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TITLE 760 DEPARTMENT OF INSURANCE

LSA Document #03-303(F)

DIGEST

Amends 760 IAC 2-1 through 760 IAC 2-20 to implement updates to the National Association of Insurance Commissioners' model regulation, to conform to the Health Insurance Portability and Accountability Act of 1996, to conform to IC 27-1-15.6 and IC 27-1-15.7, and to achieve reciprocity with other states on the licensing of insurance producers. Effective 30 days after filing with the secretary of state.

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760 IAC 2-8-1	**760 IAC 2-20-37.3**
760 IAC 2-8-2	**760 IAC 2-20-38.1**
760 IAC 2-8-3	**760 IAC 2-20-42**

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

760 IAC 2-1-1 Applicability and scope
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. Except as otherwise specifically provided, this article applies to the following:
(1) All long term care insurance policies, certificates, or subscriber agreements delivered or issued for delivery in Indiana on or after the effective date hereof by insurers.
(2) Fraternal benefit societies.
(3) Nonprofit health, hospital, and medical service corporations.
(4) Prepaid health plans.
(5) Health maintenance organizations and all similar organizations.
Certain provisions of this article apply only to federally tax-qualified long term care insurance contracts. *(Department of Insurance; 760 IAC 2-1-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed*

Oct 7, 2004, 1:00 p.m.: 28 IR 563)

SECTION 2. 760 IAC 2-2-1.5 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-1.5 "Activities of daily living" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1.5. "Activities of daily living" means, at a minimum, the following:
(1) Bathing.
(2) Continence.
(3) Dressing.
(4) Eating.
(5) Toileting.
(6) Transferring.
(Department of Insurance; 760 IAC 2-2-1.5; filed Oct 7, 2004, 1:00 p.m.: 28 IR 563)

SECTION 3. 760 IAC 2-2-3.1 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.1 "Bathing" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.1. "Bathing" means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower. *(Department of Insurance; 760 IAC 2-2-3.1; filed Oct 7, 2004, 1:00 p.m.: 28 IR 563)*

SECTION 4. 760 IAC 2-2-3.2 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.2 "Cognitive impairment" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.2. "Cognitive impairment" means a deficiency in:
(1) a person's short term or long term memory;
(2) orientation as to person, place, and time;
(3) deductive or abstract reasoning; or
(4) judgment;
as it relates to safety awareness. *(Department of Insurance; 760 IAC 2-2-3.2; filed Oct 7, 2004, 1:00 p.m.: 28 IR 563)*

SECTION 5. 760 IAC 2-2-3.3 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.3 "Continence" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.3. "Continence" means the ability to maintain control of bowel and bladder functions or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag. *(Department of Insurance; 760 IAC 2-2-3.3; filed Oct 7, 2004, 1:00 p.m.: 28 IR 564)*

SECTION 6. 760 IAC 2-2-3.4 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.4 "Department" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.4. "Department" means the department of insurance. *(Department of Insurance; 760 IAC 2-2-3.4; filed Oct 7, 2004, 1:00 p.m.: 28 IR 564)*

SECTION 7. 760 IAC 2-2-3.5 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.5 "Dressing" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.5. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. *(Department of Insurance; 760 IAC 2-2-3.5; filed Oct 7, 2004, 1:00 p.m.: 28 IR 564)*

SECTION 8. 760 IAC 2-2-3.6 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.6 "Eating" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.6. "Eating" means feeding oneself by getting food into the body:
(1) from a receptacle, such as a plate or cup;
(2) by a feeding tube; or
(3) intravenously.
(Department of Insurance; 760 IAC 2-2-3.6; filed Oct 7, 2004, 1:00 p.m.: 28 IR 564)

SECTION 9. 760 IAC 2-2-3.7 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.7 "Federally tax-qualified long term care insurance contract" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.7. (a) "Federally tax-qualified long term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:
(1) The only insurance protection provided under the contract is coverage of qualified long term care services. A contract shall not fail to satisfy this requirement by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.
(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this section do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this section by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.
(3) The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.
(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subdivision (5).
(5) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of the death of the insured or a complete surrender of cancellation of the contract cannot exceed the aggregate premiums paid under the contract.
(6) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(b) The term also means the portion of a life insurance contract that provides long term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Section 7702B(b) and 7702B(e) of the Internal Revenue Code of 1986, as amended.

(c) For purposes of this article, "similar policy forms" means all of the long term care insurance policies and certificates issued by an insurer in the same long term care benefit classification as the policy form being considered. Long term care benefit classifications are as follows:

(1) Institutional long term care benefits only.

(2) Noninstitutional long term care benefits only.

(3) Comprehensive long term care benefits.

(Department of Insurance; 760 IAC 2-2-3.7; filed Oct 7, 2004, 1:00 p.m.: 28 IR 564)

SECTION 10. 760 IAC 2-2-3.8 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-2-3.8 "Hands-on assistance" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3.8. "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activities of daily living. *(Department of Insurance; 760 IAC 2-2-3.8; filed Oct 7, 2004, 1:00 p.m.: 28 IR 565)*

SECTION 11. 760 IAC 2-2-8 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-2-8 "Skilled nursing care", "intermediate care", "personal care", "home care", and "other services" defined
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 8. "Skilled nursing care", "intermediate care", **"personal care",** "home care", and "other services" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered. *(Department of Insurance; 760 IAC 2-2-8; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 565)*

SECTION 12. 760 IAC 2-3-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-3-1 Individual long term care policies
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) The terms "guaranteed renewable" and "noncancellable" shall be used in an individual long term care insurance policy only with further explanatory language in accordance with the disclosure requirements of 760 IAC 2-4.

(b) A long term care insurance policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable".

(c) The term "guaranteed renewable" may be used only when:

(1) the insured has the right to continue the long term care insurance in force by the timely payment of premiums;

(2) ~~when~~ the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force; and

(3) the insurer cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(d) The term "noncancellable" may be used only when:

(1) the insured has the right to continue the long term care insurance in force by the timely payment of premiums; and

(2) the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(e) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(f) In addition to the other requirements of this section, a federally tax-qualified long term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(Department of Insurance; 760 IAC 2-3-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 565)

SECTION 13. 760 IAC 2-3-2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-3-2 Exclusions
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. A policy, certificate, or subscriber agreement may not be delivered or issued for delivery in Indiana as long term care insurance if the policy, certificate, or subscriber agreement limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:
(1) Preexisting conditions or diseases.
(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or related degenerative and dementing illnesses.
(3) Alcoholism and drug addiction.
(4) Illness, treatment, or medical condition arising out of:
(A) war or act of war (whether declared or undeclared);
(B) participation in a felony, riot, or insurrection;
(C) service in the armed forces or units auxiliary thereto;
(D) suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
(E) aviation (this exclusion applies only to nonfare paying passengers).
(5) Treatment provided in a government facility unless otherwise required by law as follows:
(A) Services for which benefits are available under any of the following:
(i) Medicare or other governmental program (except Medicaid).
(ii) Any state or federal workers' compensation.
(iii) Employer's liability or occupational disease law.
(iv) Any motor vehicle no-fault law.
(B) Services provided by a member of the covered person's immediate family.
(C) Services for which no charge is normally made in the absence of insurance.
(6) Expenses for services or items available or paid under another long term care insurance or health insurance policy.
(7) In the case of a federally tax-qualified long term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be reimbursable but for the application of a deductible or coinsurance amount.
This section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations. *(Department of Insurance; 760 IAC 2-3-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 565)*

