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STATE BOARD OF ACCOUNTS
302 WEST WASHINGTON STREET
ROOM E418
INDIANAPOLIS, INDIANA 46204-2765

Telephone: (317) 232-2513
Fax: (317) 232-4711
Web Site: www.in.gov/sboa

July 18, 2013

D. Douglas Stratton, Executive Director
Indiana Comprehensive Health Insurance Association
9465 Counselors Row, Suite 200
Indianapolis, IN 46240

Dear Mr. Stratton:

We have received the audit report prepared by Katz, Sapper & Miller, LLP, Independent Public Accountants, for the period January 1, 2012 to December 31, 2012. Per the auditors' opinion, the audit was conducted in accordance with auditing standards generally accepted in the United States of America and the financial statements included in the report present fairly the financial condition of the Indiana Comprehensive Health Insurance Association as of December 31, 2012, and the results of its operations for the period then ended, on the basis of accounting described in the report.

The Independent Public Accountants' report is filed with this letter in our office as a public record.

STATE BOARD OF ACCOUNTS

FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITORS' REPORT

December 31, 2012 and 2011

KSM KATZ SAPPER & MILLER

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INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

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Independent Auditors' Report

Board of Directors
Indiana Comprehensive Health Insurance Association

Report on the Financial Statements

We have audited the accompanying financial statements of Indiana Comprehensive Health Insurance Association (the Association), which comprise the statements of net position as of December 31, 2012 and 2011, and the related statements of revenue, expenses and change in net position and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Katz, Sapper & Miller, LLP
Certified Public Accountants

800 East 96th Street, Suite 500
Indianapolis, IN 46240

Tel 317.580.2000
Web ksmcpa.com

An Affiliate of
KSM Business Services, Inc.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Indiana Comprehensive Health Insurance Association as of December 31, 2012 and 2011, and its revenue, expenses, and changes in net position, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States.

Termination of Association

As discussed in Note 1 to the financial statements, due to the Affordable Care Act provisions related to the implementation of an Exchange being found to be enforceable, the Association program will no longer be needed and it will terminate effective the latter of December 31, 2013, at midnight or the date the federal health insurance exchange is operational in Indiana. Our opinion is not modified with respect to this matter.

Report on Required Supplementary Information

Accounting principles generally accepted in the United States require that the management's discussion and analysis on pages 4 and 5 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Report on Other Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The schedule of expenditures of federal awards, as required by Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated June 18, 2013 on our consideration of Indiana Comprehensive Health Insurance Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Indiana Comprehensive Health Insurance Association's internal control over financial reporting and compliance.

Katz, Sapper & Miller, LLP

Indianapolis, Indiana
June 18, 2013

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

Management's Discussion and Analysis (Unaudited)
December 31, 2012 and 2011

Introduction

The Management's Discussion and Analysis (MD&A) of Indiana Comprehensive Health Insurance Association's (the Association) financial performance provides an overall view of the entity's activities for the fiscal years ended December 31, 2012 and 2011. The intent of this discussion and analysis is to look at the Association's financial performance as a whole. Readers should also review the financial statements and notes to the financial statements to enhance their understanding of the Association's financial performance.

The MD&A is an element of the reporting model adopted by the Governmental Accounting Standards Board (GASB). The Association began presenting its financial statements on a GASB basis in 2005.

Financial Statements

The Statement of Net Position presents the Association's assets, liabilities and net position as of the Association's year end. Net position reflects the Association's overall financial position, represents total assets less liabilities of the Association, and is generally an accumulation of the excess or deficit from operations. The Statement of Revenue, Expenses and Changes in Net Position presents the results of the Association's operating and non-operating revenues and expenses for the year.

Total assets at December 31, 2012 decreased 10% from 2011 and are comprised of cash and equivalents and premium, grant, assessment, and administrative services receivables. Total liabilities increased 9% from 2011, and is primarily comprised of unearned premiums.

Membership, representing eligible persons covered, has decreased 3%, or 210 members, during 2012, compared to an increase during 2011 of 1% or 76 members.

