APPENDIX D.2
MODEL FOR A BEHAVIORAL HEALTHCARE FUNDING ACT

Model statute designed to fit here:
State Statutes
Title 16. Health
Article XX.

Cite as XXXX § XX–XX.

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Indiana's Behavioral Healthcare Funding Act of 2024 (Act) creates a program designed to stabilize and enlarge funding for the Indiana Behavioral Health Access Program for Youth Line (Be Happy), Indiana Consultations for Healthcare Providers in Addiction, Mental Health, and Perinatal Psychiatry Program (CHAMP), the Adolescent Addiction Access (AAA) Program, and to make funding possible for similar programs intending to address the shortage of resources in behavioral healthcare for residents of the state. Be Happy, CHAMP, and AAA were started with seed money from the federal Health Resources and Services Administration (HRSA) and have been exemplary in their services to date. But HRSA funds both are (i) inadequate to serve all state residents and (ii) scheduled to expire. This instability is particularly problematic in the face of the substantial growth in behavioral healthcare needs exacerbated by the recent pandemic and other factors affecting residents throughout the state. The present need is critical given the ongoing shortage of trained professionals. Consequently, Indiana continues to fall substantially short of the important objective to obtain parity of behavioral healthcare with other healthcare services.

The Act marshals resources from health payers deploying the proven and cost-effective assessment methodology used in other states. The Act requires the same transparency, efficiency, accountability, and equity which brought success to those programs. To assure fairness, the assessment is designed to cover as many health benefit programs as possible.

No state general funds are required by the Act's self-funding program. The program also funds any additional state positions needed to oversee the program. This is anticipated to be 1 FTE at the start. Assessments are expected to be well under $1 per covered life per month. Until payers determine to expand the program to other areas (e.g., for Moms as has been done in other states), the costs should be under 25 cents per covered life per month. The expected savings in other healthcare costs are expected to be several multiples of the modest assessment required.

The program operates through a dedicated not-for-profit organization created by the Act. State oversight is afforded by both the Indiana Department of Health and the Indiana Department of Insurance.

§ XX–XX–1. **Short Title.**

Chapter XX, Article XX may be cited as the "Healthcare Funding Act of 2024" or "HFA2024."

§ XX–XX–2. **Definitions**

A. "adult" means (i) all Indiana residents who are over age 18 and under age 65 and (ii) all other persons over age 18 and under age 65 who receive healthcare services in the state.

B. "assessed entity" means any health carrier or other entity that contracts or offers to insure, provide, deliver, arrange, pay for, administer any claims for or reimburse or facilitate the sharing of any of the costs of healthcare services for any person residing in or receiving healthcare services in the state, including, without limitation, the following:

(1) Any writer of individual, group, or stop loss insurance;

(2) Health Maintenance Organization;

(3) Third Party Administrator;

(4) Preferred Provider Agreement;

(5) Fraternal Benefit Society;

(6) Administrative services organization and any other organization managing claims on behalf of a self-insured entity;

(7) Any self-insurer or other entity that provides an employee or group benefit plan and does not utilize an external claims management service;

(8) Any governmental entity that provides an employee or group benefit plan and does not utilize an external claims management service; or

(9) Any entity, administrator or sponsor of any healthcare cost sharing program;

(10) Any managed care organization.

C. "assessment" means the association member liability with respect to costs determined in accordance with this chapter.

D. "association" means the Healthcare Information Line Association created by this chapter.

E. "board" means the board of directors of the association.

F. "child" or "children" means (i) all Indiana residents who are under age 19 and (ii) all other persons under age 19 who receive healthcare services in Indiana.

G. "covered lives" means all individuals who reside or receive health care in the state and who are:

(1) Covered under an individual health insurance policy issued or delivered in the state;

(2) Covered under a group health insurance policy that is issued or delivered in the state;

(3) Covered under a group health insurance policy evidenced by a certificate of insurance that is issued or delivered to an individual who resides in the state;

(4) Protected, in part, by a group excess loss insurance policy where the policy or certificate of coverage has been issued or delivered in the state; or

(5) Protected, in part, by an employee benefit plan of a self-insured entity or a government plan for any employer or government entity which (i) has an office or other worksite located in the state or (ii) has 50 or more employees in the state, or

(6) Participants or beneficiaries of a health cost sharing program or managed care organization.

