IC 27-8-10

Chapter 10. Comprehensive Health Insurance

IC 27-8-10-0.1

Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The addition of section 10 of this chapter by P.L.93-1995 applies to all small employer health insurance plans issued or renewed under IC 27-8-15, as amended by P.L.93-1995, after December 31, 1995.

(2) The addition of sections 3.5 and 3.6 of this chapter by P.L.193-2003 applies to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.

(3) The amendments made to sections 2.1, 5.1, and 6 of this chapter by P.L.193-2003 apply to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.

(4) The addition of section 3.2 of this chapter by P.L.51-2004 applies to any billing that occurs on or after March 16, 2004, regardless of when the health care services to which the bill applies were provided.

As added by P.L.220-2011, SEC.440.

IC 27-8-10-0.5

Dissolution of the association

Sec. 0.5. (a) Except as provided in this section, the insurance operations of the association cease on the later of:

(1) the date on which a health benefit exchange (as defined in IC 27-19-2-8) begins operating in Indiana; or

(2) December 31, 2013.

(b) A claim for payment under an association policy must be made to the association not later than the later of:

(1) sixty (60) days after the date on which the insurance operations cease under subsection (a); or

(2) March 1, 2014.

(c) An appeal or grievance under this chapter must be resolved not later than ninety (90) days after the date on which the insurance operations cease under subsection (a).

(d) Balance billing under this chapter by a health care provider that is not a member of a health care provider network arrangement used by the association is prohibited after the later of:

(1) ninety (90) days after the date on which the insurance operations cease under subsection (a); or

(2) March 30, 2014.

(e) The association shall, not later than June 30, 2013, submit to the commissioner a plan of dissolution for the association. The following apply to a plan of dissolution submitted under this subsection:

(1) The plan of dissolution must provide for the following:

(A) Continuity of care for an individual who is covered

under an association policy and is an inpatient on the date on which the insurance operations cease under subsection (a).

(B) A final accounting described in section 2.1(g) of this chapter of the:

(i) assessments; and

(ii) cessation of the liability;

of members of the association.

(C) Resolution of any net asset deficiency.

(D) Cessation of all liability of the association.

(E) Final dissolution of the association.

(2) The plan of dissolution may provide that, with the approval of the board and the commissioner, a power or duty of the association may be delegated to a person that is to perform functions similar to the functions of the association.

(f) The commissioner shall, after notice and hearing, approve a plan of dissolution submitted under subsection (e) if the commissioner determines that the plan:

(1) is suitable to ensure the fair, reasonable, and equitable dissolution of the association; and

(2) complies with subsection (e).

(g) A plan of dissolution submitted under subsection (e) is effective upon the written approval of the commissioner.

(h) An action by or against the association must be filed not more than one (1) year after the date on which the insurance operations cease under subsection (a).

(i) This chapter expires on the date on which final dissolution of the association occurs under the plan of dissolution approved by the commissioner under subsection (f).

(j) Funds remaining in the association on the date on which final dissolution of the association occurs must be transferred into the state general fund.

(k) The association, or the person to which the association delegates powers or duties under subsection (e), may implement this section in accordance with the plan of dissolution approved by the commissioner under subsection (f).

As added by P.L.278-2013, SEC.26.

IC 27-8-10-1

Definitions

Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee

Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federal income poverty level" has the meaning set forth in IC 12-15-2-1.

(j) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of these plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act; or

(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(k) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(l) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(m) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease,

pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(n) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(o) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(p) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(q) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(r) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(s) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(t) "Medical care payment" means amounts paid for:

(1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

(3) insurance covering medical care referred to in subdivisions (1) and (2).

(u) "Medically necessary" means health care services that the association has determined:

(1) are recommended by a legally qualified physician;

(2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and

(3) are not primarily for the scholastic education or career and technical training of the provider or patient.

(v) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(w) "Policy" means a contract, policy, or plan of health insurance.

(x) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(y) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(z) "Resident" means an individual who is:

(1) legally domiciled in Indiana for at least twelve (12) months before applying for an association policy; or

(2) a federally eligible individual and legally domiciled in Indiana.

