

SENATE BILL No. 107

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-10.

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

Effective: July 1, 2004.

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January 6, 2004, read first time and referred to Committee on Finance.

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Second Regular Session 113th General Assembly (2004)

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 2003 Regular Session of the General Assembly.

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SENATE BILL No. 107



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.178-2003,
2 SECTION 63, AND AS AMENDED BY P.L.193-2003, SECTION 4,
3 IS CORRECTED AND AMENDED TO READ AS FOLLOWS
4 [EFFECTIVE JULY 1, 2004]: Sec. 2.1. (a) There is established a
5 nonprofit legal entity to be referred to as the Indiana comprehensive
6 health insurance association, which must assure that health insurance
7 is made available throughout the year to each eligible Indiana resident
8 applying to the association for coverage. All carriers, health
9 maintenance organizations, limited service health maintenance
10 organizations, and self-insurers providing health insurance or health
11 care services in Indiana must be members of the association. The
12 association shall operate under a plan of operation established and
13 approved under subsection (c) and shall exercise its powers through a
14 board of directors established under this section.

15 (b) The board of directors of the association consists of ~~seven (7)~~
16 *nine (9)* members whose principal residence is in Indiana selected as
17 follows:



- 1 (1) ~~Three (3)~~ Four (4) members to be appointed by the
- 2 commissioner from the members of the association, one (1) of
- 3 which must be a representative of a health maintenance
- 4 organization.
- 5 (2) Two (2) members to be appointed by the commissioner shall
- 6 be consumers representing policyholders.
- 7 (3) Two (2) members shall be the state budget director or
- 8 designee and the commissioner of the department of insurance or
- 9 designee.
- 10 (4) *One (1) member to be appointed by the commissioner must be*
- 11 *a representative of health care providers.*

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

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

- 39 (1) establish procedures for the handling and accounting of assets
- 40 and money of the association;
- 41 (2) establish the amount and method of reimbursing members of
- 42 the board;

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- 1 (3) establish regular times and places for meetings of the board of
- 2 directors;
- 3 (4) establish procedures for records to be kept of all financial
- 4 transactions, and for the annual fiscal reporting to the
- 5 commissioner;
- 6 (5) establish procedures whereby selections for the board of
- 7 directors will be made and submitted to the commissioner for
- 8 approval;
- 9 (6) contain additional provisions necessary or proper for the
- 10 execution of the powers and duties of the association; and
- 11 (7) establish procedures for the periodic advertising of the general
- 12 availability of the health insurance coverages from the
- 13 association.

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

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

- 29 (1) Enter into contracts as are necessary or proper to carry out this
- 30 chapter, subject to the approval of the commissioner.
- 31 (2) Sue or be sued, including taking any legal actions necessary
- 32 or proper for recovery of any assessments for, on behalf of, or
- 33 against participating carriers.
- 34 (3) Take legal action necessary to avoid the payment of improper
- 35 claims against the association or the coverage provided by or
- 36 through the association.
- 37 (4) Establish a medical review committee to determine the
- 38 reasonably appropriate level and extent of health care services in
- 39 each instance.
- 40 (5) Establish appropriate rates, scales of rates, rate classifications
- 41 and rating adjustments, such rates not to be unreasonable in
- 42 relation to the coverage provided and the reasonable operational

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- 1 expenses of the association.
- 2 (6) Pool risks among members.
- 3 (7) Issue policies of insurance on an indemnity or provision of
- 4 service basis providing the coverage required by this chapter.
- 5 (8) Administer separate pools, separate accounts, or other plans
- 6 or arrangements considered appropriate for separate members or
- 7 groups of members.
- 8 (9) Operate and administer any combination of plans, pools, or
- 9 other mechanisms considered appropriate to best accomplish the
- 10 fair and equitable operation of the association.
- 11 (10) Appoint from among members appropriate legal, actuarial,
- 12 and other committees as necessary to provide technical assistance
- 13 in the operation of the association, policy and other contract
- 14 design, and any other function within the authority of the
- 15 association.
- 16 (11) Hire an independent consultant.
- 17 (12) Develop a method of advising applicants of the availability
- 18 of other coverages outside the association. *and may promulgate*
- 19 *a list of health conditions the existence of which would deem an*
- 20 *applicant eligible without demonstrating a rejection of coverage*
- 21 *by one (1) carrier.*
- 22 (13) Provide for the use of managed care plans for insureds,
- 23 including the use of:
- 24 (A) health maintenance organizations; and
- 25 (B) preferred provider plans.
- 26 (14) Solicit bids directly from providers for coverage under this
- 27 chapter.
- 28 (f) *The board shall obtain an actuarial recommendation for*
- 29 *development of an equitable methodology for determination of member*
- 30 *assessments.*
- 31 (g) Rates for coverages issued by the association may not be
- 32 unreasonable in relation to the benefits provided, the risk experience,
- 33 and the reasonable expenses of providing the coverage. Separate scales
- 34 of premium rates based on age apply for individual risks. Premium
- 35 rates must take into consideration the extra morbidity and
- 36 administration expenses, if any, for risks insured in the association. The
- 37 rates for a given classification may *not* be:
- 38 (1) *not* more than one hundred fifty percent (150%) of the average
- 39 premium rate for that class charged by the five (5) carriers with
- 40 the largest premium volume in the state during the preceding
- 41 calendar year *for an insured whose family income is less than*
- 42 *three hundred fifty-one percent (351%) of the federal income*

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1 *poverty level for the same size family; and*
 2 *(2) an amount equal to:*
 3 *(A) not less than one hundred fifty-one percent (151%); and*
 4 *(B) not more than two hundred percent (200%);*
 5 *of the average premium rate for that class charged by the five (5)*
 6 *carriers with the largest premium volume in the state during the*
 7 *preceding calendar year, for an insured whose family income is*
 8 *more than three hundred fifty percent (350%) of the federal*
 9 *income poverty level for the same size family.*

10 In determining the average rate of the five (5) largest carriers, the rates
 11 charged by the carriers shall be actuarially adjusted to determine the
 12 rate that would have been charged for benefits identical to those issued
 13 by the association. All rates adopted by the association must be
 14 submitted to the commissioner for approval.

