TITLE 760 DEPARTMENT OF INSURANCE

Proposed Rule
LSA Doc. #06-32

DIGEST

Amends 760 IAC 1-21, regarding requirements for proof of financial responsibility, surcharge payments and amounts, certificates of insurance, types of insurance coverage, health care providers, settlement of claims, communication with the Patient's Compensation Fund and to otherwise implement IC 34-18. Effective 30 days after filing with the publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

The proposed rule articulates procedures and coverage limitations for health care providers that participate in the Indiana Patient's Compensation Fund (IC 34-18). In addition the proposed rule states the surcharge to be paid by nursing homes to obtain coverage with the Indiana Patient's Compensation Fund (PCF).

Participation in the PCF is not mandatory. It is voluntary. Less than half of the nursing home population in Indiana chooses to participate in the PCF. The PCF provides $1,000, 0000 of coverage for medical malpractice liability in excess of the health care provider's liability of $250,000. It does not provide coverage for any other type of liability such as premises liability, workers compensation or property damage.

Pursuant to IC 34-18-5-2 the surcharge for coverage with the PCF shall be set by an actuary and shall be sufficient to cover the actuarial risk posed by the type of health care provider. There are 285 nursing homes covered by the PCF. Of these the IDOI has identified 61 that are potentially small businesses as defined by IC 4-22-2.1-4.

Estimated Average Annual Administrative Costs that Small Businesses will Incur:

Health care providers pay an annual surcharge to obtain coverage with the PCF. Pursuant to IC 34-18-5 the surcharge shall be set by an actuary and shall be sufficient to cover the risks posed to the PCF. There are no administrative costs associated with this rule. There is a change to the surcharge amount that is due.

Estimated Total Annual Economic Impact on Small Businesses:

There is a change to the surcharge due for coverage with the PCF. Currently a nursing home is required to pay 110% of the cost for the primary layer of insurance to the PCF for the excess layer of coverage. Because the surcharge is based upon the premium charged in the market place the amounts differ. The amounts remitted vary from a low of

$25 per bed to a high of $197 per bed. The average bed rate for the 61 nursing homes for the 2005 policy year was $100.33 per bed. The proposed rates will be an average annual increase of $99.47 per comprehensive bed and an average annual decrease of $37.23 for per residential care bed.

Regulatory Flexibility Analysis of Alternative Methods:

The Department retained the services of Milliman USA to perform the actuarial analysis for the surcharge rates. Milliman USA utilized the principles of actuarial practice in developing its opinion. There are no alternative methods available for determining the appropriate charges for future payments.

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SECTION 1. 760 IAC 2-21-2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-2 Definitions

Authority: IC 34-18-5-4
Affected: IC 16-21-2; IC 16-28; IC 27-28; IC 25-22.5; IC 34-18-2-14; IC 34-18-17

Sec. 2. The following definitions **and those contained in IC 34-18-2** apply throughout this rule:

(1) "Ancillary provider" means all health care providers as defined in IC 34-18-2-14, except physicians**, nursing homes** and hospitals.

(2) "Certificate of coverage" means the form prescribed by the department of insurance to show proof of financial responsibility as required by IC 34-18-3-2(1) to become a qualified provider.

(3) "Comprehensive nursing care" means nursing that that includes, but is not limited to, any of the following:

(A) Intravenous feedings.

(B) Enteral feeding.

(C) Nasopharyngeal and tracheostomy aspiration.

(D) Application of dressings to wounds that:

(i) require the use of sterile techniques, packing, or irrigation; or

(ii) are infected or otherwise complicated.

(E) Treatment of Stages 2, 3, and 4 pressure ulcers or other widespread skin disorders.

(F) Heat treatments that have been specifically ordered by a physician as part of active treatment and require observation by nurses to adequately evaluate the process.

(G) Initial phases of a regimen involving administration of medical gases.

~~(2)~~ **(4)** "Claims made coverage" means coverage for claims made during a coverage period**.**

~~(3) "Commissioner" means the commissioner of insurance of Indiana.~~

~~(4)~~ **(5)** "Department" means the Indiana department of insurance.

(6) "Employed physician" means a physician for whom an employer withholds and pays Social Security and Medicare taxes and pays unemployment tax on wages paid to the physician. The term does not include a physician that is treated as an independent contractor for purposes of the Internal Revenue Service.