SECTION 14. 760 IAC 2-3-4 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-3-4 Group long term care policies
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. (a) Group long term care insurance policies, certificates, or subscriber agreements issued in Indiana on or after the effective date of this article shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) As used in this article, ~~"a~~ "basis for continuation of coverage" means a policy provision ~~which~~ **that** maintains coverage under the existing group policy when such coverage would otherwise terminate and ~~which~~ **that** is subject only to the continued timely payment of premium. Group policies ~~which~~ **that** contain incentives to use certain providers ~~and/or~~ **or** facilities, **or both,** and group policies ~~which~~ **that** provide a restricted list of providers ~~and/or~~ **or** facilities, **or both,** shall provide continuation of benefits ~~which~~ **that** are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits. The commissioner shall consider the differences between managed care and nonmanaged care plans, including, but not limited to, the following:
(1) Provider system arrangements.

(2) Service availability.
(3) Benefit levels.
(4) Administrative complexity.

(c) As used in this article, ~~"a~~ "basis for conversion of coverage" means a policy provision ~~which~~ **that** requires that an individual:
(1) whose coverage under the group policy would otherwise terminate or has been terminated for any reason, **including discontinuance of the group policy in its entirety or with respect to an insured class;** and
(2) who has been continuously insured under the group policy (and any group policy ~~which~~ **that** it replaced) for at least six (6) months immediately prior to termination;
shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) As used in this article, "converted policy" means an individual policy of long term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers ~~and/or~~ **or** facilities, **or both,** the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, the following:
(1) Provider system arrangements.
(2) Service availability.
(3) Benefit levels.
(4) Administrative complexity.

(e) In order to maintain uninterrupted coverage, written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the insurer not later than thirty-one (31) days after:
(1) termination of coverage under the group policy; or ~~thirty-one (31) days after~~
(2) the date notification of conversion rights is mailed to the certificate holder;
whichever is later. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.

(f) If the group policy from which conversion is made:
(1) did not replace previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made; or
(2) replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
(1) termination of the individual's group coverage resulted from the individual's failure to make any required payment of premium or contribution when due; or
(2) the terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:
(A) providing benefits identical to those provided by the terminating coverage or providing benefits ~~which~~ **that** the commissioner determines to be substantially equivalent to or in excess of the benefits provided by the terminating coverage;
(B) the premium is calculated in a manner consistent with the requirements of subsection (f); and
(C) the new policy provides coverage to all individuals previously covered under the replaced policy.

(h) Notwithstanding any other provision of this rule, a converted policy issued to an individual may provide for a reduction of benefits payable to an individual only if:
(1) at the time of conversion, the individual is covered by another long term care insurance policy ~~which~~ **that** provides benefits on the basis of incurred expenses;
(2) the benefits provided by the other long term care policy together with the full benefits provided by the converted policy would result in payment of more than one hundred percent (100%) of the incurred expenses; and
(3) the reduction in benefits may only be included in the converted policy if the converted policy also provides for a premium decrease or refund ~~which~~ **that** reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this rule, any insured individual whose eligibility for group long term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship. *(Department of Insurance; 760 IAC 2-3-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 566)*

SECTION 15. 760 IAC 2-3-6 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-3-6 Premiums
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 6. The premiums charged to an insured for long term care insurance shall not increase due to either:
(1) the increasing age of the insured at ~~ages beyond~~ sixty-five (65) **years of age or beyond;** or
(2) the duration the insured has been covered under the policy.
~~This limitation shall not be required of life insurance policies or riders containing accelerated long term care benefits.~~ *(Department of Insurance; 760 IAC 2-3-6; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1391; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 567)*

SECTION 16. 760 IAC 2-3-7 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-3-7 Electronic enrollment
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 7. (a) In the case of a group long term care policy, any requirement that a signature of an insured be obtained by an insurance producer or insurer shall be deemed satisfied if the following conditions are met:
(1) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee.
(2) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure:
(A) the accuracy, retention, and prompt retrieval of records; and
(B) that the confidentiality of individually identifiable information is maintained.

(b) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. *(Department of Insurance; 760 IAC 2-3-7; filed Oct 7, 2004, 1:00 p.m.: 28 IR 567)*

SECTION 17. 760 IAC 2-3-8 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-3-8 Unintentional lapse
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 8. Each insurer offering long term care insurance shall, as a protection against unintentional lapse, comply with the following:
(1) No individual long term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one (1) person who is to receive the notice of termination in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The insurer shall notify the insured of the right to change this written designation no less often than once every two (2) years.
(2) The form used for the written designation must provide space clearly designated for listing at least one (1) person. The

designation shall include each person's full name and home address.
(3) In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice.".
(4) When the policyholder or certificate holder pays premium for a long term care insurance policy or certificate through a payroll or pension deduction plan, the requirements of this section need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.
(5) No individual long term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated to receive notice under this section at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid, and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.
(6) A long term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premiums, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy or certificate.
(Department of Insurance; 760 IAC 2-3-8; filed Oct 7, 2004, 1:00 p.m.: 28 IR 567)

SECTION 18. 760 IAC 2-4-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-4-1 Renewability provisions
Authority: IC 27-8-12-7
Affected: IC 27-8-12-10.6

Sec. 1. (a) Individual long term care insurance policies shall contain a renewability provision. The provision shall:
(1) be appropriately captioned; ~~shall~~
(2) appear on the first page of the policy; and ~~shall~~
(3) clearly state the duration ~~where limited,~~ of:
(A) renewability, ~~and the duration of~~ **where limited;**
(B) the term of coverage for which the policy is issued; and ~~the duration of~~
(C) the term of coverage for which the policy may be renewed.
This section shall not apply to policies ~~which~~ **that** do not contain a renewability provision, and under which the policies' right to nonrenew is reserved solely to the policyholder. **A long term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that the premium rate may change.**

(b) All riders or endorsements added to an individual long term care insurance policy after **the** date of issue or at reinstatement or renewal ~~which~~ **that** reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured, except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long term care insurance policy. After the date of policy issue, any rider or endorsement ~~which~~ **that** increases benefits or coverage ~~which~~ **that** also increases the premium during the policy term must be accepted ~~to~~ in writing signed by the insured ~~except if~~ **unless** the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

(c) A long term care insurance policy or certificate ~~which~~ **that** provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a long term care insurance policy, certificate, or subscriber agreement contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy, certificate, or subscriber agreement and shall be labeled as “Preexisting Condition Limitations”.

(e) A long term care insurance policy, certificate, or subscriber agreement containing any limitations or conditions for eligibility other than those prohibited in IC 27-8-12-10.6 shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy, certificate, or subscriber agreement and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits”.

(f) Life insurance policies ~~which~~ **that** provide an accelerated benefit for long term care are required to include a disclosure statement **at the time:**
(1) ~~at the time~~ of application for the policy or rider; and
(2) ~~at the time~~ the accelerated benefit payment request is submitted;
that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

(g) Activities of daily living and cognitive impairment shall be:
(1) used to measure an insured’s need for long term care;
(2) described in the policy or certificate in a separate paragraph; and
(3) labeled “Eligibility for the Payment of Benefits”.
Any additional benefit triggers shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this, too, shall be specified.