(aa) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

(bb) "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

(cc) "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

(dd) "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

(ee) "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.253-1989, SEC.1; P.L.1-1990, SEC.260; P.L.2-1992, SEC.785; P.L.26-1994, SEC.13; P.L.116-1994, SEC.64; P.L.2-1995, SEC.107; P.L.188-1995, SEC.8; P.L.91-1998, SEC.12; P.L.1-2001, SEC.33; P.L.193-2003, SEC.3; P.L.234-2007, SEC.165.

IC 27-8-10-2

Repealed

(Repealed by P.L.1-1990, SEC.261.)

IC 27-8-10-2.1

Comprehensive health insurance association; establishment; board of directors; plan of operation; powers and duties

Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All 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. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of nine (9) members whose principal residence is in Indiana selected as follows:

(1) Four (4) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

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

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

(4) One (1) member to be appointed by the commissioner must be a representative of health care providers.

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

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

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

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

(3) establish regular times and places for meetings of the board

of directors;

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

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

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

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

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

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

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

(2) Subject to section 2.6 of this chapter, sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

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

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

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

(6) Pool risks among members.

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

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or

other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(15) Subject to section 3 of this chapter, negotiate reimbursement rates and enter into contracts with individual health care providers and health care provider groups.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification must be equal to one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits substantially identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Twenty-five percent (25%) of any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums as reported to the department of insurance, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association. Seventy-five percent (75%) of any net loss shall be paid by the state. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet

the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.

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

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

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

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

(l) The association and the premium collected by the association shall be exempt from the premium tax, the adjusted gross income tax, or any combination of these upon revenues or income that may be imposed by the state.

(m) Members who, during any calendar year, have paid one (1) or more assessments levied under this chapter may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

(n) The association shall provide for the option of monthly collection of premiums.

(o) The association shall periodically certify to the budget agency the amount necessary to pay seventy-five percent (75%) of any net loss as specified in subsection (g).

As added by P.L.1-1990, SEC.262. Amended by P.L.26-1991, SEC.27; P.L.1-1994, SEC.136; P.L.116-1994, SEC.65; P.L.26-1994, SEC.14; P.L.2-1995, SEC.108; P.L.255-1995, SEC.9; P.L.91-1998, SEC.13; P.L.192-2002(ss), SEC.169; P.L.178-2003, SEC.63; P.L.193-2003, SEC.4; P.L.97-2004, SEC.99; P.L.51-2004, SEC.1; P.L.1-2007, SEC.186; P.L.229-2011, SEC.251.

IC 27-8-10-2.2

(Repealed by P.L.1-2007, SEC.248.)

IC 27-8-10-2.3
Reporting requirements

Sec. 2.3. (a) A member shall, not later than October 31 of each year, certify an independently audited report to the:

(1) association;

(2) legislative council; and

(3) department of insurance;

of the amount of tax credits taken against assessments by the member under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter during the previous calendar year. A report certified under this section to the legislative council must be in an electronic format under IC 5-14-6.

(b) A member shall, not later than October 31 of each year, certify an independently audited report to the association of the amount of assessments paid by the member against which a tax credit has not been taken under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter as of the date of the report.

As added by P.L.167-2002, SEC.1. Amended by P.L.28-2004, SEC.168; P.L.51-2004, SEC.3; P.L.2-2005, SEC.72; P.L.1-2006, SEC.488.

IC 27-8-10-2.4
Tax credits

Sec. 2.4. (a) Beginning January 1, 2005, a member that, before January 1, 2005, has:

(1) paid an assessment; and

(2) not taken a credit against taxes;

under section 2.1 of this chapter (as in effect December 31, 2004) is not entitled to claim or carry forward the unused tax credit except as provided in this section.

(b) A member described in subsection (a) may, for each taxable year beginning after December 31, 2006, take a credit of not more than ten percent (10%) of the amount of the assessments paid before January 1, 2005, against which a tax credit has not been taken before January 1, 2005. A credit under this subsection may be taken against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of the member that may be imposed by the state, up to the amount of the taxes due for each taxable year.

(c) If the maximum amount of a tax credit determined under subsection (b) for a taxable year exceeds a member's liability for the taxes described in subsection (b), the member may carry the unused portion of the tax credit forward to subsequent taxable years. Tax credits carried forward under this subsection are not subject to the ten percent (10%) limit set forth in subsection (b).