~~(5) "Health facility" means a facility named on the license issued by the state department of health under IC 16-28.~~

~~(6) "Hospital" means a public or private institution licensed under IC 16-21-2.~~

(7) "Independent ancillary provider" means an ancillary provider that holds a state issued license to provide health care and does not require direct supervision or direction in providing health care. The term includes, but is not limited to the following:

(i) dentist;

(ii) psychologist;

(iii) podiatrist;

(iv) optometrist;

(v) nurse practitioner

(vi) nurse midwife; and

(vii) certified registered nurse anesthetist.

(8) "Insurer" means any entity that issues a policy of insurance used as proof of financial responsibility under IC 34-18 including but not limited to an insurance company doing business on an admitted or non-admitted basis or a risk retention group.

~~(7)~~ **(9)** "IRMIA" means the Indiana residual malpractice insurance authority created by IC 34-18-17.

(10) "Nursing home" means a facility named on the license issued by the state department of health under IC 16-28.

~~(8)~~ **(11)** "Occurrence ~~based~~ coverage" means coverage for acts that occur during a coverage period.

(12) "PCF" means the Indiana Patient's Compensation Fund.

~~(9)~~ **(13)** "Physician" means an individual with an unlimited license to practice medicine under IC 25-22.5.

(14) "Qualified actuary" means an individual that is a member in good standing with the Casualty Actuarial Society or the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinion by the Casualty Practice Council of the American Academy of Actuaries.

(15) "Residential nursing care" means nursing that includes, but is not limited to, any of the following:

(A) Identifying human responses to actual or potential health conditions.

(B) Deriving a nursing diagnosis.

(C) Executing a minor regimen based on a nursing diagnosis or executing minor regimens as prescribed by any of the following:

(i) physician;

(ii) physician assistant;

(iii) chiropractor;

(iv) dentist;

(v) optometrist;

(vi) podiatrist; or

(vii) nurse practitioner.

(Department of Insurance; Reg 22, Sec II; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 514; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375)

SECTION 2. 760 IAC 2-21-2.5 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-21-2.5 Insurance policy as proof of financial responsibility

Authority: IC 34-18-3-7; IC 34-18-5-2; IC 34-18-5-4; IC 34-18-6-6

Affected: IC 34-18-2-14; IC 34-18-17

Sec. 2.5. (a) A health care provider may use a policy of insurance issued by any of the following types of insurer as proof of financial responsibility:

(1) An insurance company holding a certificate of authority from the department under IC 27-1-6 or IC 27-1-17.

(2) A risk retention group registered with the department.

(3) An insurer that does not hold a certificate of authority from the department through one of the following:

(A) A surplus lines transaction under IC 27-1-15.8; or

(B) An industrial insured transaction under IC 27-4-5-2(a)(8).

(b) The department has the right to review the financial condition of any insurer used as proof of financial responsibility. The department may disapprove the use of an insurer as proof of financial responsibility if the department determines, after notice and an opportunity to be heard, the insurer's financial

condition poses a financial risk to the PCF. A disapproval must be in writing and served upon the insurer. If the insurer uses an agent to file proof of financial responsibility service on that agent shall be considered service on the insurer.

(1) An insurer shall have available assets equal to the reserves associated with all potential liabilities that are neither fronted by, nor reinsured with, an insurer approved by the department. All potential liabilities includes the following:

(A) reserves for losses;

(B) allocated loss adjustment expenses;

(C) incurred by not reported losses; and

(D) unearned premium,

(2) If the insurer is a risk retention group or industrial insured it shall comply with one of the following security arrangements:

(A) Fronted by an insurance company authorized or approved to write medical malpractice insurance under the laws of Indiana;

(B) Reinsured by an insurance company authorized or approved to reinsure risks under the laws of Indiana;

(C) Secured by an irrevocable trust established for the purpose of paying medical malpractice claims incurred by its policyholders in a form and under terms approved by the Commissioner.

(D) Funded by an irrevocable letter of credit or other arrangement that is approved in writing by the Commissioner.

(E) Funded by any other security arrangement approved in writing by the Commissioner.

The Commissioner may require an insurer to increase the funding of any security arrangement.

(c) An insurer shall file with the medical malpractice division within the department a copy of the policy form and premium rates used as proof of financial responsibility.