Cash and cash equivalents, representing 36% of total assets at December 31, 2012, has decreased $6 million during the year. Premiums, assessments and grant proceeds collected and investment earnings totaled $143 million, compared to benefits and administrative expenses paid of $149 million.

Premiums receivable, representing amounts due from insureds but not yet collected, increased 174% at December 31, 2012 compared to December 31, 2011. Increase is due to timing of premium payment from the Indiana State Department of Health.

A receivable was recorded for approximately $125,000 at December 31, 2012 for a payment due from a third party administrator due to fraudulent activity by their personnel. The fraud was discovered by the third party administrator and they have put additional controls into place to help prevent similar fraudulent activity.

The liability for unpaid claims and claims adjustment expenses represents claims incurred by covered members prior to December 31, 2012 but not yet reported or paid, and represents 57% of total liabilities at December 31, 2012.

Unearned premiums represent premiums billed and collected, but not yet earned. The balance at December 31, 2012 decreased 2% compared to the December 31, 2011 balance.

Accrued expenses and other liabilities represent primarily unpaid expenses of the Association and are a function of the timing of payments.

Financial Statements (Continued)

Unrestricted net position represents the accumulation of operating revenue (primarily premiums earned), member assessments and investment income less operating expenses. During 2012, the change in net position was a decrease of $4.1 million, compared to an increase in 2011 of $747 thousand. Restricted net position represents the balance of grant funds received that have not yet been expended for the purpose outlined in the grant agreement.

Premiums earned increased 7% in 2012, or $4.5 million, over the 2011 amount, largely as a result of a 2012 premium increase during the year.

The increase in policy benefits incurred of $14.4 million, or 11%, is largely attributable to increased utilization by the insureds, increased benefits offered, and rising health care costs.

Total operating expenses increased 10% in 2012 from 2011, primarily due to the items noted in the previous paragraph. Other general and administrative operating expenses increased approximately $243,000. The increase is due to bonus grant expenses and when these expenses are removed for 2012 and 2011, the other general and administrative expenses are flat between the two years.

Plan administrative fees are based on a per-member-per-month fixed rate plus other actual expenses incurred. The decrease in membership noted during 2012 resulted in a decrease in the plan administrative fees of approximately $52,000, or 1%, over the 2011 amount.

The Association recognized operating grant revenue in 2012 of $1 million, to be used to offset operating losses, and bonus grant revenue of $1 million, to be used to subsidize premiums to low income insureds and assist with a disease management program from the Center for Medicare and Medicaid Services.

Due to the Affordable Care Act provisions related to the implementation of an Exchange being found to be enforceable, the Association program will no longer be needed and it will terminate effective the latter of December 31, 2013, at midnight or the date the federal health insurance exchange is operational in Indiana. A plan of transition and a transition team has been put into place and is being monitored by the Association. After the termination date, certain administrative functions of the Association will continue for six months.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

STATEMENTS OF NET POSITION
December 31, 2012 and 2011

	2012	2011
ASSETS		
Cash and equivalents	$ 4,759,722	$ 10,808,070
Premiums receivable	7,562,610	2,763,956
Grant receivable	400,000	1,244,025
Assessments receivable	446,077	27,821
Administrative services receivable	125,342	
TOTAL ASSETS	$ 13,293,751	$ 14,843,872
LIABILITIES		
Unpaid claims and claims adjustment expenses	$ 18,485,563	$ 18,735,860
Unearned premiums	13,068,855	10,583,116
Accrued expenses	734,356	385,610
Other liabilities	278,645	268,135
Total Liabilities	32,567,419	29,972,721
NET POSITION		
Unrestricted	(19,889,923)	(15,320,580)
Restricted	616,255	191,731
Total Net Position	(19,273,668)	(15,128,849)
TOTAL LIABILITIES AND NET POSITION	$ 13,293,751	$ 14,843,872

See accompanying notes.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

STATEMENTS OF REVENUE, EXPENSES AND CHANGE IN NET POSITION
Years Ended December 31, 2012 and 2011