(h) A federally tax-qualified long term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in 760 IAC 2-17-1(e)(3) that the policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(i) A nonfederally tax-qualified long term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in 760 IAC 2-17-1(e)(3) that the policy is not intended to be a federally tax-qualified long term care insurance contract. *(Department of Insurance; 760 IAC 2-4-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 568)*

SECTION 19. 760 IAC 2-4-2 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-4-2 Required disclosure of rating practices to consumers
Authority: IC 27-8-12-7
Affected: IC 27-8-12-10.6

Sec. 2. (a) Except as provided in subsection (b), this section applies to any long term care policy or certificate issued in this state on or after January 1, 2005.

(b) For certificates issued on or after January 2, 2005, under a group long term care insurance policy that was in force on July 1, 2005, this section shall apply on the policy anniversary following July 1, 2006.

(c) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide the following information to the applicant at the time of application or enrollment unless the method of application does not allow for delivery at that time, in which case, an insurer shall provide the following information to the applicant no later than the time of delivery of the policy or certificate:
(1) A statement that the policy may be subject to rate increases in the future.
(2) An explanation of potential future premium rate revisions and the policyholder’s or certificate holder’s option in the event of a premium rate revision.
(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.
(4) A general explanation for applying premium rate or rate schedule adjustments that shall include the following:
(A) A description of when premium rate or rate schedule adjustments will be effective.

(B) The right to a revised premium rate or rate schedule if the premium rate or rate schedule is changed.
(5) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies the policy forms for which premium rates have been increased, the calendar years when the form was available for purchase, and the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as a minimum and maximum percentage if the rate increase is variable by rating characteristics and as follows:
(A) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.
(B) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.
(C) If an acquiring insurer files for a rate increase on a long term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four (24) month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with this section.
(D) If the acquiring insurer files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by this section including disclosure of the earlier rate increases.

(d) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsection (c). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(e) An insurer shall use the forms in 760 IAC 2-19.5-1 and 760 IAC 2-19.5-2 to comply with the requirements of this section.

(f) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (c) when the rate increase is implemented. *(Department of Insurance; 760 IAC 2-4-2; filed Oct 7, 2004, 1:00 p.m.: 28 IR 569; errata filed Oct 12, 2004, 3:20 p.m.: 28 IR 609)*

SECTION 20. 760 IAC 2-7-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-7-1 General provisions
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) **No insurer may offer a long term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long term care services covered by the policy.** Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature ~~An inflation protection feature shall provide at least~~ **no less favorable than** one (1) of the following:
(1) Increase benefit levels annually to be compounded annually at a rate not less than five percent (5%).
(2) Guarantee the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be more than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.
(3) Cover a specified percentage of actual or reasonable charges and ~~do~~ **does** not include a maximum specified indemnity amount or limit.

(b) Inflation protection benefit increases under a policy ~~which~~ **that** contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(c) An offer of inflation protection ~~which~~ **that** provides for automatic benefit increases shall include an offer of a premium ~~which~~

that the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(d) Inflation protection as provided in subsection (a) shall be included in a long term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder. The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection and I reject inflation protection.

____

(Signature of Applicant(s))".
(Department of Insurance; 760 IAC 2-7-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 570)

SECTION 21. 760 IAC 2-8-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-8-1 Questions
Authority: IC 27-8-12-7
Affected: IC 27-8-5-16; IC 27-8-12

Sec. 1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long term care insurance policy, certificate, or subscriber agreement in force or whether a long term care policy, certificate, or subscriber agreement is intended to replace any other accident and sickness or long term care policy, certificate, or subscriber agreement presently in force:
(1) Do you have another long term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?
(2) Did you have another long term care insurance policy or certificate in force during the last twelve (12) months? If so:
(A) with which company; and
(B) if that policy lapsed, when did it lapse?
(3) Are you covered by Medicaid?
(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?
A supplementary application or other form to be signed by the applicant and ~~agent,~~ **insurance producer,** except where the coverage is sold without an ~~agent,~~ **insurance producer,** containing such questions may be used. With regard to a replacement policy issued to a group defined by IC 27-8-5-16(1), the questions in this section may be modified only to the extent necessary to elicit information about health or long term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement. *(Department of Insurance; 760 IAC 2-8-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 570)*

SECTION 22. 760 IAC 2-8-2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-8-2 Any other health insurance policies
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. ~~(a) Agents~~ **Insurance producers** shall list **the following:**
(1) Any other health insurance policies they have sold to the applicant.
~~(b) Agents shall list~~ **(2)** Policies sold which are still in force.
~~(c) Agents shall list~~ **(3)** Policies sold in the past five (5) years ~~which~~ **that** are no longer in force.
(Department of Insurance; 760 IAC 2-8-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 863; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 571)

SECTION 23. 760 IAC 2-8-3 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-8-3 Notice regarding replacement of accident and sickness or long term care insurance
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its ~~agent,~~ **insurance producer,** shall furnish the applicant, prior to issuance or delivery of the long term care insurance policy, a notice regarding replacement of accident and sickness or long term care coverage. One (1) copy of such notice shall be retained by the applicant, and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND SICKNESS
OR LONG TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT
TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with a long term care insurance policy to be issued by [company name]. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors ~~which~~ **that** may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY ~~AGENT~~ **INSURANCE PRODUCER** [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions, which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its ~~agent~~ **insurance producer** regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

____
(Signature of ~~Agent,~~ **Insurance producer,** Broker, or Other Representative)

____
[Typed Name and Address of ~~Agent~~ **Insurance producer** or Broker]

The above "Notice to Applicant" was delivered to me on:

____
(Date)

____
(Applicant's Signature)

(Department of Insurance; 760 IAC 2-8-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 863; errata filed Jan 19, 1993, 10:00 a.m.: 16 IR 1514; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 571)

SECTION 24. 760 IAC 2-8-4 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-8-4 Direct response solicitations
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long term care coverage to the applicant upon issuance of the policy, certificate, or subscriber agreement. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND SICKNESS
OR LONG TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT
TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with the long term care insurance [policy] [certificate] [subscriber agreement] delivered herewith issued by [company name]. Your new [policy] [certificate] [subscriber agreement] provides thirty (30) days within which you may decide, without cost, whether you desire to keep the [policy] [certificate] [subscriber agreement]. For your own information and protection, you should be aware of and seriously consider certain factors ~~which~~ **that** may affect the insurance protection available to you under the new [policy] [certificate] [subscriber agreement].

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

1. Health conditions, which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its ~~agent~~ **insurance producer** regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

(Department of Insurance; 760 IAC 2-8-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 864; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 572)

SECTION 25. 760 IAC 2-8-6 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-8-6 Life insurance policies
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 6. Life insurance policies that accelerate benefits for long term care shall comply with this rule if the policy being replaced is a long term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 760 IAC 1-16.1. If a life insurance policy that accelerates benefits for long term care is replaced by another such policy, the replacing insurer shall comply with both the long term care and the life insurance replacement requirements. *(Department of Insurance; 760 IAC 2-8-6; filed Oct 7, 2004, 1:00 p.m.: 28 IR 572)*

SECTION 26. 760 IAC 2-9-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-9-1 Reporting
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) Every insurer shall maintain records for each ~~agent~~ **insurance producer** of that ~~agent's~~ **insurance producer's** amount of replacement sales as a percent of the ~~agent's~~ **insurance producer's** total annual sales and the amount of lapses of long term care insurance policies sold by the ~~agent~~ **insurance producer** as a percent of the ~~agent's~~ **insurance producer's** total annual sales.

