
SENATE BILL No. 338

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-10-2.1; IC 27-8-10-4.

Synopsis: ICHIA expenses and assessments. Limits the annual total assessment to members of the comprehensive health insurance association to \$100,000,000. Provides for assessment of an annual net loss of more than \$100,000,000 to the state general fund. Limits payments under an association policy to \$1,000,000 during an insured's lifetime.

Effective: July 1, 2003.

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January 15, 2003, read first time and referred to Committee on Finance.

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First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

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SENATE BILL No. 338



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

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

1 SECTION 1. IC 27-8-10-2.1, AS AMENDED BY P.L.192-2002(ss),
2 SECTION 169, IS AMENDED TO READ AS FOLLOWS
3 [EFFECTIVE JULY 1, 2003]: Sec. 2.1. (a) There is established a
4 nonprofit legal entity to be referred to as the Indiana comprehensive
5 health insurance association, which must assure that health insurance
6 is made available throughout the year to each eligible Indiana resident
7 applying to the association for coverage. All carriers, health
8 maintenance organizations, limited service health maintenance
9 organizations, and self-insurers providing health insurance or health
10 care services in Indiana must be members of the association. The
11 association shall operate under a plan of operation established and
12 approved under subsection (c) and shall exercise its powers through a
13 board of directors established under this section.

14 (b) The board of directors of the association consists of seven (7)
15 members whose principal residence is in Indiana selected as follows:

16 (1) Three (3) members to be appointed by the commissioner from
17 the members of the association, one (1) of which must be a



1 representative of a health maintenance organization.

2 (2) Two (2) members to be appointed by the commissioner shall
3 be consumers representing policyholders.

4 (3) Two (2) members shall be the ~~state~~ budget director or
5 designee and the commissioner of the department of insurance or
6 designee.

7 The commissioner shall appoint the chairman of the board, and the
8 board shall elect a secretary from its membership. The term of office
9 of each appointed member is three (3) years, subject to eligibility for
10 reappointment. Members of the board who are not state employees may
11 be reimbursed from the association's funds for expenses incurred in
12 attending meetings. The board shall meet at least semiannually, with
13 the first meeting to be held not later than May 15 of each year.

14 (c) The association shall submit to the commissioner a plan of
15 operation for the association and any amendments to the plan necessary
16 or suitable to assure the fair, reasonable, and equitable administration
17 of the association. The plan of operation becomes effective upon
18 approval in writing by the commissioner consistent with the date on
19 which the coverage under this chapter must be made available. The
20 commissioner shall, after notice and hearing, approve the plan of
21 operation if the plan is determined to be suitable to assure the fair,
22 reasonable, and equitable administration of the association and
23 provides for the sharing of association losses on an equitable,
24 proportionate basis among the member carriers, health maintenance
25 organizations, limited service health maintenance organizations, and
26 self-insurers. If the association fails to submit a suitable plan of
27 operation within one hundred eighty (180) days after the appointment
28 of the board of directors, or at any time thereafter the association fails
29 to submit suitable amendments to the plan, the commissioner shall
30 adopt rules under IC 4-22-2 necessary or advisable to implement this
31 section. These rules are effective until modified by the commissioner
32 or superseded by a plan submitted by the association and approved by
33 the commissioner. The plan of operation must:

34 (1) establish procedures for the handling and accounting of assets
35 and money of the association;

36 (2) establish the amount and method of reimbursing members of
37 the board;

38 (3) establish regular times and places for meetings of the board of
39 directors;

40 (4) establish procedures for records to be kept of all financial
41 transactions, and for the annual fiscal reporting to the
42 commissioner;

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1 (5) establish procedures whereby selections for the board of
 2 directors will be made and submitted to the commissioner for
 3 approval;

4 (6) contain additional provisions necessary or proper for the
 5 execution of the powers and duties of the association; and

6 (7) establish procedures for the periodic advertising of the general
 7 availability of the health insurance coverages from the
 8 association.

9 (d) The plan of operation may provide that any of the powers and
 10 duties of the association be delegated to a person who will perform
 11 functions similar to those of this association. A delegation under this
 12 section takes effect only with the approval of both the board of
 13 directors and the commissioner. The commissioner may not approve a
 14 delegation unless the protections afforded to the insured are
 15 substantially equivalent to or greater than those provided under this
 16 chapter.