(d) Claims made coverage or occurrence coverage may be used as proof of financial responsibility. No other policy type of coverage may be used as proof of financial responsibility until the policy form is:

(1) submitted to the medical malpractice division of the department; and

(2) is approved by the commissioner, in writing, specifically for use as proof of financial responsibility under IC 34-18-3 and IC 34-18-4.

(e) The health care provider's coverage with the PCF is of the same coverage type and scope as the policy used for proof of financial responsibility. However, the PCF will not allow retroactive coverage that begins before the date of issue of the first policy of insurance from any insurer used as proof of financial responsibility for the PCF.

(f) In the event a policy of insurance is rescinded, the health care provider's

status as a qualified health care provider is similarly rescinded. The department will refund any surcharge that was received for the period that was subject to the rescission. The insurer shall notify the department within ten (10) days of any policy that is rescinded.

(g) If an insurer is placed into insolvency or receivership and the department has not previously disapproved the insurer as acceptable for establishing financial responsibility under subsection (b), the following apply:

(1) The health care provider remains a qualified health care provider.

(2) The PCF is not responsible for any amounts due by the health care provider except as provided in IC 34-18-15-4.

(3) The PCF does not assume the insurer's obligation to pay costs to defend a claim.

(Department of Insurance; 760 IAC 2-21-2.5)

SECTION 3. 760 IAC 2-21-3 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-3 Establishment of financial responsibility by ancillary provider or physician by means other than insurance

Authority: IC 34-18-5-4

Affected: IC 34-18-4-1

Sec. 3. (a) An ancillary provider, **independent ancillary provider, nursing home** or ~~a~~ physician desiring to establish financial responsibility under IC 34-18-4-1 by a means
other than insurance may do so by submitting, to the commissioner, the following:

(1) An agreement in writing, in a form and manner prescribed by the commissioner, to pay any final judgment or agreed
settlement arising from claims of malpractice in accordance with the limits on liability set forth in IC 34-18-4-1(1).

(2) Filing and maintaining with the commissioner, cash or surety bonds, from a company acceptable to the commissioner, in
accordance with the limits on liability set forth in IC 34-18-4-1(1) for each year in which financial responsibility is established by a means other than insurance.

(b) An ancillary provider**, independent ancillary provider, nursing home** or physician that establishes proof of financial responsibility under this section may obtain only occurrence ~~based~~ coverage. Claims made coverage is not available. *(Department of Insurance; Reg 22, Sec III; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 514; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375)*

SECTION 4. 760 IAC 2-21-4 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-4 Retention of deposit during liability

Authority: IC 34-18-5-4

Affected: IC 34-18-4-1; IC 34-18-4-2

Sec. 4. If an ancillary provider**, independent ancillary provider, nursing home** or physician that has established financial responsibility, in the manner set forth in section 3 of this rule:

(1) ceases practice;

(2) establishes financial responsibility by means of insurance; or

(3) decides that he or she no longer wishes to establish financial responsibility under IC 34-18;

any cash or surety bond filed with the commissioner shall remain on deposit until liability ceases to exist. *(Department of Insurance; Reg 22, Sec IV; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 515; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375)*

SECTION 5. 760 IAC 2-21-5 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-5 Financial responsibility of hospital

Authority: IC 34-18-5-4

Affected: IC 16-21-2; IC 34-18-4-1; IC 34-18-5-3

Sec. 5. A hospital may establish financial responsibility for itself, its officers, agents, and employees by submitting, to the commissioner, all of the following at least sixty (60) days before the requested effective date of coverage with the ~~patient's compensation fund~~ **PCF.**

(1) An agreement in writing, in a form and manner prescribed by the commissioner, to pay any final judgment or agreed settlement arising from claims of malpractice subject to the limits on liability set forth in IC 34-18-4-1(1)(A)(i) and IC 34-18-4-1(1)(A)(ii).

(2) An agreement in writing that the hospital will establish and maintain a claims management and risk management program,

the program shall include, at a minimum, the following:

(A) Procedures satisfactory to the commissioner for the prompt investigation of each malpractice claim reported to the hospital to determine:

(i) whether malpractice liability exists; and

(ii) its cause.

(B) Procedures for the efficient processing, adjustment, and reasonable settlement of claims.

(C) Procedures for the defense by legal counsel of claims that cannot be adjusted or settled.

(D) Procedures to examine the cause of losses and to take action to reduce their frequency and severity, including a safety program and employee and professional training program.