H. “director” means a director of the association.

I. “executive director” means the executive director of the association.

J. "health carrier" or "carrier" means an entity subject to the insurance laws and rules of the state, or subject to the jurisdiction of the insurance commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

K. “health cost sharing program” means any cost sharing or similar program which seeks to share or coordinate the sharing of the costs of healthcare services and which in the preceding twelve (12) months either has (a) coordinated payment for or reimbursed over $10,000 of costs for health services delivered in Indiana or (b) communicated by mail or electronic media to residents of Indiana concerning their potential participation.

L. “healthcare information line” or “HIL” means any information line or referral service, including, without limitation, Indiana Behavioral Health Access Program for Youth Line (Be Happy), Indiana Consultations for Healthcare Providers in Addiction, Mental Health, and Perinatal Psychiatry Program (CHAMP), and the Adolescent Addiction Access (AAA) Program, which is available to providers in the state, and which is funded pursuant to the association’s plan of operation.

M. “insurance commissioner” means the insurance commissioner of the Indiana Department of Insurance.

N. “member” means any organization subject to assessments under this act.

O. "provider" means a person licensed by the state to provide healthcare services or a partnership or corporation or other entity made up of those persons.

P. “senior” means (i) all Indiana residents who are over age 64 and (ii) all other persons over age 64 who receive healthcare services in Indiana.

Q. “state” means the state of Indiana.

R. "state health commissioner" means the state health commissioner of the Indiana Department of Health.

§ XX–XX–3. **Association and HIL Fund Created**

A. There is hereby created the Indiana Healthcare Information Line Association or "HILA" for the primary purpose of equitably determining and collecting assessments for the cost of HILs in the state which are not covered by other federal or state funding.

B. The association shall be comprised of all assessed entities, as defined in this chapter.

C. A HIL fund "HIL Fund" shall be maintained in the custody of the state treasurer. Receipts from public and private sources for funding HILs may be deposited into the account in the manner and method specified in the association's plan of operation. Expenditures from the account must be used exclusively for the costs of operating any HILs funded by the association, at no cost to providers. Only the state health commissioner or such state health commissioner's designee may authorize expenditures from the account.

§ XX–XX–4. **Powers and Duties**

A. The association shall be a not-for-profit, voluntary corporation and shall possess all general powers as derive from that status under state law and such additional powers and duties as are specified in this section.

B. The directors' terms and method of appointments shall be specified in the plan of operation. The board of directors shall include:

(1) The state health commissioner or the state health commissioner's designee.

(a) The insurance commissioner or the insurance commissioner's designee.

(2) Three health carrier representatives.

(3) Two provider representatives, one of whom serves primarily children and one of whom serves primarily adults.

(4) One representative from a third-party administrator which is not a health carrier.

(5) The board may include up to three additional members as specified in the association's plan of operation.

C. Any director may designate a personal representative to act for the director at a meeting or on a committee. A personal representative shall notify the meeting's presiding officer of such designation. A director may revoke any such designation at any time.

D. The board shall have the following duties:

(1) Prepare and adopt articles of association and bylaws.

(2) Prepare and adopt a plan of operation.

(3) Submit the plan of operation to the state health commissioner for approval following opportunity for comment by the insurance commissioner.

(4) Conduct all activities in accordance with the approved plan of operation.

(5) Undertake reasonable steps to minimize (i) duplicate counting of covered lives or (ii) duplicate assessments.

(6) Pay the association's operating costs.

(7) Remit collected assessments, after costs and reserves, to the state treasurer for credit to the HIL Fund.

(8) Submit to the state health commissioner, no later than 120 days after the close of the association's fiscal year, a financial report in a form acceptable to the state health commissioner.

(9) Submit a periodic noncompliance report to the state health commissioner and the insurance commissioner listing any assessed entities that failed to either (i) remit assessments in accordance with the plan of operation or (ii) after notice from the association, comply with any reporting or auditing requirement of this chapter or the plan of operation.

E. The board shall have the following powers:

(1) Enter into contracts, including one or more contracts for executive director and administrative services to administer the association.

(2) Sue or be sued, including taking any legal action for the recovery of any assessment or interest or other cost reimbursement due to the association. Reasonable legal fees and costs for any amounts determined to be due to the association shall also be awarded to the association.

(3) Appoint, from among its directors, committees to provide technical assistance and to supplement those committees with non-board members.

(4) Engage professionals including auditors, attorneys, and independent consultants.