17 (e) The association has the general powers and authority enumerated
 18 by this subsection in accordance with the plan of operation approved
 19 by the commissioner under subsection (c). The association has the
 20 general powers and authority granted under the laws of Indiana to
 21 carriers licensed to transact the kinds of health care services or health
 22 insurance described in section 1 of this chapter and also has the
 23 specific authority to do the following:

24 (1) Enter into contracts as are necessary or proper to carry out this
 25 chapter, subject to the approval of the commissioner.

26 (2) Sue or be sued, including taking any legal actions necessary
 27 or proper for recovery of any assessments for, on behalf of, or
 28 against participating carriers.

29 (3) Take legal action necessary to avoid the payment of improper
 30 claims against the association or the coverage provided by or
 31 through the association.

32 (4) Establish a medical review committee to determine the
 33 reasonably appropriate level and extent of health care services in
 34 each instance.

35 (5) Establish appropriate rates, scales of rates, rate classifications
 36 and rating adjustments, such rates not to be unreasonable in
 37 relation to the coverage provided and the reasonable operational
 38 expenses of the association.

39 (6) Pool risks among members.

40 (7) Issue policies of insurance on an indemnity or provision of
 41 service basis providing the coverage required by this chapter.

42 (8) Administer separate pools, separate accounts, or other plans

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- 1 or arrangements considered appropriate for separate members or
 2 groups of members.
- 3 (9) Operate and administer any combination of plans, pools, or
 4 other mechanisms considered appropriate to best accomplish the
 5 fair and equitable operation of the association.
- 6 (10) Appoint from among members appropriate legal, actuarial,
 7 and other committees as necessary to provide technical assistance
 8 in the operation of the association, policy and other contract
 9 design, and any other function within the authority of the
 10 association.
- 11 (11) Hire an independent consultant.
- 12 (12) Develop a method of advising applicants of the availability
 13 of other coverages outside the association and may promulgate a
 14 list of health conditions the existence of which would deem an
 15 applicant eligible without demonstrating a rejection of coverage
 16 by one (1) carrier.
- 17 (13) Provide for the use of managed care plans for insureds,
 18 including the use of:
- 19 (A) health maintenance organizations; and
 20 (B) preferred provider plans.
- 21 (14) Solicit bids directly from providers for coverage under this
 22 chapter.
- 23 (f) Rates for coverages issued by the association may not be
 24 unreasonable in relation to the benefits provided, the risk experience,
 25 and the reasonable expenses of providing the coverage. Separate scales
 26 of premium rates based on age apply for individual risks. Premium
 27 rates must take into consideration the extra morbidity and
 28 administration expenses, if any, for risks insured in the association. The
 29 rates for a given classification may not be more than one hundred fifty
 30 percent (150%) of the average premium rate for that class charged by
 31 the five (5) carriers with the largest premium volume in the state during
 32 the preceding calendar year. In determining the average rate of the five
 33 (5) largest carriers, the rates charged by the carriers shall be actuarially
 34 adjusted to determine the rate that would have been charged for
 35 benefits identical to those issued by the association. All rates adopted
 36 by the association must be submitted to the commissioner for approval.
- 37 (g) Following the close of the association's fiscal year, the
 38 association shall determine the net premiums, the expenses of
 39 administration, and the incurred losses for the year. **The amount of any**
 40 **net loss that does not exceed one hundred million dollars**
 41 **(\$100,000,000)** shall be assessed by the association to all members in
 42 proportion to their respective shares of total health insurance