	2012	2011
OPERATING REVENUE		
Premiums earned	$ 68,715,741	$ 64,207,997
OPERATING EXPENSES		
Claims incurred	143,913,446	129,559,528
Plan administration fees	4,225,333	4,276,963
Other general and administrative	628,631	385,156
Total Operating Expenses	148,767,410	134,221,647
Operating Loss	(80,051,669)	(70,013,650)
NONOPERATING REVENUES (EXPENSES)		
Grants	2,064,614	1,896,103
Investment income	9,670	1,452
Other expenses	(159,922)	(143,457)
Total Nonoperating Revenues (Expenses)	1,914,362	1,754,098
Loss before Assessments	(78,137,307)	(68,259,552)
MEMBER ASSESSMENTS	73,992,488	69,006,546
CHANGE IN NET POSITION	(4,144,819)	746,994
NET POSITION		
Beginning of Year	(15,128,849)	(15,875,843)
End of Year	$ (19,273,668)	$ (15,128,849)

See accompanying notes.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

STATEMENTS OF CASH FLOWS
Years Ended December 31, 2012 and 2011

	2012	2011
OPERATING ACTIVITIES		
Premiums collected	$ 66,402,826	$ 65,539,460
Claims and claims adjustment expenses paid	(144,289,085)	(128,588,695)
General and administrative expenses paid	(4,494,708)	(5,041,303)
Net Cash Used by Operating Activities	(82,380,967)	(68,090,538)
FINANCING ACTIVITIES		
Assessments collected	73,574,232	71,095,400
Investment earnings	9,670	1,452
Other expenses	(159,922)	(143,457)
Grants received	2,908,639	652,078
Net Cash Provided by Financing Activities	76,332,619	71,605,473
NET INCREASE (DECREASE) IN CASH AND EQUIVALENTS	(6,048,348)	3,514,935
CASH AND EQUIVALENTS		
Beginning of Year	10,808,070	7,293,135
End of Year	$ 4,759,722	$ 10,808,070
RECONCILIATION OF OPERATING LOSS TO NET CASH USED BY OPERATING ACTIVITIES		
Operating loss	$ (80,051,669)	$ (70,013,650)
Changes in assets and liabilities		
Premiums receivable	(4,798,654)	(440,178)
Administrative services receivable	(125,342)	
Unpaid claims and claims adjustment expenses	(250,297)	970,833
Unearned premiums	2,485,739	1,771,641
Accrued expenses	348,746	10,110
Other liabilities	10,510	(389,294)
Net Cash Used by Operating Activities	$ (82,380,967)	$ (68,090,538)

See accompanying notes.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

NOTES TO FINANCIAL STATEMENTS
December 31, 2012 and 2011

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Indiana Comprehensive Health Insurance Association (the Association), a nonprofit legal entity, was established by the State of Indiana to assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the Association for coverage. At December 31, 2012 and 2011, the Association had 7,193 and 7,403 eligible persons covered, respectively.

All insurance carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the Association. A member shall comply with the Association's Plan of Operation, under Indiana Code 27-8-1 0-2.5 (a).

Due to the Affordable Care Act provisions related to the implementation of an Exchange being found to be enforceable, the Association program will no longer be needed and it will terminate effective the latter of December 31, 2013, at midnight or the date the federal health insurance exchange is operational in Indiana. A plan of transition and a transition team has been put into place and is being monitored by the Association. During 2013, the Association will continue to follow the normal assessment process as noted in Note 2. After the termination date, certain administrative functions of the Association will continue for six months and assessments may be completed during this time period to fulfill final obligations of the Association.

Basis of Presentation: The Association prepares its financial statements in accordance with Governmental Accounting Standards. As a proprietary fund, the Association's financial statements are reported using the accrual basis of accounting in conformity with accounting principles generally accepted in the United States. Revenues are recorded when earned, and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows.

The Association distinguishes operating revenues and expenses from nonoperating. Operating revenues and expenses generally result from providing services in connection with the Association's principal ongoing operations. The principal operating revenues and expenses of the Association relate to premium revenues, claims incurred and administrative expenses. Net investment earnings and grants are reported as nonoperating revenues.