(5) Borrow and repay working capital, reserve, or other funds and grant security interests in assets and future assessments as may be helpful or necessary for such purposes.

(6) Maintain one or more bank accounts for collection of assessments, refund overpayments, and pay the association's costs of operation.

(7) Invest reserves as the board determines to be appropriate from time to time.

(8) Provide member and public information about its operations.

(9) Enter into one or more agreements with other state or federal authorities, including similar funding associations in other states, to assure equitable allocation of funding responsibility with respect to individuals who may reside in one state but receive healthcare services in another. Any amounts owed under any such agreements shall be included in the estimated costs for assessment rate setting purposes.

(10) Enter into one or more agreements with assessed entities for one or more alternative payment methodologies for the respective assessed entity's covered lives.

(11) Assist the state health commissioner in qualification for grant and other resources from the federal government and adjust its procedures as may be needed from time to time so that appropriate adjustments are made to any assessment liability with respect to any person who is eligible for federally funded services.

(12) Perform any other functions the board determines to be helpful or necessary to carry out the plan of operation or the purposes of this chapter.

§ XX–XX–5. **Assessments**

A. Assessment rates shall be determined as follows:

(1) The state health commissioner shall provide estimated HIL operation costs, not covered by any other state or federal funds, for the succeeding year no later than 120 days prior to the commencement of each year and shall update such estimate at such times as reasonably may be requested by the association.

(2) Add estimates to cover the association's operating costs, including for the upcoming year, any interest payable and estimated administrative allowance payable to the Department of Health.

(3) Add a reserve of up to 10% of the sum of the preceding (1) and (2) for unanticipated costs.

(4) Add a working capital reserve in such amount as may be reasonably determined by the board from time to time.

(5) Subtract the amount of any unexpended fund balance, including any net investment income earned, as of the end of the preceding year.

(6) Calculate a per child covered life per month and per adult covered life per month and a per senior covered life per month amount to be self-reported and paid by all assessed entities by dividing the annual amount determined in accordance with the above subparagraphs (1) through (5) by the number of covered lives in each age band, respectively, projected to be covered by the assessed entities during the succeeding program year, divided by 12. At the option of the association, the assessment may, instead, be calculated (i) as a single per covered life assessment, not segregated for child and adult and senior covered lives or (ii) as separate child and adult covered lives assessment with the senior covered lives included with the adult covered lives.

B. Within 45 days of the close of each calendar quarter, each assessed entity must report its covered lives and pay its assessments. Unless otherwise determined by the board, the assessed entity which would have been responsible for payment or coordination of payment or reimbursement of any primary care provider healthcare services for any individual shall be the entity responsible for reporting the respective covered lives and for payment of the corresponding assessment.

C. At any time after one full year of operation under paragraphs A and B above, the association, upon two-thirds (2/3) vote of its board and the approval of the state health commissioner, may:

(1) Make changes to the assessment collection mechanism outlined in those subsections; or

(2) Add any healthcare information line or other services for which the board determines funding pursuant to this Act is desirable to those services funded by this act. Any such changes shall be reflected in an updated plan of operation available to the public.

D. If an assessed entity has not paid in accordance with this section, interest accrues at 1% per month, compounded monthly on or after the due date.

E. The board may determine an interim assessment for new programs covered or to cover any funding shortfall. The board shall calculate a supplemental interim assessment using the methodology for regular assessments, but payable over the remaining fiscal year, and such interim assessment shall be payable together with the regular assessment commencing the calendar quarter that begins no less than 30 days following the establishment of the interim assessment. The board may not impose more than one interim assessment per year, except in the case of a public health emergency declared in accordance with state or federal law.

F. For purposes of rate setting, medical loss ratio calculations, and reimbursement by plan sponsors, all association assessments are considered medical benefit costs and not regulatory or administrative costs.

G. In the event of any insolvency or similar proceedings affecting any payer, assessments shall be included in the highest priority of obligations to be paid by or on behalf of such payer.

H. **[Alternative A – Annual Accounting]** The state treasurer shall supply funds as needed for HIL operations throughout the state's fiscal year. No later than 45 days following the close of the state's fiscal year, the state treasurer shall provide an accounting of HIL operating costs not covered by any other state or federal program and advise the association of the final amount needed to cover the prior fiscal year. The association shall reimburse such amount within 45 days of receiving the accounting, provided, however, that with respect to all or any part of any amount due which exceeds 105% of the amount which had been projected by the state health commissioner to be needed for such fiscal year, the association may defer such payment and the state treasurer shall include such deferral in the subsequent year's accounting. In the event of such deferral, any such remaining unreimbursed amount shall be included in the assessment calculation by the association for the funds to be raised by the association in the subsequent year.