15 ~~(g)~~ (h) Following the close of the association's fiscal year, the
 16 association shall determine the net premiums, the expenses of
 17 administration, and the incurred losses for the year. **The amount of any**
 18 **net loss that does not exceed one hundred million dollars**
 19 **(\$100,000,000)** shall be assessed by the association to all members in
 20 proportion to their respective shares of total health insurance
 21 premiums, excluding premiums for Medicaid contracts with the state
 22 of Indiana, received in Indiana during the calendar year (or with paid
 23 losses in the year) coinciding with or ending during the fiscal year of
 24 the association or any other equitable basis as may be provided in the
 25 plan of operation. *For self-insurers, health maintenance organizations,*
 26 *and limited service health maintenance organizations that are*
 27 *members of the association, the proportionate share of losses must be*
 28 *determined through the application of an equitable formula based*
 29 *upon claims paid, excluding claims for Medicaid contracts with the*
 30 *state of Indiana, or the value of services provided.* In sharing losses,
 31 the association may abate or defer in any part the assessment of a
 32 member, if, in the opinion of the board, payment of the assessment
 33 would endanger the ability of the member to fulfill its contractual
 34 obligations. The association may also provide for interim assessments
 35 against members of the association if necessary to assure the financial
 36 capability of the association to meet the incurred or estimated claims
 37 expenses or operating expenses of the association until the association's
 38 next fiscal year is completed. *Except as provided in sections 12 and 13*
 39 *of this chapter, net gains, if any, must be held at interest to offset future*
 40 *losses or allocated to reduce future premiums. Assessments must be*
 41 *determined by the board members specified in subsection (b)(1),*
 42 *subject to final approval by the commissioner. **The amount of a net***

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1 **loss that exceeds one hundred million dollars (\$100,000,000) shall**
 2 **be assessed to and paid from the state general fund.**
 3 ~~(i)~~ (i) The association shall conduct periodic audits to assure the
 4 general accuracy of the financial data submitted to the association, and
 5 the association shall have an annual audit of its operations by an
 6 independent certified public accountant.
 7 ~~(j)~~ (j) The association is subject to examination by the department
 8 of insurance under IC 27-1-3.1. The board of directors shall submit, not
 9 later than March 30 of each year, a financial report for the preceding
 10 calendar year in a form approved by the commissioner.
 11 ~~(k)~~ (k) All policy forms issued by the association must conform in
 12 substance to prototype forms developed by the association, must in all
 13 other respects conform to the requirements of this chapter, and must be
 14 filed with and approved by the commissioner before their use.
 15 ~~(l)~~ (l) The association may not issue an association policy to any
 16 individual who, on the effective date of the coverage applied for, does
 17 not meet the eligibility requirements of section 5.1 of this chapter.
 18 ~~(l) The association shall pay an agent's insurance producer's~~
 19 ~~referral fee of twenty-five dollars (\$25) to each insurance agent~~
 20 ~~producer who refers an applicant to the association if that applicant~~
 21 ~~is accepted.~~
 22 (m) The association and the premium collected by the association
 23 shall be exempt from the premium tax, the adjusted gross income tax,
 24 or any combination of these upon revenues or income that may be
 25 imposed by the state.
 26 (n) Members who after July 1, 1983, during any calendar year, have
 27 paid one (1) or more assessments levied under this chapter may either:
 28 (1) take a credit against premium taxes, adjusted gross income
 29 taxes, or any combination of these, or similar taxes upon revenues
 30 or income of member insurers that may be imposed by the state,
 31 up to the amount of the taxes due for each calendar year in which
 32 the assessments were paid and for succeeding years until the
 33 aggregate of those assessments have been offset by either credits
 34 against those taxes or refunds from the association; or
 35 (2) any member insurer may include in the rates for premiums
 36 charged for insurance policies to which this chapter applies
 37 amounts sufficient to recoup a sum equal to the amounts paid to
 38 the association by the member less any amounts returned to the
 39 member insurer by the association, and the rates shall not be
 40 deemed excessive by virtue of including an amount reasonably
 41 calculated to recoup assessments paid by the member.
 42 (o) The association shall provide for the option of monthly

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collection of premiums.

SECTION 2. IC 27-8-10-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 4. (a) Subject to the limitation provided in subsection (c), an association policy offered in accordance with this chapter must impose a five hundred dollar (\$500) deductible on a per person per policy year basis. The deductible must be applied to the first five hundred dollars (\$500) of eligible expenses incurred by the covered person.

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

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

(d) The maximum amount that may be paid under an association policy for eligible expenses of an insured during the insured's lifetime may not exceed one million dollars (\$1,000,000). This subsection applies to payment for eligible expenses incurred after June 30, 2004.

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