The hospital may undertake such a claims management and risk management program through its own qualified personnel, or it may undertake part or all of the program through the services of qualified independent contractors.

(3) A verified financial statement that demonstrates the financial resources of the hospital are sufficient to satisfy all malpractice claims incurred by it up to the limits on liability set forth in IC 34-18-4-1(3). Notwithstanding, if the hospital is an agency of any governmental unit and desires to use the taxing power of that governmental unit to establish its financial security, it may establish financial responsibility by filing with the commissioner a copy of an ordinance or resolution of the taxing governing body of the governmental unit, authorizing the hospital to do so, and acknowledging the responsibility of the governmental unit for any judgment or settlement arising from claims of malpractice.

(4) An agreement in writing that if the hospital discontinues operation or decides to purchase insurance to establish financial responsibility under IC 34-18 et seq., the hospital will continue to be liable in the amounts set forth in subdivision (1) until liability ceases to exist.

(5) For each year in which the hospital establishes proof of financial responsibility under this section, the hospital shall obtain the quotation **from IRMIA** for the surcharge amount to be paid to the ~~patient's compensation fund from IRMIA~~ **PCF**. In support of this calculation, the hospital shall submit to IRMIA the following:

(A) The hospital's most recent application for licensure to operate a hospital pursuant to IC 16-21-2 on file with the state ~~of Indiana~~ department of health.

(B) Any other information reasonably requested by IRMIA to accurately determine the surcharge amount.

This information shall be submitted to IRMIA at least sixty (60) days before the requested effective date of coverage with the ~~patient's compensation fund~~ **PCF**. IRMIA shall retain this information for a period of ten (10) years.

(6) A hospital that establishes proof of financial responsibility under this section may obtain only occurrence based coverage. Claims made coverage is not available.

(7) The department can reject or refuse to renew a hospital's request to establish financial responsibility under this section if the department determines, after notice and an opportunity to be heard, that the hospital's financial condition is not sufficient or poses a financial risk to the PCF.

(8) The department may require a hospital to:

(A) submit to an independent audit; or

(B) provide a certification by an independent person acceptable to the commissioner;

of the surcharge calculations. Any costs related thereto shall be borne by the hospital.

(Department of Insurance; Reg 22, Sec V; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 515; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2875; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375)

SECTION 6. 760 IAC 2-21-6 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-6 Financial reserves
Authority: IC 16-9.5-2-7
Affected: IC 16-9.5-1-1; IC 16-10-1-6

Sec. 6. A health care provider that establishes financial responsibility by a means other than insurance must maintain reserves adequate to cover the possible loss and expected litigation costs in conjunction with ~~the~~ **any** claim submitted against that health care provider. Such reserves must be established within **sixty (**60**)** days after a claim is reported. **Upon the request of the department the health care provider shall provide an actuarial opinion that states the health care provider has adequate reserves for its potential liabilities under generally accepted standards of actuarial practice. Any information received by the department regarding claim reserves is confidential under IC 5-14-3 and IC 34-18-9-3. The Department shall request no more than one (1) report in a twelve (12) month period unless the Department receives information that indicates a financial issue.** *(Department of Insurance; Reg 22,Sec VI; filed Jan 27, 1977, 2:35 pm: Rules and Regs. 1978, p. 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

SECTION 7. 760 IAC 2-21-7 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-7 Cash deposits
Authority: IC 16-9.5-2-7
Affected: IC 16-9.5-1-1; IC 16-10-1-6

Sec. 7. Cash deposited by a health care provider under **IC 34-18-4-1(2) and** this regulation may be deposited in an interest-bearing account in any bank located in Indiana. Such a deposit must be in a joint account under the control of the Commissioner of Insurance and the health care provider. The health care provider may withdraw accrued interest from the account. *(Department of Insurance; Reg 22, Sec VII; filed Jan 27, 1977, 2:35 pm: Rules and Regs. 1978, p. 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

SECTION 8. 760 IAC 2-21-8 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-8 Payment into patient's compensation fund; annual surcharge for ancillary provider
Authority: IC 34-18-5-4
Affected: IC 27-1-6; IC 27-1-17; IC 27-7-10-14; IC 34-18-5-2; IC 34-18-5-3

Sec. 8. ~~(a)~~ The annual surcharge for an ancillary provider **or independent ancillary provider** shall be ~~one hundred ten percent (110%) of the cost to the ancillary provider for maintenance of financial responsibility~~ **as follows:**

(1) An ancillary provider or independent ancillary provider that purchases insurance as proof of financial responsibility shall pay one hundred ten percent (110%) of the premium charged by the insurer.

