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TITLE 760 DEPARTMENT OF INSURANCE

Proposed Rule
LSA Document #04-140

DIGEST

Amends 760 IAC 1-21 regarding definitions, filing of proof of financial responsibility, use of insurance and means other than insurance for proof of financial responsibility, certificates of insurance, deposits, reserves, surcharge payment and amount, corporations as qualified health care providers, the annual aggregate, settlement of claims and communication between the Department of Insurance and the health care provider. Effective 30 days after filing with the secretary of state.

760 IAC 1-21-2 **760 IAC 1-21-8**
760 IAC 1-21-3 **760 IAC 1-21-10**
760 IAC 1-21-4 **760 IAC 1-21-11**
760 IAC 1-21-5

SECTION 1. 760 IAC 1-21-2 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 25-22.5; IC 34-18-2-14; IC 34-18-17

Sec. 2. ~~As used in~~ **The following definitions apply throughout** this rule:
(1) ~~"Health care~~ **"Ancillary** provider" means all health care providers as defined in IC 34-18-2-14, except physicians and hospitals.
~~(2) "Hospital" means a public or private institution licensed under IC 16-21-2.~~
(2) "Claims made coverage" means coverage for claims made during a coverage period.
(3) "Commissioner" means the commissioner of insurance of Indiana.
(4) "Department" means the Indiana department of insurance.
(5) "Health facility" means a facility named on the license issued by the Indiana state department of health under IC 16-28.
(6) "Hospital" means a public or private institution licensed under IC 16-21-2.
(7) "IRMIA" means the Indiana residual malpractice insurance authority created by IC 34-18-17.
(8) "Occurrence based coverage" means coverage for acts that occur during a coverage period.
~~(4)~~ **(9)** "Physician" means an individual with an unlimited license to practice medicine under IC 25-22.5.
(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)

SECTION 2. 760 IAC 1-21-3 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-3 Establishment of financial responsibility by ancillary provider or physician
Authority: IC 34-18-5-4
Affected: IC 34-18-4-1

Sec. 3. ~~A health care~~ **(a) An ancillary** provider 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 or physician that establishes proof of financial responsibility under this section may obtain only occurrence based coverage with the patient's compensation fund. 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)*

SECTION 3. 760 IAC 1-21-4 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 ~~a health care~~ **an ancillary** provider 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)*

SECTION 4. 760 IAC 1-21-5 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~~ **under IC 34-18-4-1(3)** 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:**
(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, which 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 ~~to determine~~
(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 for the surcharge amount to be paid to the patient's compensation fund from IRMIA. 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 under IC 16-21-2 on file with the Indiana state 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. 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 with the patient's compensation fund. Claims made coverage is not available.

(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)

SECTION 5. 760 IAC 1-21-8 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-21-8 Payment into patient's compensation fund; annual surcharge

Authority: IC 34-18-5-4

Affected: IC 27-1-6; IC 27-1-17; IC 34-18-5-2; IC 34-18-5-3

Sec. 8. (a) The annual surcharge for ~~a health care~~ **an ancillary** provider shall be one hundred **ten** percent ~~(100%)~~ **(110%)** of the cost to the ~~health care~~ **ancillary** provider for ~~maintenance~~ **the purchase of insurance as proof** of financial responsibility **as long as the premium is deemed by the commissioner to be reasonable in relation to the benefits provided as follows:**

(1) If an ancillary provider purchases insurance from an insurance company that:

(A) holds a certificate of authority under IC 27-1-6 or IC 27-1-17; and

(B) has premium rates on file with, and not subject to objection by, the department;

then the premium is deemed reasonable.

(2) If an ancillary provider purchases insurance from an authorized surplus lines company, the following items must be provided to the department:

(A) The name, address, and state or country of domicile of the insurance company.

(B) A statement from a qualified actuary that the premium rate charged is reasonable in relation to the benefits provided.

If the department has no objection to the actuary's statement, then the premium is deemed to be reasonable.