(b) Each insurer shall report annually by June 30 the ten percent (10%) of its ~~agents~~ **insurance producers** with the greatest percentages of lapses and replacements as measured by subsection (a).

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely ~~agent~~ **insurance producer** activities regarding the sale of long term care insurance.

(d) Every insurer shall report annually by June 30 the number of **the following:**
(1) Lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.
~~(e) Every insurer shall report annually by June 30 the number of~~ **(2)** Replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.
(3) Claims denied for each class of business as a percentage of claims.

~~(f)~~ **(e)** For purposes of this rule:
(1) "claim" means a request for payment of benefits under a policy in force regardless of whether the benefit claimed is covered under the policy and any terms or conditions of the policy have been met;
(2) "denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition;
(3) "policy" means only long term care insurance; and
(4) "report" means on a statewide basis.

(f) Reports required under this section shall be filed with the commissioner. *(Department of Insurance; 760 IAC 2-9-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 572)*

SECTION 27. 760 IAC 2-10-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-10-1 Licensing
Authority: IC 27-8-12-7
Affected: IC 27-1-15.5-3; IC 27-1-15.7-2

Sec. 1. (a) No ~~agent is authorized to market, sell, solicit,~~ **insurer shall allow any long term care product to be marketed, sold, or solicited,** or otherwise **allow the** contact **of** any person for the purpose of marketing long term care insurance ~~until~~ **unless the insurance producer doing so has met all of the following criteria:**
(1) The ~~agent~~ **insurance producer** has successfully passed eight (8) hours of approved continuing education courses in long term care and long term care insurance. An ~~agent~~ **insurance producer** who completes the eight (8) hours of continuing education required by this subsection during the first two (2) years of a four (4) year license shall also comply with subsection (b) during the second two (2) years of the license.
(2) The insurance producer has successfully completed five (5) hours of approved continuing education in long term care or long term care insurance every two (2) years for a total of ten (10) hours in every four (4) year license renewal period.
(3) Has completed and passed the continuing education courses set out in this rule prior to accepting applications from the insurance producer or paying the insurance producer commission for the sale of long term care coverage.

~~(b) An agent shall successfully complete five (5) hours of approved continuing education in long term care or long term care insurance every two (2) years for a total of ten (10) hours in every four (4) year license renewal period.~~

~~(c)~~ **(b)** Continuing education courses completed ~~pursuant to subsections (a) and (b)~~ **under this section** may be used to satisfy the continuing education requirements set forth in ~~IC 27-1-15.5-7.1.~~ **IC 27-1-15.7-2.**

~~(d) Each insurer shall require an agent to provide documentation certifying that the agent has satisfied the requirements of this rule prior to accepting applications from the agent or paying the agent commission for the sale of long term care coverage.~~ *(Department of Insurance; 760 IAC 2-10-1; filed Oct. 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed*

Oct 2, 2001, 4:50 p.m.: 25 IR 382; filed Oct 7, 2004, 1:00 p.m.: 28 IR 573)

SECTION 28. 760 IAC 2-13-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-13-1 Relevant factors
Authority: IC 27-8-12-7
Affected: IC 27-1-12-7; IC 27-8-12-14.5; IC 27-8-12-14.6

Sec. 1. **(a)** Benefits under individual long term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner ~~which~~ **that** provides for adequate reserving of the long term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:
(1) Statistical credibility of incurred claims experience and earned premiums.
(2) The period for which rates are computed to provide coverage.
(3) Experienced and projected trends.
(4) Concentration of experience within early policy duration.
(5) Expected claim fluctuation.
(6) Experience refunds, adjustments, or dividends.
(7) Renewability features.
(8) All appropriate expense factors.
(9) Interest.
(10) Experimental nature of the coverage.
(11) Policy reserves.
(12) Mix of business by risk classification.
(13) Product features, such as long elimination periods, high deductibles, and high maximum limits.

(b) This section does not apply to life insurance policies that accelerate benefits for long term care. A life insurance policy that funds long term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premium paid, if the policy complies with all of the following provisions:
(1) The interest credited internally to determine cash value accumulations, including long term care, if any, is guaranteed to be no less than the minimum guaranteed interest rate for cash value accumulations without long term care set forth in the policy.
(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of IC 27-1-12-7.
(3) The policy meets the disclosure requirements of IC 27-8-12-14.5 and IC 27-8-12-14.6.
(4) Any policy illustrations meet the applicable requirements of 760 IAC 1-62.
(5) An actuarial memorandum is filed with the commissioner that includes the following:
(A) A description of the basis on which the long term care rates were determined.
(B) A description of the basis for the reserves.
(C) A summary of the following:
(i) Type of policy.
(ii) Benefits.
(iii) Renewability.
(iv) General marketing method.
(v) Limits on ages of issuance.
(D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any.
(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives.
(F) The estimated average annual premium per policy and the average issue age.
(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used, and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.
(H) A description of the effect of the long term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long term care claim status.

(Department of Insurance; 760 IAC 2-13-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 866; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 573)

SECTION 29. 760 IAC 2-15-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-15-1 Standards
Authority: IC 27-8-12-7
Affected: IC 27-4-1-4; IC 27-8-12

Sec. 1. (a) Every insurer, health care service plan, or other entity marketing long term care insurance coverage in this state, directly or through its producers, shall do the following:

(1) Establish marketing procedures to assure that any comparison of policies by its ~~agents~~ ~~or~~ ~~other~~ **insurance** producers will be fair and accurate.
(2) Establish marketing procedures to assure excessive insurance is not sold or issued.
(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, certificate, or subscriber agreement the following: "Notice to buyer: This [policy] [certificate] [subscriber agreement] may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all [policy] [certificate] [subscriber agreement] limitations.".
(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long term care insurance already has accident and sickness or long term care insurance and the types and amounts of any such insurance.
(5) Every insurer or entity marketing long term care insurance shall establish auditable procedures for verifying compliance with this subsection.
(6) Every insurer shall, at solicitation, provide written notice to the prospective policyholder or certificate holder about the existence and availability of the following programs:
(A) The Senior Health Insurance Information Program administered by the department along with the name, address, and telephone number of the program.
(B) The Indiana Long Term Care Insurance Program along with the name, address, and telephone number of the program.
(7) For long term care health insurance policies and certificates, use the terms "noncancellable" or "guaranteed renewable" only when the policy or certificate conforms to 760 IAC 2-3-1.
(8) Provide an explanation of contingent benefit upon lapse provided for in 760 IAC 2-16.1-1(d).
(9) Provide copies of the disclosure forms required by 760 IAC 2-4-2(e).

