that always pays in addition to other coverage.
   (9) A student health plan.
   (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.

SECTION 11. IC 27-8-5.8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

   (1) Accident only, credit, dental, vision, Medicare, 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 limited benefit health insurance policy.
(6) A short term insurance plan that:
   (A) may not be renewed and for the greater of:
       (i) thirty-six (36) months; or
       (ii) the maximum term permitted under federal law;
   (B) has a duration term of not more than six (6) months; three
       hundred sixty-four (364) days; and
   (C) has an annual limit of at least two million dollars
       ($2,000,000).
(7) A policy that provides a stipulated daily, weekly, or monthly
    payment to an insured during hospital confinement, without
    regard to the actual expense of the confinement.
(8) Worker's compensation or similar insurance.
(9) A student health insurance policy.

SECTION 12. IC 27-8-5.9 IS ADDED TO THE INDIANA CODE
AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2019]:

Chapter 5.9. Short Term Insurance Plan
Sec. 1. As used in this chapter, "covered individual" means an
individual entitled to coverage under a short term insurance plan.
Sec. 2. As used in this chapter, "PPACA" has the meaning set
Sec. 3. As used in this chapter, "short term insurance plan"
means a policy of accident and sickness insurance (as defined in
IC 27-8-5-1) that:
   (1) may be renewed for the greater of:
       (A) thirty-six (36) months; or
       (B) the maximum term permitted under federal law;
   (2) has a term of not more than three hundred sixty-four (364)
       days; and
   (3) has an annual limit of at least two million dollars
       ($2,000,000).
Sec. 4. An insurer shall not require underwriting of an existing
insured upon renewal of a short term insurance plan.
Sec. 5. A short term insurance plan shall include coverage for
the following, as provided under PPACA:
   (1) Ambulatory patient services.
   (2) Hospitalization.
   (3) Emergency services.
   (4) Laboratory services.
Sec. 6. (a) An insurer that issues a short term insurance plan

ES 392—LS 6939/DI 97
shall disclose to an applicant, in bold, 10 point type, the following:

(1) That the short term insurance plan does not include coverage for the essential health benefits required under PPACA, other than the essential health benefits specified in section 5 of this chapter.

(2) That the short term insurance plan does not provide the coverage that is required under PPACA.

(3) That enrollment in health coverage that provides the coverage that is required under PPACA may be done during the next PPACA open enrollment period.

(4) The dates of the next PPACA open enrollment period during which the applicant may enroll in coverage described in subdivision (3).

(b) An insurer shall obtain the signature of an applicant to whom the disclosures required by subsection (a) are made.

Sec. 7. An insurer shall not, as a condition of enrollment or continued enrollment in a short term insurance plan, require an individual to pay a premium or contribution greater than the premium or contribution for a similarly situated individual enrolled in the short term insurance plan on the basis of a health status related factor in relation to the individual or a dependent of the individual.

Sec. 8. This chapter does not prevent an insurer from establishing a premium discount, a rebate, or out-of-pocket payment modifications in return for adherence to programs of health promotion and disease prevention.

SECTION 13. IC 27-8-6-6, AS ADDED BY P.L.133-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 6. (a) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. However, the term 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 for the greater of:

(i) thirty-six (36) months; or

(ii) the maximum term permitted under federal law;

(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

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

(b) A policy of accident and sickness insurance that provides coverage for physical medicine and rehabilitative services shall provide the coverage for physical medicine and rehabilitative services that are:

(1) rendered by an athletic trainer who is licensed under IC 25-5.1; and

(2) within the athletic trainer's scope of practice.

(c) This section does not require a policy of accident and sickness insurance to provide coverage for physical medicine or rehabilitative services generally."

Page 3, after line 22, begin a new paragraph and insert:

"SECTION 16. IC 27-8-13.4-1, AS ADDED BY P.L.124-2014, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, Class 1(b) and Class 2(a); and
(2) is issued on a group or individual basis.

(b) As used in this chapter, "accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:

(A) may not be renewed and for the greater of:
 
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;

(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and

(C) has an annual limit of at least two million dollars ($2,000,000)."
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) 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.

SECTION 17. IC 27-8-13.5-4, AS ADDED BY P.L.126-2013, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term 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 for the greater of:
      (i) thirty-six (36) months; or
      (ii) the maximum term permitted under federal law;
      (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
      (C) has an annual limit of at least two million dollars ($2,000,000).
   (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.

ES 392—LS 6939/DI 97
SECTION 18. IC 27-8-14-1, AS AMENDED BY P.L.173-2007,
SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and
sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described
in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) The term 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:

(A) may not be renewed and for the greater of:
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a duration term of not more than six (6) months; three
hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars
($2,000,000).

(7) 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.

(8) A supplemental plan that always pays in addition to other
coverage.
(9) A student health plan.
(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.

SECTION 19. IC 27-8-14.1-1, AS AMENDED BY P.L.173-2007,
SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and
sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described
in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) As used in this chapter, "accident and sickness insurance policy"
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. Worker's compensation or similar insurance.
4. Automobile medical payment insurance.
5. A specified disease policy.
6. A short term insurance plan that:
   A. may not be renewed and for the greater of:
      i. thirty-six (36) months; or
      ii. the maximum term permitted under federal law;
   B. has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
   C. has an annual limit of at least two million dollars ($2,000,000).
7. 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.
8. 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.

SECTION 20. IC 27-8-14.2-1, AS AMENDED BY P.L.173-2007, SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) The term 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. Worker's compensation or similar insurance.
4. Automobile medical payment insurance.
5. A specified disease policy.
6. A short term insurance plan that:
   A. may not be renewed and for the greater of:
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

(7) 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.