Estimates: Management uses estimates and assumptions in preparing financial statements in accordance with accounting principles generally accepted in the United States. Those estimates and assumptions affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities and the reported amounts of revenues and expenses. Actual results could vary from those estimates.

Cash and Equivalents: All investments with a remaining maturity of three months or less at the date of acquisition are considered cash equivalents. Interest-bearing deposits at the Association’s financial institution are insured by the Federal Deposit Insurance Corporation up to $250,000 and noninterest-bearing deposits are insured on an unlimited basis through December 31, 2012. At December 31, 2012 and 2011, the Association’s uninsured cash and equivalents on deposit totaled $7,120,985 and $12,733,293, respectively. To date, there have been no losses in such accounts. Starting on January 1, 2013, interest-bearing and noninterest-bearing deposits are aggregated and the total amount insured by the Federal Deposit Insurance Corporation is $250,000.

Administrative Services Receivable: A receivable was recorded for approximately $125,000 at December 31, 2012 for a payment due from a third party administrator due to fraudulent activity by their personnel. The fraud was discovered by the third party administrator and they have put additional controls into place to help prevent similar fraudulent activity. The payment will be received by the Association during 2013.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Unpaid Claims and Claims Adjustment Expenses: The liability for unpaid claims and claims adjustment expenses is estimated based on historical claims development. Considerable variability is inherent in such estimates. However, management believes that the liability for unpaid claims and claims adjustment expenses is adequate. The estimates are continually reviewed and updated as experience develops or new information becomes known; such adjustments are reflected in current operations.

Income Taxes: The Association is exempt from federal income taxes under Section 501(c)(26) of the Internal Revenue Code. Therefore, no provision or liability for income taxes has been included in the financial statements. In addition, the Association has been determined by the Internal Revenue Service not to be a private foundation within the meaning of Section 509(a) of the Internal Revenue Code. There was no unrelated business income for the years ended December 31, 2012 and 2011.

The Association files U.S. federal and State of Indiana information tax returns. The Association is no longer subject to U.S. federal and state tax examinations by tax authorities for years before 2009.

Assessments: Member assessments are recorded upon approval of the Board of Directors and generally are made in two interim assessments during the year (January and July) based on projected losses and cash flow needs. Subsequent to December 31, a true-up of projected amounts compared to actual results is made and any excess loss is assessed, or if assessments have exceeded the actual losses, then members are allowed a credit against the next interim assessment. Also, uncollectable assessments are allocated to members as part of the true-up. True-up assessments are not recorded until approved by the Board of Directors.

Assessments receivable represent outstanding balances assessed to the member insurance carriers and the State of Indiana but not yet collected. Assessments are recognized as an increase to unrestricted net position.

Revenue Recognition: Premiums are earned pro rata over the policy periods to which the premiums relate. Unearned premiums include amounts billed and collected, but not yet earned.

Grant Revenue in the amount of $2,064,614 and $1,896,103 was recognized by the Association from the Center for Medicare and Medicaid services during the years ended December 31, 2012 and 2011, respectively. These grants were received for the operation of Qualified High Risk Pools, premium subsidies, and disease management. Unconditional promises to give are recognized as revenues or gains in the period received and as assets. Conditional promises to give are recognized when the conditions on which they depend are substantially met. When expenditures are incurred that meet the purpose of both unrestricted and restricted resources, the restricted resources are applied before unrestricted resources. Expenditures that are incurred for specific grant purposes, but are not yet reimbursed are included as grant receivable on the statements of net position.

Subsequent Events: The Association has evaluated the financial statements for subsequent events occurring through June 18, 2013, the date the financial statements were available to be issued.

NOTE 2 - ASSESSMENTS AND NET POSITION

The Association has the statutory authority to assess the member insurance carriers writing business in Indiana for 25% of its net loss, with the remaining 75% to be paid by the State of Indiana. The two assessments during the year are calculated based on projected losses and current cash flow needs of the Association. According to the statute, a true-up assessment is made in July of the following year for the difference between the net losses and actual assessments made during the year.