(b) In addition to the practices prohibited in IC 27-4-1-4, the following acts and practices are prohibited:
(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies, coverage, or insurers for the purpose of inducing, or tending to induce, any person to:
(A) lapse;
(B) forfeit;
(C) surrender;
(D) terminate;
(E) retain;
(F) pledge;
(G) assign;
(H) borrow on; or
(I) convert;
any insurance policy or coverage or to take out a policy of insurance with another insurer.
(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through:
(A) force;
(B) fright;
(C) threat, whether explicit or implied; or
(D) undue pressure;
to purchase or recommend the purchase of insurance.
(3) Cold lead advertising. Making use directly or indirectly of any method of marketing ~~which~~ **that** fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an

insurance ~~agent~~ **producer** or insurance company.
(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long term care insurance policy.

(c) With respect to the obligations set forth in this subsection, the primary responsibility of an association, when endorsing or selling long term care insurance, shall be to educate its members concerning long term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(d) The insurer shall file with the department the following material:
(1) The policy and certificate.
(2) A corresponding outline of coverage.
(3) Premium rates
(4) All advertisements requested by the department.

(e) The association shall disclose the following in any long term care insurance solicitation:
(1) The specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees, and other forms of financial support that the association receives from endorsement or sale of the policy or certificate to its members.
(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(f) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members. The board of directors of associations selling or endorsing long term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer. The association shall also do the following:
(1) At the time of the association's decision to endorse, engage the services of a person with expertise in long term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change.
(2) Actively monitor the marketing efforts of the insurer and its insurance producers.
(3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.
Subdivisions (1) through (3) shall not apply to federally tax-qualified long term care insurance contracts.

(g) No group long term care insurance policy or certificate may be issued to an association unless the insurer files with the department the information required in this section.

(h) The insurer shall not issue a long term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this section.

(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of IC 27-4-1-4. *(Department of Insurance; 760 IAC 2-15-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 574; errata filed Oct 12, 2004, 3:20 p.m.: 28 IR 609)*

SECTION 30. 760 IAC 2-15.5 IS ADDED TO READ AS FOLLOWS:

Rule 15.5. Suitability

760 IAC 2-15.5-1 Suitability
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) This section shall not apply to life insurance policies that accelerate benefits for long term care.

(b) Every insurer, health care service plan, or other entity marketing long term care insurance (the "issuer") shall do the

following:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long term care insurance is appropriate for the needs of the applicant.

(2) Train its insurance producers in the use of its suitability standards.

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) To determine whether the applicant meets the standards developed by the issuer, the insurance producer and issuer shall develop procedures that take the following into consideration:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(2) The applicant's goals or needs with respect to long term care and the advantages and disadvantages of insurance to meet these goals or needs.

(3) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(d) The issuer and, where an insurance producer is involved, the insurance producer shall make reasonable efforts to obtain the information set out in subsection (c). The efforts shall include presentation to the applicant, at or prior to application, of the "Long Term Care Insurance Personal Worksheet". The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in 760 IAC 2-19.5, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

(e) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long term care insurance to employees and their spouses.

(f) The sale or dissemination outside the company or agency by the issuer or insurance producer of information obtained through the personal worksheet is prohibited.

(g) The issuer shall use the suitability standards it has developed under this section in determining whether issuing long term care insurance coverage to an applicant is appropriate.

(h) Producers shall use the suitability standards developed by the issuer in marketing long term care insurance.

(i) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long Term Care Insurance" shall be provided. The form shall be in the format contained in 760 IAC 2-19.5-3 in not less than 12-point type.

(j) If the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the information, the issuer may reject the application. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(k) The issuer shall report annually to the commissioner the total number of the following:

(1) Applications received from residents of this state.

(2) Those who declined to provide information on the personal worksheet.

(3) Applicants who did not meet the suitability standards.

(4) Those who chose to confirm after receiving a suitability letter.

(Department of Insurance; 760 IAC 2-15.5-1; filed Oct 7, 2004, 1:00 p.m.: 28 IR 575)

SECTION 31. 760 IAC 2-16-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-16-1 Appropriateness of recommended purchase

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 1. In recommending the purchase or replacement of any long term care insurance policy, certificate, or subscriber agreement, an ~~agent~~ **insurance producer** shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. *(Department of Insurance; 760 IAC 2-16-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 576)*

SECTION 32. 760 IAC 2-16.1 IS ADDED TO READ AS FOLLOWS:

Rule 16.1. Nonforfeiture Benefit Requirement

760 IAC 2-16.1-1 Nonforfeiture
Authority: IC 27-8-12-7; IC 27-8-12-14
Affected: IC 27-8-12

Sec. 1. (a) This section does not apply to life insurance policies or riders containing accelerated long term care benefits.

(b) A long term care insurance policy may not be delivered or issued for delivery in Indiana unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (e). The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(c) If the offer is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(d) After rejection of the offer, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	**Percent Increase Over Initial Premium**
29 and under	**200%**
30-34	**190%**
35-39	**170%**
40-44	**150%**
45-49	**130%**
50-54	**110%**
55-59	**90%**
60	**70%**
61	**66%**
62	**62%**
63	**58%**
64	**54%**
65	**50%**
66	**48%**
67	**46%**
68	**44%**
69	**42%**
70	**40%**

71	**38%**
72	**36%**
73	**34%**
74	**32%**
75	**30%**
76	**28%**
77	**26%**
78	**24%**
79	**22%**
80	**20%**
81	**19%**
82	**18%**
83	**17%**
84	**16%**
85	**15%**
86	**14%**
87	**13%**
88	**12%**
89	**11%**
90 and over	**10%**

On or before the effective date of a substantial premium increase, the insurer shall do the following:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased.

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (e). This option may be elected at any time during the one hundred twenty (120) day period referenced in subdivision (3).

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in this subdivision shall be deemed to be the election of the offer to convert in subsection (b).

(e) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are as follows:

(1) For purposes of this subsection, "attained age rating" means a schedule of premiums starting from the issue date that increases at least one percent (1%) per year prior to fifty (50) years of age, and at least three percent (3%) per year beyond fifty (50) years of age.

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subdivision (3).

(3) The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall be not less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (f).

(4) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter. For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of the end of:

(A) the tenth year following the policy or certificate issue date; or

(B) the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(f) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium paying status.

(g) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(h) The requirements set forth in this section shall become effective twelve (12) months after adoption of this rule and shall apply as follows:
(1) Except as provided in subdivision (2), this section applies to any long term care policy issued in this state on or after the effective date of this section.
(2) For certificates issued on or after the effective date of this section, under a group long term care insurance policy, which policy was in force at the time this section became effective, this section shall not apply.

(i) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 760 IAC 2-13 treating the policy as a whole.

(j) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (d), a replacing insurer that purchased or otherwise assumed a block or blocks of long term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(k) A nonforfeiture benefit for federally tax-qualified long term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
(1) The nonforfeiture provision shall be appropriately captioned.
(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form.
(3) The nonforfeiture provision shall provide at least one (1) of the following:
(A) Reduced paid-up insurance.
(B) Extended term insurance.
(C) Shortened benefit period.
(D) Other similar offerings approved by the commissioner.
(Department of Insurance; 760 IAC 2-16.1-1; filed Oct 7, 2004, 1:00 p.m.: 28 IR 576)

760 IAC 2-16.1-2 Standards for benefit triggers
Authority: IC 27-8-12-7; IC 27-8-12-14
Affected: IC 27-8-12

Sec. 2. (a) A long term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

(b) Insurers may use additional activities of daily living to trigger covered benefits as long as they are defined in the policy.