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

(9) A student health plan.

(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.

SECTION 21. IC 27-8-14.5-1, AS AMENDED BY P.L.173-2007, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "health insurance plan" means any:
   (1) hospital or medical expense incurred policy or certificate;
   (2) hospital or medical service plan contract; or
   (3) health maintenance organization subscriber contract;
   provided to an insured.

(b) The term 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) Worker’s compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy.
   (6) A short term insurance plan that:
       (A) may not be renewed and for the greater of:
           (i) thirty-six (36) months; or
           (ii) the maximum term permitted under federal law;
       (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
       (C) has an annual limit of at least two million dollars ($2,000,000).

(7) 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.
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.

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

(9) A student health plan.

(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.

SECTION 22. IC 27-8-14.7-1, AS AMENDED BY P.L.173-2007, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" 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) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed and for the greater of:

(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;

(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and

(C) has an annual limit of at least two million dollars ($2,000,000).

(7) 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.

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

(9) A student health plan.

ES 392—LS 6939/DI 97
(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.

SECTION 23. IC 27-8-14.8-1, AS AMENDED BY P.L.173-2007, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
   (1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
   (2) is issued on a group basis.
   (b) "Accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
      (4) Automobile medical payment insurance.
      (5) A specified disease policy.
      (6) A short term insurance plan that:
         (A) may not be renewed and for the greater of:
            (i) thirty-six (36) months; or
            (ii) the maximum term permitted under federal law;
         (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
         (C) has an annual limit of at least two million dollars ($2,000,000).
      (7) 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.
      (8) A supplemental plan that always pays in addition to other coverage.
      (9) A student health plan.
      (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.

SECTION 24. IC 27-8-15-9, AS AMENDED BY P.L.11-2011, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 9. (a) Except as provided in section 28 of this
chapter, as used in this chapter, "health insurance plan" or "plan"
means any:

(1) hospital or medical expense incurred policy or certificate;
(2) hospital or medical service plan contract; or
(3) health maintenance organization subscriber contract;
provided to the employees of a small employer.

(b) The term 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
    (A) may not be renewed and for the greater of:
        (i) thirty-six (36) months; or
        (ii) the maximum term permitted under federal law;
    (B) has a duration term of not more than six (6) months; three
        hundred sixty-four (364) days; and
    (C) has an annual limit of at least two million dollars
        ($2,000,000).
(7) 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.
(8) A supplemental plan that always pays in addition to other
    coverage.
(9) A student health plan.
(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.

SECTION 25. 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

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

ES 392—LS 6939/DI 97
(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 26. 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 27. IC 27-8-24.1-1, AS AMENDED BY P.L.173-2007, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis.

(b) The term 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. Worker's compensation or similar insurance.
4. Automobile medical payment insurance.
5. A specified disease policy.
6. A short term insurance plan that:
(A) may not be renewed and for the greater of:
   (i) thirty-six (36) months; or
   (ii) the maximum term permitted under federal law;
(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

(7) 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.

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

(9) A student health plan.

(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.

SECTION 28. IC 27-8-24.2-3, AS ADDED BY P.L.109-2008, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 3. (a) As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

(b) The term does not include the following:
   (1) Accident only, credit, dental, vision, Medicare, 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 limited benefit health insurance policy.
   (6) A short term insurance plan that:
      (A) may not be renewed and for the greater of:
         (i) thirty-six (36) months; or
         (ii) the maximum term permitted under federal law;
      (B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
      (C) has an annual limit of at least two million dollars ($2,000,000).
   (7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
   (8) Worker's compensation or similar insurance.
(9) A student health insurance policy.

SECTION 29. IC 27-8-27-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4. (a) For purposes of this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;
(2) hospital or medical service plan contract; or
(3) health maintenance organization subscriber contract;
provided to an insured.

(b) The term does not include the following:

(1) Accident-only, credit, dental, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy issued as an individual policy.
(6) A limited benefit health insurance plan issued as an individual policy.

(7) A short term insurance plan that:

(A) may not be renewed and for the greater of:
(i) thirty-six (36) months; or
(ii) the maximum term permitted under federal law;
(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

SECTION 30. IC 27-8-28-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the kinds of insurance described in Class 1(b) and 2(a) of IC 27-1-5-1.

(b) The term 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 issued as an individual policy.
(5) A limited benefit health insurance policy issued as an individual policy.
(6) A short term insurance plan that:

ES 392—LS 6939/DI 97
(A) may not be renewed and for the greater of:
   (i) thirty-six (36) months; or
   (ii) the maximum term permitted under federal law;
(B) has a duration term of not more than six (6) months; three hundred sixty-four (364) days; and
(C) has an annual limit of at least two million dollars ($2,000,000).

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

SECTION 31. 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, "preexisting condition exclusion" has the meaning set forth in 45 CFR 144.103, as in effect on January 1, 2019.

Sec. 2. 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. 3. 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. 4. (a) This section applies to any of the following:
   (1) An individual contract.
   (2) A small group contract.
   (b) Except as provided in subsection (c), a health maintenance organization may vary, by not more than five (5) to one (1), 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.
   (c) A health maintenance organization may vary the premium rate for coverage under an individual contract or a small group contract based on tobacco use.

ES 392—LS 6939/DI 97
(d) 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.

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

SECTION 32. [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."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 392 as printed February 22, 2019.)

CARBAUGH

Committee Vote: yeas 11, nays 0.