(d) The total amount of credits taken by a member under this section in all taxable years may not exceed the total amount of assessments paid by the member before January 1, 2005, minus the total amount of tax credits taken by the member under section 2.1 of this chapter (as in effect December 31, 2004) before January 1, 2005.

As added by P.L.51-2004, SEC.4.

IC 27-8-10-2.5
Members; general requirements

Sec. 2.5. (a) A member shall comply with the association's plan of operation.

(b) A member assessment under section 2.1 of this chapter is due not more than thirty (30) days after the member receives written notice of the assessment. A member that pays an assessment after the due date shall pay interest on the assessment at the rate of six percent (6%) per annum.

As added by P.L.51-2004, SEC.5.

IC 27-8-10-2.6
Member and health care provider grievances

Sec. 2.6. (a) If a:

(1) member is aggrieved by an act of the association; or

(2) health care provider is aggrieved by an act of the association with respect to reimbursement to the provider under an association policy;

the member or health care provider shall, not more than ninety (90) days after the act occurs, appeal to the board of directors for review of the act.

(b) If:

(1) within thirty (30) days after an appeal is filed under subsection (a), the board of directors has not acted on the appeal; or

(2) a member or health care provider is aggrieved by a final action or decision of the board of directors;

the member or health care provider may appeal to the commissioner.

(c) An appeal to the commissioner under subsection (b) must be filed less than thirty (30) days after the:

(1) expiration of the thirty (30) day period specified in subsection (b)(1); or

(2) action or decision specified in subsection (b)(2).

(d) The commissioner shall, not more than forty-five (45) days after an appeal is filed under subsection (c), take a final action or issue an order regarding the appeal.

(e) A final action or order of the commissioner on an appeal filed under this section is subject to judicial review.

(f) If a member or health care provider sues the association, the court shall not award to the member or health care provider:

(1) attorney's fees or costs; or

(2) punitive damages.

As added by P.L.51-2004, SEC.6.

IC 27-8-10-3
Association policy coverage; reimbursement methods; eligible expenses; managed care

Sec. 3. (a) An association policy issued under this chapter may

pay an amount for medically necessary eligible expenses related to the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. Payment under an association policy must be based on one (1) or a combination of the following reimbursement methods, as determined by the board of directors:

(1) The association's usual and customary fee schedule in effect on January 1, 2004. If payment is based on the usual and customary fee schedule in effect on January 1, 2004, the rates of reimbursement under the fee schedule must be adjusted annually by a percentage equal to the percentage change in the Indiana medical care component of the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics during the preceding calendar year.

(2) A health care provider network arrangement. If payment is based on a health care provider network arrangement, reimbursement under an association policy must be made according to:

(A) a network fee schedule for network health care providers and nonnetwork health care providers; and

(B) any additional coinsurance that applies to the insured under the association policy if the insured obtains health care services from a nonnetwork health care provider.

(3) Reimbursement for an eligible expense in an amount equal to not less than the federal Medicare reimbursement rate for the eligible expense plus ten percent (10%).

(b) Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

(1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or, at the physician's direction, by the physician's staff of registered or licensed nurses, and allied health professionals.

(3) The first twenty (20) professional visits for the diagnosis or treatment of one (1) or more mental conditions rendered during the year by one (1) or more physicians or, at their direction, by their staff of registered or licensed nurses, and allied health professionals.

(4) Drugs and contraceptive devices requiring a physician's prescription.

(5) Services of a skilled nursing facility for not more than one hundred eighty (180) days in a year.

(6) Services of a home health agency up to two hundred seventy (270) days of service a year.

(7) Use of radium or other radioactive materials.

(8) Oxygen.

(9) Anesthetics.

(10) Prostheses, other than dental.

(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.

(12) Diagnostic X-rays and laboratory tests.

(13) Oral surgery for:

(A) excision of partially or completely erupted impacted teeth;

(B) excision of a tooth root without the extraction of the entire tooth; or

(C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(14) Services of a physical therapist and services of a speech therapist.

(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.

(16) Other medical supplies required by a physician's orders.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon such conditions, limitations, and requirements as may be determined by the board of directors.