~~(b)~~ **(2)** An ancillary provider ~~establishing~~ **or independent ancillary provider that establishes** financial responsibility by means other than insurance under section 3 of this rule shall pay ~~into the patient's compensation fund~~ an amount equal to one hundred ten percent (110%) of the premium that would be charged to the ancillary provider by IRMIA. The payment must be made each year under IC 34-18-5-3 within thirty (30) days after qualification.

(Department of Insurance; Reg 22, Sec VIII; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 516; filed Mar 18, 1986, 10:41 a.m.: 9 IR 2057, eff Apr 18, 1986; filed May 28, 1987, 4:00 p.m.: 10 IR 2298; filed Aug 13, 1991, 4:00 p.m.: 15 IR 7; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2875; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2376)

SECTION 9. 760 IAC 2-21-8.5 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-21-8.5 Payment into patient's compensation fund; annual surcharge for nursing homes

Authority: IC 34-18-3-7; IC 34-18-5-2; IC 34-18-5-4; IC 34-18-6-6
Affected: IC 27-1-6; IC 27-1-17; IC 27-7-10-14; IC 34-18-5-2; IC 34-18-5-3

Sec. 8.5. A nursing home shall calculate their surcharge rate on a form prescribed by the department. The calculation shall include the following.

(1) The actual number and type of beds licensed by the state department of health.

(2) An per bed charge as follows:

(A) one hundred ninety-nine dollars and seventy cents ($199.70) for each comprehensive nursing care bed; and

(B) sixty-three dollars and ten cents ($62.10) for each residential nursing care bed.

(3) A factor or factors for the existence or absence of a risk management program and other risk related factors.

(4) A charge for each employed physician covered by the nursing home.

(Department of Insurance; 760 IAC 1-21-8.5)

SECTION 10. 760 IAC 2-21-10 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-10 Scope of coverage

Authority: IC 34-18-5-4
Affected: IC 16-21-2; IC 34-18-2-24.5; IC 34-18-5-2; IC 34-18-5-3; IC 34-18-5-4

Sec. 10. (a) A hospital's coverage with the ~~patient's compensation fund~~ **PCF** is limited to facilities identified in the hospital's application for licensure to operate a hospital under IC 16-21-2 as facilities operated under the hospital license. Each hospital

shall identify on the surcharge calculation worksheet prescribed by the department all of the facilities operated under the hospital's license and classes of employees intended to be included in the hospital's coverage.

~~(b) An ancillary provider shall identify in the certificate of coverage prescribed by the department any employed physician and the physician's specialty class as defined at 760 IAC 1-60.~~

~~(c)~~ **(b)** Any health care provider that uses an assumed business name must state the assumed business name on the certificate of coverage filed with the department for the assumed business name to be included in the health care provider's status as a qualified provider as defined by IC 34-18-2-24.5. **A health care provider may amend a filing to add a d/b/a as long as no claim has been filed. The health care provider shall remit the greater of the following:**

(1) additional surcharge if the d/b/a brings any additional risk to the coverage already filed; or

(2) a minimum surcharge payment of one hundred dollars ($100).

(c) Each physician and independent ancillary provider shall file individual proof of financial responsibility and pay a surcharge as required by 760 IAC 1-60 and/or IC 34-18-5. No ancillary provider may include a physician or independent ancillary provider in its qualification.

(d) A hospital or nursing home may include an employed physician in its qualification under the following conditions:

(1) The hospital or nursing home shall pay the appropriate surcharge for each physician under 760 IAC 1-60; and

(2) The physician's qualification status is limited to duties performed within the scope of his/her employment for the hospital as an employee of the hospital.

(Department of Insurance; 760 IAC 1-21-10; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2376)

SECTION 11. 760 IAC 2-21-12 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-21-12 Severability

Authority: IC 34-18-3-7; IC 34-18-5-2; IC 34-18-5-4; IC 34-18-6-6
Affected: IC 16-28; IC 34-18-5-2; IC 34-18-5-3

Sec. 12. If any section or portion of a section of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected. *(Department of Insurance; 760 IAC 1-21-12)*

THE FOLLOWING SECTIONS ARE REPEALED: 760 IAC 1-21-1; 760 IAC 1-21-11