

- (1) The entire money and other considerations for the policy are expressed in the policy.
- (2) The time at which the insurance takes effect and terminates is expressed in the policy.
- (3) The policy purports to insure only one (1) person, except that a policy ~~may~~ **must** insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children ~~under a specified age, which shall not exceed nineteen (19)~~ **who are less than twenty-four (24) years of age**, and any other person dependent upon the policyholder.
- (4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).
- (5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.
- (6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.
- (7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the

policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both:

- (A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and
- (B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a child who has mental retardation or a mental or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in

subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

SECTION 46. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the

coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any

successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of

persons other than the employers or the unions or organizations, subject to the following requirements:

- (A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.
- (B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.
- (C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.
- (5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining

insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

- (A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.
 - (B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.
 - (C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.
 - (D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.
- (6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:
- (A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.
 - (B) The premium for the policy shall be paid by the

policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 47. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), or 16(7), or **16(8)** of this chapter unless the commissioner finds that:

- (1) the issuance of the policy is not contrary to the best interest of the public;
- (2) the issuance of the policy would result in economies of acquisition or administration; and
- (3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

SECTION 48. IC 27-8-5-28 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-four (24) years of age.**

SECTION 49. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE

AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 10.1. High Risk Indiana Check-Up Plan Participants

Sec. 1. As used in this chapter, "association" means the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.

Sec. 2. As used in this chapter, "participant" means an individual entitled to coverage under the plan.

Sec. 3. As used in this chapter, "plan" refers to the Indiana check-up plan established by IC 12-15-44-3.

Sec. 4. (a) The association shall administer the plan for participants who are referred to the association by the office of the secretary of family and social services.

(b) Coverage under the plan is separate from the coverage provided under IC 27-8-10.

(c) The following apply to the administration of the plan under this chapter:

(1) Only participants referred by the office of the secretary of family and social services are eligible for plan coverage administered under this chapter.

(2) Plan coverage administered under this chapter must provide medical management services.

(d) A participant who is referred to the association under subsection (a) shall participate in medical management services provided under this chapter.

SECTION 50. IC 27-13-7-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

- (1) The name and address of the health maintenance organization.**
- (2) Eligibility requirements.**
- (3) Benefits and services within the service area.**
- (4) Emergency care benefits and services.**
- (5) Any out-of-area benefits and services.**
- (6) Copayments, deductibles, and other out-of-pocket costs.**
- (7) Limitations and exclusions.**
- (8) Enrollee termination provisions.**
- (9) Any enrollee reinstatement provisions.**
- (10) Claims procedures.**
- (11) Enrollee grievance procedures.**

- (12) Continuation of coverage provisions.
- (13) Conversion provisions.
- (14) Extension of benefit provisions.
- (15) Coordination of benefit provisions.
- (16) Any subrogation provisions.
- (17) A description of the service area.
- (18) The entire contract provisions.
- (19) The term of the coverage provided by the contract.
- (20) Any right of cancellation of the group or individual contract holder.
- (21) Right of renewal provisions.
- (22) Provisions regarding reinstatement of a group or an individual contract holder.
- (23) Grace period provisions.
- (24) A provision on conformity with state law.
- (25) A provision or provisions that comply with the:
 - (A) guaranteed renewability; and
 - (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the date the child becomes twenty-four (24) years of age.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

SECTION 51. IC 34-30-2-45.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 45.7. IC 12-16-5.5-2 (Concerning ~~hospitals~~ **providers** for providing information verifying indigency of patient).

SECTION 52. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2007]: IC 12-15-15-9.8; IC 12-15-20.7-3; IC 12-16-2.5-6.5; IC 12-16-8.5; IC 12-16-12.5.

SECTION 53. [EFFECTIVE JANUARY 1, 2007 (RETROACTIVE)] **IC 6-3.1-31 and IC 6-3.1-31.2, both as added by this act, apply only to taxable years beginning after December 31, 2006.**

SECTION 54. [EFFECTIVE JULY 1, 2007] **Notwithstanding IC 6-7-1-14, revenue stamps paid for before July 1, 2007, and in the**

possession of a distributor may be used after June 30, 2007, only if the full amount of the tax imposed by IC 6-7-1-12, as effective after June 30, 2007, and as amended by this act, is remitted to the department of state revenue under the procedures prescribed by the department.