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1 premiums, excluding premiums for Medicaid contracts with the state
 2 of Indiana, received in Indiana during the calendar year (or with paid
 3 losses in the year) coinciding with or ending during the fiscal year of
 4 the association or any other equitable basis as may be provided in the
 5 plan of operation. For self-insurers, health maintenance organizations,
 6 and limited service health maintenance organizations that are members
 7 of the association, the proportionate share of losses must be determined
 8 through the application of an equitable formula based upon claims
 9 paid, excluding claims for Medicaid contracts with the state of Indiana,
 10 or the value of services provided. In sharing losses, the association may
 11 abate or defer in any part the assessment of a member, if, in the opinion
 12 of the board, payment of the assessment would endanger the ability of
 13 the member to fulfill its contractual obligations. The association may
 14 also provide for interim assessments against members of the
 15 association if necessary to assure the financial capability of the
 16 association to meet the incurred or estimated claims expenses or
 17 operating expenses of the association until the association's next fiscal
 18 year is completed. Net gains, if any, must be held at interest to offset
 19 future losses or allocated to reduce future premiums. Assessments must
 20 be determined by the board members specified in subsection (b)(1),
 21 subject to final approval by the commissioner. **The amount of a net
 22 loss that exceeds one hundred million dollars (\$100,000,000) shall
 23 be assessed to and paid from the state general fund.**

24 (h) The association shall conduct periodic audits to assure the
 25 general accuracy of the financial data submitted to the association, and
 26 the association shall have an annual audit of its operations by an
 27 independent certified public accountant.

28 (i) The association is subject to examination by the department of
 29 insurance under IC 27-1-3.1. The board of directors shall submit, not
 30 later than March 30 of each year, a financial report for the preceding
 31 calendar year in a form approved by the commissioner.

32 (j) All policy forms issued by the association must conform in
 33 substance to prototype forms developed by the association, must in all
 34 other respects conform to the requirements of this chapter, and must be
 35 filed with and approved by the commissioner before their use.

36 (k) The association may not issue an association policy to any
 37 individual who, on the effective date of the coverage applied for, does
 38 not meet the eligibility requirements of section 5.1 of this chapter.

39 (l) The association shall pay an agent's referral fee of twenty-five
 40 dollars (\$25) to each insurance agent who refers an applicant to the
 41 association if that applicant is accepted.

42 (m) The association and the premium collected by the association

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1 shall be exempt from the premium tax, the adjusted gross income tax,
 2 or any combination of these upon revenues or income that may be
 3 imposed by the state.

4 (n) Members who after July 1, 1983, during any calendar year, have
 5 paid one (1) or more assessments levied under this chapter may either:

6 (1) take a credit against premium taxes, adjusted gross income
 7 taxes, or any combination of these, or similar taxes upon revenues
 8 or income of member insurers that may be imposed by the state,
 9 up to the amount of the taxes due for each calendar year in which
 10 the assessments were paid and for succeeding years until the
 11 aggregate of those assessments have been offset by either credits
 12 against those taxes or refunds from the association; or

13 (2) any member insurer may include in the rates for premiums
 14 charged for insurance policies to which this chapter applies
 15 amounts sufficient to recoup a sum equal to the amounts paid to
 16 the association by the member less any amounts returned to the
 17 member insurer by the association, and the rates shall not be
 18 deemed excessive by virtue of including an amount reasonably
 19 calculated to recoup assessments paid by the member.

20 (o) The association shall provide for the option of monthly
 21 collection of premiums.

22 SECTION 2. IC 27-8-10-4 IS AMENDED TO READ AS
 23 FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 4. (a) Subject to the
 24 limitation provided in subsection (c), an association policy offered in
 25 accordance with this chapter must impose a five hundred dollar (\$500)
 26 deductible on a per person per policy year basis. The deductible must
 27 be applied to the first five hundred dollars (\$500) of eligible expenses
 28 incurred by the covered person.

29 (b) Subject to the limitation provided in subsection (c), a mandatory
 30 coinsurance requirement shall be imposed at the rate of twenty percent
 31 (20%) of eligible expenses in excess of the mandatory deductible.

32 (c) The maximum aggregate out-of-pocket payments for eligible
 33 expenses by the insured in the form of deductibles and coinsurance
 34 may not exceed one thousand five hundred dollars (\$1,500) per
 35 individual or two thousand five hundred dollars (\$2,500) per family,
 36 per policy year.

37 **(d) The maximum amount that may be paid under an**
 38 **association policy for eligible expenses of an insured during the**
 39 **insured's lifetime may not exceed one million dollars (\$1,000,000).**
 40 **This subsection applies to payment for eligible expenses incurred**
 41 **after June 30, 2003.**

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