[Alternative B – Just in Time Funding] The state health commissioner's designee shall advise the association not later than 5 business days in advance of the association's share of funding for each HIL program expense payment. Not later than 2 business days prior to the payment due date, the association shall transfer by automated clearinghouse transaction or wire or otherwise deposit such share into the HIL Fund.

I. If the association discontinues operation for any reason, any unexpended assessments, including unexpended funds from prior assessments in the HIL Fund, after the association's expenses, shall be refunded to payees in proportion to the respective assessment payments by payees over the most recent eight quarters prior to discontinuation of association operations.

§ XX–XX–6. **Reports and Audits**

A. Each assessed entity is required to report its respective numbers of covered lives in a timely fashion as prescribed in this chapter or the plan of operation and respond to any audit requests by the association related to covered lives or assessments due to the association. Upon failure of any assessed entity to respond to an audit request within 10 days of the receipt of notification of said audit request by the association, the assessed entity shall be responsible for prompt payment of the fees of any outside auditor engaged by the association to determine such information and shall make all books and records requested by said auditors available for inspection and copying at such location within the state as may be specified by such auditor.

B. Failure to cure non-compliance with any reporting, auditing, or assessment obligation to the association within 30 days from the postmarked date of written notice of noncompliance shall subject the assessed entity to all the fines and penalties, including suspension or loss of license, allowable under any provision of any other state statute. Any monetary fine or penalty shall be remitted to the HIL Fund and, thereby, reduce future obligations of the association for HIL funding. The assessed entity also shall pay for reasonable attorneys' fees and any other costs of enforcement under this section.

§ XX–XX–7. **Immunity**

Apart from liabilities of assessed entities expressly stated in this chapter or the plan of operation, there shall be no liability on the part of and no cause of action of any nature shall arise against (i) any association member or a member's agents, independent contractors, or employees, (ii) the association or its agents, contractors, or employees, (iii) members of the board of directors, (iv) the state health commissioner or the representatives thereof, or (v) the insurance commissioner or the representatives thereof, for any action or omission by any of them related to activities under this chapter.

§ XX–XX–8. **Tax Exempt Status**

The association is expressly granted exemption from all taxes levied either by the state or any governmental entity located therein.

§ XX–XX–9. **Severability**

If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

§ XX–XX–10. **Rulemaking**

The state health commissioner and the insurance commissioner or either one acting alone may adopt rules to carry out the purposes of this chapter.

§ XX–XX–11. **Administrative Allowance to Department of Health**

Within forty-five days following the close of each calendar quarter, the association shall transfer from assessments raised a sum equal to three percent (3%) of the costs funded by the association to the Indiana Department of Health's account in recognition of the support from the department and its staff in enabling association members to meet their obligations for funding healthcare services at lower cost.

§ XX–XX–12. **Transitional Matters**

The initial board, prior to adoption of the plan of operation, shall be appointed by the state health commissioner, after consultation with the insurance commissioner, within ninety (90) days of the adoption of this act.

To generate sufficient start-up funding, the association may accept prepayments from one or more member assessed entities, subject to offset of future amounts otherwise owing or other repayment method as determined by the board.

This act shall take effect July 1, 2024. However, no assessment shall become due before February 15, 2025.

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It is the mission of KV Foundation to reduce barriers that limit healthcare services for individuals, no matter their medical insurance coverage. KV Foundation encourages best practices in the funding of healthcare but is not itself a policy maker.

The draft is offered as an uncompensated service to local policy officials or industry organizations with the understanding that it would be reviewed by appropriate legislative services staff in the respective state prior to being made part of any bill. In particular, the titles of all state officials should be conformed to state practice.

KV Foundation is pleased to assist states, state agencies, and state-chartered not-for-profit organizations prior to state policy being set by the respective state legislature. Ideally, this occurs after consultation and consensus building involving appropriate health and health insurance agencies along with key private stakeholders, including, at a minimum, key organizations concerned with medical care and health insurance operations in the state.

KV FOUNDATION
PO Box 1885 • Concord, NH 03302-1885

phone + fax 855.KVFound (583-6863)
email SMack@KidsVax.org