(c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections (a) and (b).

(d) For purposes of this section, the determination of a deficiency shall not be more restrictive than the following:
(1) The hands-on assistance of another person to perform the prescribed activities of daily living.
(2) If the deficiency is due to the presence of a cognitive impairment, supervision, or verbal cuing by another person in order to protect the insured or others.

(e) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

(f) Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

(g) This section shall be effective July 1, 2005, and shall apply as follows:
(1) Except as provided in subdivision (2), this section applies to a long term care policy issued in this state on or after the effective date of this section.
(2) For certificates issued on or after the effective date of this section, under a group long term care insurance policy that was in force at the time this section became effective, this rule shall not apply.
(Department of Insurance; 760 IAC 2-16.1-2; filed Oct 7, 2004, 1:00 p.m.: 28 IR 578)

760 IAC 2-16.1-3 Standards for benefit triggers for federally tax-qualified long term care insurance contracts
Authority: IC 27-8-12-7; IC 27-8-12-14
Affected: IC 27-8-12

Sec. 3. (a) For purposes of this section the following definitions apply:
(1) "Federally tax-qualified long term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as necessary:
(A) diagnostic;
(B) preventive;
(C) therapeutic;
(D) curative;
(E) treatment;
(F) mitigation;
(G) rehabilitative; and
(H) maintenance or personal care;
services that are required by a chronically ill individual and are provided under a plan of care prescribed by a licensed health care practitioner.
(2) "Chronically ill individual" has the meaning set forth in Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, the term means any individual who has been certified by a licensed health care practitioner as:
(A) being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or
(B) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
The term shall not include an individual otherwise meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements.
(3) "Licensed health care practitioner" means one (1) of the following:
(A) A physician, as defined in Section 1861(r)(1) of the Social Security Act.
(B) A registered professional nurse.
(C) A licensed social worker.
(D) An individual who meets requirements prescribed by the Secretary of the Treasury.
(4) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(b) A federally tax-qualified long term care insurance contract shall pay only for federally tax-qualified long term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner.

(c) A federally tax-qualified long term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

(d) Certifications regarding activities of daily living and cognitive impairment required under subsection (c) shall be performed by the following licensed or certified professionals:

(1) Physicians.
(2) Registered professional nurses.
(3) Licensed social workers.
(4) Other individuals who meet requirements prescribed by the Secretary of the Treasury.

(e) Certifications required under subsection (c) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded, and additional certifications may not be performed until after the expiration of the ninety (90) day period.

(f) Federally tax-qualified long term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations. *(Department of Insurance; 760 IAC 2-16.1-3; filed Oct 7, 2004, 1:00 p.m.: 28 IR 579)*

SECTION 33. 760 IAC 2-17-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-17-1 Standard
Authority: IC 27-8-12-7; IC 27-8-12-14
Affected: IC 27-8-12

Sec. 1. (a) The outline of coverage shall be a free-standing document, using no smaller than ~~ten (10) point~~ **12-point** type.

(b) The outline of coverage shall contain no material of an advertising nature.

(c) Text ~~which~~ **that** is capitalized or underscored in the standard format outline of coverage may be emphasized by other means ~~which~~ **that** provide prominence equivalent to such capitalization or underscoring.

(d) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(e) The format for the outline of coverage shall be as follows:

[COMPANY NAME]
[ADDRESS – CITY AND STATE]
[TELEPHONE NUMBER]
LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies, certificates, or subscriber agreements ~~which~~ **that** are guaranteed issue, the following caution statement, or language substantially similar, must appear in the outline of coverage.]

Caution: The issuance of this long term care insurance [policy] [certificate] [subscriber agreement] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] ~~which~~ **that** was issued in the [indicate jurisdiction in which group policy was issued]).
2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!
3. **FEDERAL TAX CONSEQUENCES. This [policy] [certificate] is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended.**

OR

Federal Tax Implications of this [policy] [certificate]. This [policy] [certificate] is not intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [policy] [certificate] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.]

(c) [Describe waiver of premium provisions or state that there are no such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In boldface type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

~~3.~~ **6.** TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return – “free look” provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

~~4.~~ **7.** THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from the insurance company.

(a) [For ~~agents]~~ **insurance producers]** Neither [insert company name] nor its ~~agents~~ **insurance producers** represent Medicare, the federal government, or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

~~5.~~ **8.** LONG TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

~~6.~~ **9.** BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for payment of benefits. [Activities of daily living and cognitive impairment shall be used to measure an insured’s need for long term care and must be defined and described as part of the outline of coverage.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured’s need for long term care, then these qualifying criteria or screens must be explained.]

~~7.~~ **10.** LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions.

(b) Noneligible facilities/provider.

(c) Noneligible levels of care, e.g., unlicensed providers, care or treatment provided by a family member, etc.
(d) Exclusions/exceptions.
(e) Limitations.]

[This section should provide a brief specific description of any policy provisions ~~which~~ **that** limit, exclude, restrict, reduce, delay, or, in any other manner, operate to qualify payment of the benefits described in ~~(6)~~ **(9)** above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

~~8.~~ **11.** RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:
(a) That the benefit level will not increase over time.
(b) Any automatic benefit adjustment provisions.
(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.
(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.
(e) And finally, describe whether there will be any additional premium charge imposed and how that is to be calculated.]

~~9.~~ **12.** TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.
[(a) Describe the policy renewability provisions.
(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.
(c) Describe waiver of premium provisions or state that there are ~~not~~ **no** such provisions.
(d) State whether or not the company has a right to change premium and, if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

~~10.~~ **13.** ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.
[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision ~~which~~ **that** provides preconditions to the availability of policy benefits for such an insured.]

~~11.~~ **14.** PREMIUM.
[(a) State the total annual premium for the policy.
(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium ~~which~~ **that** corresponds to each benefit option.]

~~12.~~ **15.** ADDITIONAL FEATURES.
[(a) Indicate if medical underwriting is used.
(b) Describe other important features.]

16. CONTACT THE STATE SENIOR HEALTH INSURANCE INFORMATION PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY OR CERTIFICATE.

(Department of Insurance; 760 IAC 2-17-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 868; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 580)

SECTION 34. 760 IAC 2-18-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-18-1 Delivery
Authority: IC 27-8-12-7
Affected: IC 27-8-12-14.5

Sec. 1. (a) A long term care insurance shopper's guide in a format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long term care insurance policy or certificate. Delivery shall be as follows:
(1) ~~In the case of agent~~ **For insurance producer** solicitations, an ~~agent~~ **insurance producer** must deliver the shopper's guide prior to the presentation of an application or enrollment form.
(2) ~~In the case of~~ **For** direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(b) Life insurance policies or riders containing accelerated long term care benefits are not required to furnish the guide referenced in subsection (a), but shall furnish the policy summary required under IC 27-8-12-14.5. *(Department of Insurance; 760 IAC 2-18-1;*

filed Oct 30, 1992, 12:00 p.m.: 16 IR 869; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 582)

SECTION 35. 760 IAC 2-19-2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-19-2 Other sanctions
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. In addition to any other sanction provided under the laws or rules of this state, the commissioner may impose a penalty against the insurance ~~agent~~ **producer** who has violated the laws or rules. The penalty shall be the greater of **the following:**
(1) Three (3) times the amount of the commissions paid for each policy involved in the violation. ~~or~~
(2) Two thousand five hundred dollars ($2,500).
(Department of Insurance; 760 IAC 2-19-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 870; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 582)

SECTION 36. 760 IAC 2-19.5 IS ADDED TO READ AS FOLLOWS:

Rule 19.5. Standard Forms

760 IAC 2-19.5-1 Long term care insurance personal worksheet
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. The long term care insurance personal worksheet is as follows:

Long Term Care Insurance
Personal Worksheet

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information
Policy Form Numbers ____________________________
The premium for the coverage you are considering will be [$___________ per month, or $_________ per year,] [a one-time single premium of $___________________.]