Subject to Board of Directors approval, the additional assessment to be applied and recorded in 2013 will be approximately $8.0 million and, if approved, will decrease the Association's net position by that amount. The remaining $11.4 million of the net position is due to assessment procedures in place prior to the current process.

The following table provides a reconciliation of the member assessments as reported on the statements of revenue, expenses, and change in net position for 2012 and 2011:

	2012	2011
Assessments – January	$35,300,000	$38,600,000
Assessments – July	35,000,000	26,000,000
Assessments - previous year true-up	3,692,488	4,406,546
Total Member Assessments	$73,992,488	$69,006,546

NOTE 3 - LIABILITY FOR UNPAID CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

The following table provides a reconciliation of the liability for unpaid claims and claims adjustment expenses for the years ended December 31, 2012 and 2011:

	2012	2011
Balance at Beginning of Year	$ 18,735,860	$ 17,765,027
Claims incurred related to:		
Current year	144,837,513	130,053,203
Prior year	(924,067)	(493,675)
Total claims incurred	143,913,446	129,559,528
Paid related to:		
Current year	126,516,331	111,384,960
Prior year	17,647,412	17,203,735
Total paid	144,163,743	128,588,695
Balance at End of Year	$ 18,485,563	$ 18,735,860

Claims incurred related to prior years vary from previously estimated liabilities, as the claims are ultimately settled. Negative amounts reported for incurred losses and loss adjustment expenses related to prior years are indicative of favorable development in the related prior year end liability.

NOTE 4 - CONTINGENCIES

In the normal course of operations, the Association is subject to various litigation, claims and assessments that it intends to defend. The range of loss from these claims and assessments cannot be reasonably estimated. However, management believes that the ultimate resolution of these matters will not have a material adverse effect on the Association's results of operation or financial position.

NOTE 5 - PLAN ADMINISTRATION AGREEMENT

The Association has outsourced its administrative services to Affiliated Computer Services, Inc. (ACS). Under the agreement, which expires in June 2014, ACS is compensated based on the number of eligible persons covered. Additional charges are described in the Administrative Services Agreement.

NOTE 6 - LINE OF CREDIT

The Association has a secured revolving line of credit agreement with Key Bank National Association, which provides for borrowings up to a maximum of $7,000,000, with interest computed at the Bank's prime lending rate. No borrowings were outstanding on the line of credit at December 31, 2012 and 2011. The line of credit is secured by assessments receivable.

OTHER REPORTS AND SCHEDULES

Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

Board of Directors
Indiana Comprehensive Health Insurance Association

We have audited, in accordance with the auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Indiana Comprehensive Health Insurance Association, which comprise the statement of net position as of December 31, 2012, and the related statements of revenue, expenses and change in net position and cash flows for the year then ended, and the related notes to the financial statements and have issued our report thereon dated June 18, 2013.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Indiana Comprehensive Health Insurance Association's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Indiana Comprehensive Health Insurance Association's internal control. Accordingly, we do not express an opinion on the effectiveness of Indiana Comprehensive Health Insurance Association's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Katz, Sapper & Miller, LLP
Certified Public Accountants

800 East 96th Street, Suite 500
Indianapolis, IN 46240

Tel 317.580.2000
Web ksmcpa.com

An Affiliate of
KSM Business Services, Inc.

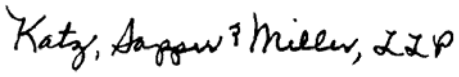
Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We did identify a certain deficiency in internal control, described in the accompanying schedule of findings and questioned costs as item 2012-1 that we consider to be a significant deficiency.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Indiana Comprehensive Health Insurance Association's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed an instance of noncompliance or another matter that is required to be reported under *Government Auditing Standards* and which is described in the accompanying schedule of findings and questioned costs as item 2012-1.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.