(c) A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(d) This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

(e) For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

(f) The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens

by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

(g) The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

(h) This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

(i) This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.28-1988, SEC.106; P.L.253-1989, SEC.3; P.L.116-1994, SEC.66; P.L.259-1995, SEC.1; P.L.51-2004, SEC.7; P.L.229-2011, SEC.252.

IC 27-8-10-3.2

Balance billing

Sec. 3.2. Except as provided in section 3.6 of this chapter, a health care provider shall not bill an insured for any amount that exceeds:

(1) the payment made by the association under the association policy for eligible expenses incurred by the insured; and

(2) any copayment, deductible, or coinsurance amounts applicable under the association policy.

As added by P.L.51-2004, SEC.8.

IC 27-8-10-3.5

Chronic disease and pharmaceutical management programs

Sec. 3.5. (a) The association shall:

(1) approve and implement chronic disease management and pharmaceutical management programs based on:

(A) an analysis of the highest cost health care services covered under association policies;

(B) a review of chronic disease management and pharmaceutical management programs used in populations similar to insureds; and

(C) a determination of the chronic disease management and pharmaceutical management programs expected to best improve health outcomes in a cost effective manner;

(2) consider recommendations of the drug utilization review board established by IC 12-15-35-19 concerning chronic disease management and pharmaceutical management programs;

(3) when practicable, coordinate programs adopted under this section with comparable programs implemented by the state; and

(4) implement a copayment structure for prescription drugs covered under an association policy.

(b) A program approved and implemented under this section may not require prior authorization for a prescription drug that is prescribed for the treatment of:

(1) human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and is included on the AIDS drug assistance program formulary adopted by the state department of health under the federal Ryan White CARE Act (42 U.S.C. 300ff et seq.); or

(2) hemophilia according to recommendations of the:

(A) Advisory Committee on Blood Safety and Availability of the United States Department of Health and Human Services; or

(B) Medical and Scientific Advisory Council of the National Hemophilia Foundation.

(c) The copayment structure implemented under subsection (a) must be based on an annual actuarial analysis.

(d) A disease management program for which federal funding is available is considered to be approved by the association under this section.

(e) An insured who has a chronic disease for which at least one (1) chronic disease management program is approved under this section shall participate in an approved chronic disease management program for the chronic disease as a condition of coverage of treatment for the chronic disease under an association policy.

As added by P.L.193-2003, SEC.5.

IC 27-8-10-3.6

Mail order or Internet based pharmacy

Sec. 3.6. (a) The association shall approve a mail order or Internet

based pharmacy (as defined in IC 25-26-18-1) through which an insured may obtain prescription drugs covered under an association policy.

(b) A prescription drug that is covered under an association policy is covered if the prescription drug is obtained from:

(1) a pharmacy approved under subsection (a); or

(2) a pharmacy that:

(A) is not approved under subsection (a); and

(B) agrees to sell the prescription drug at the same price as a pharmacy approved under subsection (a).

(c) A prescription drug that is:

(1) covered under an association policy; and

(2) obtained from a pharmacy not described in subsection (b);

is covered for an amount equal to the price at which a pharmacy described in subsection (b) will sell the prescription drug, with the remainder of the charge for the prescription drug to be paid by the insured.

As added by P.L.193-2003, SEC.6.

IC 27-8-10-4

Policies; deductible and coinsurance requirements; limitations

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.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.253-1989, SEC.4.

IC 27-8-10-5

Repealed

(Repealed by P.L.1-1990, SEC.263.)

IC 27-8-10-5.1

Policies; eligible persons; dependent coverage; preexisting conditions

Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for any of the coverage described in subdivisions (1) and (2). A person other than a federally eligible individual may not apply for an association policy unless the person has applied for:

(1) Medicaid; and

(2) coverage under the:

(A) preexisting condition insurance plan program established by the Secretary of Health and Human Services under Section 1101 of Title I of the federal Patient Protection and Affordable Care Act (P.L. 111-148); and

(B) Indiana check-up plan under IC 12-15-44.2;

not more than sixty (60) days before applying for the association policy.

(b) Except as provided in subsection (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. However, an offer of coverage described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed), IC 27-8-5-2.7, IC 27-8-5-19.2(e) (expired July 1, 2007, and repealed), or IC 27-8-5-19.3 does not affect an individual's eligibility for an association policy under this subsection. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(c) Except as provided in IC 27-13-16-4 and subsection (a), a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(d) Coverage under an association policy terminates as follows:

(1) On the first date on which an insured is no longer a resident of Indiana.