Type of Policy (noncancellable/guaranteed renewable):
____

The Company's Right to Increase Premiums:
____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History
The company has sold long term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?
From my Income
From my Savings/Investments
My Family will Pay
[Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

What is your annual income? (check one)
Under $10,000
$[10-20,000]
$[20-30,000]
$[30-50,000]
Over $50,000

How do you expect your income to change over the next 10 years? (check one)
No change
Increase
Decrease
If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
From my Income
From my Savings/Investments
My Family will Pay
The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days __________ Approximate cost $____________ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
From my Income
From my Savings/Investments
My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
Under $20,000
$20,000-$30,000
$30,000-$50,000
Over $50,000

How do you expect your assets to change over the next ten years? (check one)
Stay about the same
Increase
Decrease
If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care.

Disclosure Statement

The answers to the questions above describe my financial situation.
Or
I choose not to complete this information.
(Check one.)

I acknowledge that the carrier and/or its insurance producer (below) has reviewed this form with me including the premium, premium rate increase history, and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history, and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).
Signed: ____
(Applicant)

____
(Date)

[I explained to the applicant the importance of completing this information.
Signed: ____
(Insurance Producer)

____
(Date)
Agent's Printed Name: ______________________________]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.
Signed: ____]
(Applicant)

____
(Date)

The company may contact you to verify your answers.
(Department of Insurance; 760 IAC 2-19.5-1; filed Oct 7, 2004, 1:00 p.m.: 28 IR 582)

760 IAC 2-19.5-2 Potential rate increase disclosure form
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. The form required by 760 IAC 2-4-2(e) is as follows:
Instructions:
This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.
Insurers shall provide all of the following information to the applicant:
Long Term Care Insurance
Potential Rate Increase Disclosure Form
1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][$_________________])
2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.
3. Rate Schedule Adjustments:
The company will provide a description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date, next billing date, etc.) (fill in the blank): _________________.
4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one (1) of the following options:

§ Pay the increased premium and continue your policy in force as is.

§ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)

§ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

§ Exercise your contingent nonforfeiture rights*. (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you did not buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here is how to tell if you are eligible:

You will keep some long term care insurance coverage, if:

- **Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and**
- **You lapse (not pay more premiums) within one hundred twenty (120) days of the increase.**

The amount of coverage (for example, new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- **You bought the policy at age sixty-five (65) and paid the one thousand dollars ($1,000) annual premium for ten (10) years, so you have paid a total of ten thousand dollars ($10,000) in premium.**
- **In the eleventh year, you receive a rate increase of fifty percent (50%), or five hundred ($500) for a new annual premium of one thousand five hundred ($1,500), and you decide to lapse the policy (not pay any more premiums).**
- **Your "paid-up" policy benefits are ten thousand dollars ($10,000) (provided you have a least ten thousand dollars ($10,000) of benefits remaining under your policy.)**

Turn the Page

Contingent Nonforfeiture

Cumulative Premium Increase over Initial Premium

That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%

68	**44%**
69	**42%**
70	**40%**
71	**38%**
72	**36%**
73	**34%**
74	**32%**
75	**30%**
76	**28%**
77	**26%**
78	**24%**
79	**22%**
80	**20%**
81	**19%**
82	**18%**
83	**17%**
84	**16%**
85	**15%**
86	**14%**
87	**13%**
88	**12%**
89	**11%**
90 and over	**10%**

(Department of Insurance; 760 IAC 2-19.5-2; filed Oct 7, 2004, 1:00 p.m.: 28 IR 584)

760 IAC 2-19.5-3 Disclosure form
Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. The form required by 760 IAC 2-15.5-1(i) is as follows:

Things You Should Know Before You Buy Long Term Care Insurance

- **A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.**
- **[You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]**

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- **The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.**

Medicare

- **Medicare does not pay for most long term care.**

Medicaid

- **Medicaid will generally pay for long term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.**
- **Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.**
- **When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.**
- **Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.**

Shopper's Guide

- **Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long Term Care Insurance". Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within thirty (30) days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.**

Counseling

- **Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.**

(Department of Insurance, 760 IAC 2-19.5-3; filed Oct 7, 2004, 1:00 p.m.: 28 IR 585)

SECTION 37. 760 IAC 2-20-10 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-10 "Case management agency" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 10. As used in this rule, "case management agency" means an agency or other entity approved by DDARS **and OMPP** as meeting DDARS case management standards contained in the DDARS community and home care services provider manual. *(Department of Insurance; 760 IAC 2-20-10; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 585)*

SECTION 38. 760 IAC 2-20-31.1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-31.1 "Residential care facility" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2; IC 16-28

Sec. 31.1. As used in this rule, "residential care facility", also referred to as assisted living facility and alternate care facility, means a facility ~~licensed under IC 16-28 and 410 IAC 16.2-5 which:~~ **that:**
(1) provides twenty-four (24) hour a day care and services sufficient to support needs resulting from **an** inability to perform activities of daily living or cognitive impairment;
(2) has a trained and ready to respond employee on duty in the facility at all times to provide care;
(3) provides three (3) meals a day and accommodates special dietary needs;
(4) has written contractual arrangements or otherwise ensures that residents receive the medical care services of a physician or nurse in case of emergency; and
(5) has appropriate methods and procedures for the handling and administration of prescribed medications and treatments.

A requirement that a residential care facility be licensed under IC 16-28 and 410 IAC 16.2-5 is optional for the issuer. *(Department of Insurance; 760 IAC 2-20-31.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 586)*

SECTION 39. 760 IAC 2-20-34 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-34 Standards for marketing
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6; IC 27-1-15.5-7.1; IC 27-1-15.5-7.3

Sec. 34. No long term care insurance policy, ~~or~~ certificate, or rider may be advertised, solicited, or issued for delivery in this state as a qualified long term care insurance policy, ~~or~~ certificate, or rider ~~which~~ **that** does not meet the requirements of this article and has not been approved by the commissioner of the department ~~of insurance~~ as a qualified long term care insurance policy, ~~or~~ certificate, or rider. Each issuer seeking to qualify a long term care policy, ~~or~~ certificate, or rider for participation in the Indiana long term care program must do the following:
(1) Use applications to be signed by the applicant ~~which~~ **that** indicate, as described as follows, that he or she:
(A) Received from the issuer the current edition of a booklet developed by OMPP titled "What you should know about long term care: The most commonly asked questions about the Indiana Long Term Care Program".
(B) Received a description of the issuer's qualified long term care policy or certificate benefit option meeting the requirements of sections 36.1(2) and 36.2(2) of this rule.
(C) Agrees to the release of information by the issuer to the state as may be needed to evaluate the Indiana long term care program and document a claim for Medicaid asset protection in the following format:

"CONSENT AND AUTHORIZATION

TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long term care policy or certificate by the [insert issuer name] to the State of Indiana for the purposes of documenting a claim for Asset Protection under the State Medicaid program, evaluating the Indiana Long Term Care Program and meeting Medicaid or Department of Insurance audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above and will be kept strictly confidential by the State of Indiana.