SECTION 55. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) The office shall apply to the United States Department of Health and Human Services for any amendment to the state Medicaid plan or demonstration waiver that is needed to provide for presumptive eligibility for a pregnant woman described in IC 12-15-2-13, as amended by this act.

(c) The office may not implement the amendment or waiver until the office files an affidavit with the governor attesting that the amendment or waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that the amendment or waiver is approved.

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

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

SECTION 56. [EFFECTIVE JULY 1, 2007] (a) IC 27-8-5-2, as amended by this act, and IC 27-8-5-28, as added by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

(b) IC 27-13-7-3, as amended by this act, applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

SECTION 57. [EFFECTIVE JULY 1, 2007] (a) The definitions in IC 12-15-44, as added by this act, apply to this SECTION.

(b) As used in this SECTION, "task force" refers to the Indiana check-up plan task force established by subsection (c).

(c) The Indiana check-up plan task force is established to:

(1) study, monitor, provide guidance, and make recommendations to the state concerning the Indiana check-up plan;

(2) develop methods to increase availability of affordable coverage for health care services for all Indiana residents;

(3) develop an education and orientation program for individuals participating in the plan; and

(4) make recommendations to the legislative council.

(d) The affirmative votes of a majority of the voting members appointed to the task force are required for the task force to take action on any measure, including final reports.

(e) The office of Medicaid policy and planning established by IC 12-8-6-1 shall staff the task force.

(f) The task force consists of the following voting members:

(1) Four (4) members described in subsection (g)(1) through (g)(4) appointed by the speaker of the house of representatives, two (2) of whom are appointed based on the recommendation of the minority leader of the house of representatives and none of whom are legislators.

(2) Four (4) members described in subsection (g)(5) through (g)(8) appointed by the president pro tempore of the senate, two (2) of whom are appointed based on the recommendation of the minority leader of the senate and none of whom are legislators.

(3) Four (4) members described in subsection (g)(9) through (g)(12) appointed by the governor, not more than two (2) of whom are members of the same political party.

(g) The members appointed under subsection (f) must represent the following interests:

(1) Hospitals.

(2) Insurance companies.

(3) Primary care providers.

(4) Health professionals who are not primary care providers.

(5) Minority health concern experts.

(6) Business.

(7) Organized labor.

(8) Consumers.

(9) Children's health issues.

(10) Adult health issues.

(11) Mental health issues.

(12) Pharmaceutical industry.

(h) The secretary of the office of the secretary of family and social services shall call the first meeting of the task force, at which the members shall elect the chairperson of the task force.

(i) The task force shall report findings and make recommendations to the governor and to the legislative council in an electronic format under IC 5-14-6 as follows:

(1) A report not later than November 1, 2008.

(2) A final report not later than November 1, 2009.

(j) The task force members are not eligible for per diem reimbursement or reimbursement for expenses incurred for travel to and from task force meetings.

(k) This SECTION expires December 31, 2009.

SECTION 58. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) The office shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver or a Medicaid state plan amendment to develop and implement the following:

(1) Health insurance coverage program to cover individuals who meet the following requirements:

(A) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(B) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(C) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(D) The individual is not eligible for health insurance coverage through the individual's employer.

(E) The individual has been without health insurance coverage for at least six (6) months or is without health insurance coverage because of a change in employment.

(2) A premium assistance program described in IC 12-15-44-20, as added by this act.

(c) The office shall include in the waiver application or state plan amendment a request to fund the program in part by using:

- (1) enhanced federal financial participation; and
- (2) hospital care for the indigent dollars, upper payment limit dollars, or disproportionate share hospital dollars.

(d) The office may not implement the waiver or state plan amendment until the office:

- (1) files an affidavit with the governor attesting that the federal waiver or amendment applied for under this SECTION is in effect; and
- (2) has sufficient funding for the program.

The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver or amendment is approved.

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

(f) This SECTION expires December 31, 2013.

SECTION 59. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) The office shall apply to the United States Department of Health and Human Services for approval of an amendment to the state's Medicaid plan that is necessary to do the following:

- (1) Amend the state's upper payment limit program.
- (2) Make changes to the state's disproportionate share hospital program.

(c) The office may not implement an approved amendment to the state plan until the office files an affidavit with the governor attesting that the state plan amendment applied for under subsection (b)(1) or (b)(2) of this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment is approved.