(2) On the date on which an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(e) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried

child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(f) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(g) Except as provided in subsection (h), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (c), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(i) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

As added by P.L.1-1990, SEC.264. Amended by P.L.23-1993, SEC.155; P.L.130-1994, SEC.46; P.L.116-1994, SEC.67; P.L.26-1994, SEC.15; P.L.2-1995, SEC.109; P.L.91-1998, SEC.14;

P.L.207-1999, SEC.5 and P.L.233-1999, SEC.11; P.L.193-2003, SEC.7; P.L.211-2003, SEC.5; P.L.97-2004, SEC.100; P.L.211-2005, SEC.3; P.L.3-2008, SEC.213; P.L.229-2011, SEC.253.

IC 27-8-10-6

Policies; renewal provisions; election to continue coverage upon death of policyholder

Sec. 6. (a) An association policy offered under this chapter must contain provisions under which the association is obligated to renew the contract until:

(1) the date on which coverage terminates under section 5.1 of this chapter; or

(2) the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the durational requirement of this subdivision.

(b) The association may not change the rates for association policies or Medicare supplement policies except on a class basis with a clear disclosure in the policy of the association's right to do so.

(c) An association policy offered under this chapter must provide that upon the death of the individual in whose name the contract is issued, every other individual then covered under the contract may elect, within a period specified in the contract, to continue coverage under the same or a different contract until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.116-1994, SEC.68; P.L.193-2003, SEC.8.

IC 27-8-10-7

Rules; adoption

Sec. 7. The commissioner may adopt rules, under IC 4-22-2, that:

(1) provide for disclosure by carriers of the availability of insurance coverage from the association; and

(2) implement this chapter.

As added by Acts 1981, P.L.249, SEC.1.

IC 27-8-10-8

Civil or criminal liability of association or members

Sec. 8. Neither the participation by carriers or members in the association, the establishment of rates, forms, or procedures for coverages issued by the association, nor any joint or collective action required by this chapter shall be the basis of any legal action, civil, or criminal liability against the association or members of it either jointly or separately.

As added by Acts 1981, P.L.249, SEC.1.

IC 27-8-10-9

Medicare supplement policies

Sec. 9. (a) The association may issue Medicare supplement policies to individuals who reside in Indiana.

(b) A Medicare supplement policy issued under this section:

(1) must be based on a model policy adopted by the commissioner under IC 27-8-13-10.1; and

(2) must meet the standards for Medicare supplement policy benefits established under IC 27-8-13-10.1.

(c) A Medicare supplement policy issued under this section is not subject to the deductible and coinsurance requirements and the eligibility restrictions applying to association policies under sections 4 and 5.1 of this chapter. However, the association may provide that an individual is not eligible for a Medicare supplement policy issued under this section unless the individual has applied to one (1) carrier for a Medicare supplement policy and the application of the individual has been rejected.

As added by P.L.116-1994, SEC.69.

IC 27-8-10-10

Eligibility guidelines

Sec. 10. Before January 1, 1996, the board of directors of the association shall establish eligibility guidelines for the issuance of an association policy under this chapter to prohibit an:

(1) employer;

(2) insurance producer; or

(3) insurance broker;

from placing in or referring to the association an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002).

As added by P.L.93-1995, SEC.9. Amended by P.L.178-2003, SEC.64.

IC 27-8-10-11.2

Use of diagnostic or procedure codes

Sec. 11.2. (a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) the association shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the association pays claims for services provided under an association policy; and

(2) a health care provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the health care provider submits claims for payment for services provided under an association policy.

(b) If a health care provider provides services that are covered under an association policy:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (a); and

(2) before the association begins using the most current version of the diagnostic or procedure code;

the association shall reimburse the health care provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

As added by P.L.161-2001, SEC.3. Amended by P.L.66-2002, SEC.15.

IC 27-8-10-12

Repealed

(Repealed by P.L.51-2004, SEC.10.)

IC 27-8-10-13

Repealed

(Repealed by P.L.51-2004, SEC.10.)

IC 27-8-10-14

Repealed

(Repealed by P.L.1-2007, SEC.248.)