(b) ~~A health care~~ **An ancillary** provider establishing financial responsibility by means other than insurance under section 3 of this rule **or through purchasing insurance from an insurer that:**

(1) does not hold a certificate of authority from the department; and

(2) is not an authorized surplus lines company;

shall pay into the patient's compensation fund an amount equal to one hundred **ten** percent ~~(100%)~~ **(110%)** of the premium that would be charged to the ~~health care~~ **ancillary** provider by ~~the residual malpractice insurance authority.~~ **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)*

SECTION 6. 760 IAC 1-21-10 IS ADDED 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 34-18-6-6; IC 34-18-14-3

Sec. 10. (a) A hospital's coverage with the patient's compensation fund may include claims against the following:

(1) The hospital's officers, agents, and employees.

(2) 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.

A hospital may not cover claims for independent contractors. 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 may cover claims against its officers, agents, and employees. An ancillary provider's coverage

shall not include claims for independent contractors. 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) 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.

(d) Any health care provider that establishes proof of financial responsibility by means other than insurance under section 3 or 5 of this rule or through purchasing insurance from an authorized surplus lines company of any other insurer not holding a certificate of authority from the department shall file a statement signed by the health provider that states the following:

(1) The ancillary provider is aware that:

(A) the insurer does not hold a certificate of authority from the department (if applicable); and

(B) he or she is not entitled to coverage under the Indiana Insurance Guaranty Association.

(2) In the event of insolvency, the ancillary provider agrees not to seek reimbursement from the patient's compensation fund for any amounts due that are the responsibility of the ancillary provider under IC 34-18-14-3 or for the cost of defending a claim except in the event the ancillary provider has exhausted its annual aggregate as provided by IC 34-18-6-6.

(Department of Insurance; 760 IAC 1-21-10)

SECTION 7. 760 IAC 1-21-11 IS ADDED TO READ AS FOLLOWS:

760 IAC 1-21-11 Filings by health facilities

Authority: IC 34-18-5-4

Affected: IC 34-18-5-2; IC 34-18-5-3

Sec. 11. (a) A health facility shall submit the following information to the department with its certificate of coverage and surcharge payment:

Number of occupied beds	Type of bed
XX	Skilled Care
XX	Intermediate Care
XX	Residential Care
XX	Independent Living

(b) The following definitions apply throughout this section:

(1) "Independent living" means residents:

(A) are retirement age;

(B) are in general good health;

(C) occupy apartments or dwelling units that normally include cooking facilities;

(D) administer their own medications without assistance; and

(E) do not receive health care services.

(2) "Intermediate care" means residents require nursing care during the day shift, seven (7) days per week, by registered or licensed nurses. There is no complex nursing care provided. Complex nursing care consists of functions such as intravenous medications or tube feedings. Assistance is provided with activities of daily living such as the following:

(A) Walking.

(B) Bathing.

(C) Dressing.

(D) Eating.

Some assistance is provided in the administration of medication.

(3) "Residential care" means residents are ambulatory with possible minor medical disorders. A protected environment is provided including meals and planned programs for social or spiritual needs. Incidental health care services are provided, such as medication assistance. A registered nurse may be required to provide consultative services.

(4) "Skilled care" means residents require nursing care during twenty-four (24) hours per day by registered or licensed nurses. Nursing care provided includes some or all of the following:

(A) Medication administration.

(B) Injections.
(C) Tube feedings.
(D) Catheterizations.
(E) Other procedures ordered by a physician.
(Department of Insurance; 760 IAC 1-21-11)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on January 24, 2005 at 10:00 a.m., at the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana the Department of Insurance will hold a public hearing on proposed amendments concerning definitions, filing of proof of financial responsibility, use of insurance and means other than insurance for proof of financial responsibility, certificates of insurance, deposits, reserves, surcharge payment and amount, corporations as qualified health care providers, the annual aggregate, settlement of claims and communication between the Department of Insurance and the health care provider. Copies are available on the Department of Insurance's Web site at www.state.in.us/idoi. Copies of these rules are now on file at the Department of Insurance, 311 West Washington Street, Suite 300 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Amy E. Strati
Acting Commissioner
Department of Insurance