Indianapolis, Indiana
June 18, 2013

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
Year Ended December 31, 2012

	CFDA Number	Program or Award Amount	Revenue Recognized	Expenditures
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES				
Grants to States for Operation of Qualified High-Risk Pools	93.780	$ 19,232,503	$ 2,064,614	$ 1,640,090
TOTAL FEDERAL AWARDS			$ 2,064,614	$ 1,640,090

See accompanying notes to schedule of expenditures of federal awards.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
Year Ended December 31, 2012

NOTE 1 - BASIS OF PRESENTATION

The accompanying schedule of expenditures of federal awards includes the federal grant activity of Indiana Comprehensive Health Insurance Association under programs of the federal government for the year ended December 31, 2012. The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the basic financial statements.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in OMB Circular A-122, *Cost Principles for Non-profit Organizations*, wherein certain types of expenditures are not allowable or are limited as to reimbursement.

Revenue: Unconditional promises to give are recognized as revenues or gains in the period received and as assets. Conditional promises to give are recognized when the conditions on which they depend are substantially met.

Independent Auditors' Reports on Compliance
For Each Major Federal Program and on
Internal Control Over Compliance

Board of Directors
Indiana Comprehensive Health Insurance Association

Report on Compliance for Each Major Federal Program

We have audited Indiana Comprehensive Health Insurance Association's compliance with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on each of Indiana Comprehensive Health Insurance Association's major federal programs for the year ended December 31, 2012. Indiana Comprehensive Health Insurance Association's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of Indiana Comprehensive Health Insurance Association's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about Indiana Comprehensive Health Insurance Association's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of Indiana Comprehensive Health Insurance Association's compliance.

Katz, Sapper & Miller, LLP
Certified Public Accountants

800 East 96th Street, Suite 500
Indianapolis, IN 46240

Tel 317.580.2000
Web ksmcpa.com

An Affiliate of
KSM Business Services, Inc.

Opinion on Each Major Federal Program

In our opinion, Indiana Comprehensive Health Insurance Association complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2012.

Report on Internal Control Over Compliance

Management of Indiana Comprehensive Health Insurance Association is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered Indiana Comprehensive Health Insurance Association's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Indiana Comprehensive Health Insurance Association's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

Katz, Sapper & Miller, LLP

Indianapolis, Indiana
June 18, 2013

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
Year Ended December 31, 2012

Summary of Auditors' Results

Financial Statements

The type of auditors' report issued was unmodified.

Internal control over financial reporting:

- No material weaknesses were identified.
- A significant deficiency was reported that is not considered to be a material weakness.
- No noncompliance material to the financial statements was noted.

Federal Awards

Internal control over major programs:

- No material weaknesses were identified.
- No significant deficiencies were reported that were not considered to be material weaknesses.

The type of auditors' report issued on compliance for major programs was unmodified.

There were audit findings disclosed that are required to be reported in accordance with section 510(a) of OMB Circular A-133.

Identification of major programs:

CFDA Numbers	Name of Federal Program or Cluster
93.780	Grants to States for Operation of Qualified High-Risk Pools

The dollar threshold used to distinguish between type A and type B programs was $300,000.

The auditee did not qualify as low-risk auditee.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

SCHEDULE OF FINDINGS AND QUESTIONED COSTS (CONTINUED)
Year Ended December 31, 2012

Financial Statement Findings

2012-01: Override of Controls – Significant Deficiency in Internal Control over Financial Reporting

Criteria: Fraudulent activity should be prevented and detected by Indiana Comprehensive Health Insurance Association's internal controls.

Condition and Context: A third party administrator, that writes checks out of Indiana Comprehensive Health Insurance Association's bank account, discovered that one of their employees had obtained access to a signature stamp used to sign checks and used the stamp to sign Indiana Comprehensive Health Insurance Association checks that were made out to the employee. The fraudulent activity had been occurring since November 2011 and approximately $125,000 had been taken by the employee. The third party administrator will reimburse Indiana Comprehensive Health Insurance Association for the amounts that were taken.

Cause and Effect: Prior to 2013, Indiana Comprehensive Health Insurance Association's internal controls did not identify the fraudulent activity.

Recommendation: We recommend management strengthen internal controls over cash disbursements to help prevent fraudulent activity from occurring again.

Management Response: Management agrees with this finding and has discussed the changes in internal controls with the third party administrator that should prevent similar fraudulent activity in the future.

Federal Award Findings and Questioned Costs

None