(d) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(e) This SECTION expires December 31, 2013.

SECTION 60. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(c) The office shall report to the commission during the 2007 interim, updating the commission on the status of the development and implementation of the Indiana check-up plan established by IC 12-15-44-3, as added by this act.

(d) The commission shall, during the 2007 interim of the general assembly, study the following:

(1) Whether the acute care hospital in Gary, Indiana, should be converted from a private corporation to a county hospital, a municipal hospital, or other governmental hospital. In considering whether a conversion should occur, the commission shall consider the following:

(A) Whether the conversion would result in better quality care that would be sufficient to meet the needs of the community.

(B) Whether the hospital's finances would be improved.

(C) The legal requirements to convert the hospital.

(2) Ways in which the state and other entities can encourage physicians to practice in rural and county hospitals.

(3) The manner in which a not-for-profit hospital can be converted into a county or municipal hospital.

(4) Federal guidelines concerning county hospitals and intergovernmental transfers.

(5) A prohibition against smoking in public places in Indiana.

(6) Mechanisms for providing programs to provide health care coverage for uninsured individuals in Indiana.

(7) Review of the use of sources of funding for Medicaid reimbursement and implications for the uses of the funding sources.

(e) This SECTION expires December 31, 2008.

SECTION 61. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

(b) The commissioner of the department of insurance and the office of the secretary of family and social services may implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION.

SECTION 62. [EFFECTIVE JULY 1, 2007] (a) There is annually transferred from the state general fund to the Indiana tobacco use prevention and cessation trust fund established by IC 4-12-4-10 one million two hundred thousand dollars (\$1,200,000) on a schedule determined by the office of management and budget. The transfer shall be treated as part of the amount described in IC 6-7-1-28.1(7), as added by this act. There is annually appropriated to the Indiana tobacco use prevention and cessation executive board one million two hundred thousand dollars (\$1,200,000) from the state general fund for the purpose of tobacco education, prevention, and use control. The appropriation under this subsection is in addition to any other appropriation made by the general assembly to the Indiana tobacco use prevention and cessation executive board.

(b) There is appropriated from the Indiana check-up plan trust fund established by IC 12-15-44-17, as added by this act, for the period beginning July 1, 2007, and ending June 30, 2008, eleven million dollars (\$11,000,000) to the state department of health for use in childhood immunization programs. On June 30, 2008, the state department shall transfer to the Indiana check-up plan trust fund any unexpended funds appropriated to the state department under this subsection.

(c) There is appropriated from the Indiana check-up plan trust fund established by IC 12-15-44-17, as added by this act, for the period beginning July 1, 2008, and ending June 30, 2009, eleven million dollars (\$11,000,000) to the state department of health for use in childhood immunization programs. On June 30, 2009, the state department shall transfer to the Indiana check-up plan trust fund any unexpended funds appropriated to the state department under this subsection.

(d) The money in the Indiana check-up plan trust fund established by IC 12-15-44-17, as added by this act, is appropriated to the office of the secretary of family and social services for the

period beginning July 1, 2007, and ending June 30, 2009, for the purposes of the fund.

SECTION 63. An emergency is declared for this act.

P.L.219-2007

[S.287. Approved May 11, 2007.]

AN ACT to amend the Indiana Code concerning taxation.

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

SECTION 1. IC 3-8-1-23 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2008]: Sec. 23. **(a) Subject to subsection (b),** a candidate for the office of county assessor must:

- (1) have resided in the county for at least one (1) year before the election, as provided in Article 6, Section 4 of the Constitution of the State of Indiana; and
- (2) own real property located in the county upon taking office.

(b) A candidate for the office of county assessor who runs in an election after June 30, 2008, must have attained the certification of a level two assessor-appraiser under IC 6-1.1-35.5.

SECTION 2. IC 3-8-1-23.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2008]: Sec. 23.5. **(a) A person who runs in an election after June 30, 2008, for the office of township assessor under IC 36-6-5-1 must have attained the certification of a level two assessor-appraiser under IC 6-1.1-35.5 before taking office.**

(b) A person who runs in an election after June 30, 2008, for the office of township trustee who performs all the duties and has all the rights and powers of a township assessor under IC 36-6-5-1 must have attained the certification of a level two assessor-appraiser under IC 6-1.1-35.5 before taking office to qualify to perform those duties and to assume those rights and