____

(Signature of Applicant(s))

____

Date".

(D) Received a graphic comparison showing the differences in premiums and benefits, over at least a twenty (20) year period, between a policy or certificate that increases benefits over the policy or certificate period and a policy or certificate that does not increase benefits.

(E) Agrees that, at the time of application, he or she is a resident of the state of Indiana.

(2) Obtain a signed statement from all applicants for a qualifying long term care facility policy or certificate indicating that they have been offered a qualifying integrated policy or certificate and declined this option. This statement shall be considered part of the application and shall state the following:

"I have been offered a policy or certificate qualifying under the Indiana Long Term Care Program ~~which~~ **that** provides coverage for both nursing home and home and community care services, and I decline the offer to apply for this coverage.

I understand that in the event I later want to purchase qualifying home and community care benefits through a qualifying rider, I may be required to furnish evidence of insurability and the insurer will have the right to refuse my request.

I also understand that the cost of purchasing home and community care benefits at a later date will be more expensive, since the premium for these benefits will be based upon my age at the time of such purchase.

____

Date

____

Signature of Applicant".

(3) Provide to the applicant, **on the application,** the option of having the application date of the policy being issued as the effective date. Where the policy is issued to a group and the group designates a day other than the application date as the effective date, any applicant for a certificate of coverage in an amount that meets or exceeds the state-set dollar amount at the time of application will be issued a certificate with coverage equal to the greater of the following:

(A) The certificate value applied for. ~~or~~

(B) The state-set dollar amount in force on the certificate's effective date.

In the event the value increases as a result of this provision, the premium may be adjusted accordingly. An election to choose the lesser value in a certificate shall be supported by a statement signed by the applicant that clearly discloses the certificate will earn dollar-for-dollar asset protection.

(4) Provide to the policyholder or certificate holder upon delivery of a qualified long term care insurance policy or certificate a complete description of the asset protection options under the Indiana long term care program and a description of Medicaid in a format prescribed by OMPP.

~~(5) Report to the commissioner of the department of insurance all sales involving replacement of existing policies and certificates by qualified policies or certificates within thirty (30) days of the issue date of the newly issued qualified policy or certificate. The report shall include the following:~~

~~(A) The name and address of the insured.~~

~~(B) The name of the company whose policy or certificate is being replaced.~~

~~(C) The name of the agent replacing the coverage.~~

~~This report shall also include a comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing issuer shall not cancel, nonrenew, or rescind a replacement policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.~~

(5) Obtain a signed statement from all applicants for a qualified long term care facility policy or certificate that earns dollar-for-dollar asset protection indicating that they are aware the policy or certificate will earn dollar-for-dollar asset protection, and not total asset protection, and that this is their intention.

(6) Provide written evidence to the department ~~of insurance~~ that procedures are in place to assure that no ~~agent~~ **insurance producer** or telemarketer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a qualified long term care insurance policy or certificate unless the ~~agent~~ **insurance producer** or telemarketer has completed fifteen

(15) hours of ~~continuing education~~ training on long term care insurance, consisting of eight (8) hours in general long term care and seven (7) hours on the Indiana long term care program specifically.
(7) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in ~~bold~~ **boldface** type and in a separate box as follows:

THIS POLICY [CERTIFICATE] QUALIFIES UNDER THE INDIANA LONG TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY [CERTIFICATE] MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE PROGRAM.

(8) For all long term care facility policies or certificates, include a statement on the outline of coverage and the front page of the policy or certificate in ~~bold~~ **boldface** type and prominently displayed ~~which~~ **that** states: LONG TERM CARE FACILITY POLICY [CERTIFICATE].
(9) Include a statement on the qualified rider in ~~bold~~ **boldface** type and in a separate box as follows:

THIS RIDER QUALIFIES UNDER THE INDIANA LONG TERM CARE PROGRAM FOR MEDICAID ASSET PROTECTION WHEN ATTACHED TO A LONG TERM CARE POLICY ~~WHICH~~ **THAT** ALSO QUALIFIES FOR MEDICAID ASSET PROTECTION. THIS RIDER MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE PROGRAM.

(10) Long term care insurance policies or certificates sold after April 1, 1993, that are not qualified under the Indiana long term care program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in ~~bold~~ **boldface** type and in a separate box as follows:

THIS POLICY [CERTIFICATE] DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE INDIANA LONG TERM CARE PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE INDIANA LONG TERM CARE PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DEPARTMENT OF INSURANCE AT 1-800-452-4800.

(11) Provide that no qualified long term care policy or certificate form shall be sold, transferred, or otherwise ceded to another issuer without first having obtained approval from the commissioner. This provision does not apply to **the following:**

(A) Any reinsurance agreement or transaction in which the ceding issuer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement. ~~and~~

(B) The ceding issuer remains responsible for complying with all requirements of sections ~~37~~ **37.1** through 42 of this rule.

(12) Except as provided in clause (A), an issuer shall continue to make available for purchase any qualified policy form or certificate form issued that has been approved by the commissioner. The following describe the process and result of discontinuing the availability of a qualified policy form or certificate form:

(A) An issuer may discontinue the availability of a qualified policy form or certificate form if the issuer provides the commissioner, in writing, its decision at least thirty (30) days prior to discontinuing the availability of the form of the qualified policy or certificate. The following shall be considered a discontinuance of the availability of a qualified policy form or certificate form:

(i) The sale or other transfer of a qualified policy form or certificate form to another issuer.

(ii) Failure to actively offer for sale a qualified policy form or certificate form in the previous twelve (12) months.

(iii) A change in the rating structure or methodology unless the issuer complies with the following requirements:

(AA) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(BB) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential ~~which~~ **that** is in the public interest.

(B) An issuer that discontinues the availability of a qualified policy form or certificate form under clause (A) shall not file for approval of a new long term care policy form or certificate form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. This clause does not apply if one (1) of the following are met:

(i) An issuer discontinues a qualified policy form or certificate form due to requirements from amendment to this article or IC 27-8-12.

(ii) All existing policyholders and certificate holders of a discontinued qualified policy form or certificate form who are not receiving benefits are notified by the issuer of the availability of the new benefits and provisions of the new qualified policy form by the time of their next renewal date and are offered the opportunity by the issuer to acquire the new benefits ~~and/or~~ **or** provisions, **or both,** by either:

(AA) adding a qualified rider to the original qualified policy, in which case a separate premium, if any, will be calculated for the qualified rider based on the policyholder's original issue age; or

(BB) replacing the existing qualified policy with the new qualified policy form with the premium calculation for the new qualified policy based on the policyholder's original issue age.

This item does not prohibit an issuer ~~for~~ **from** underwriting in accordance with the issuer's established underwriting standards based on an application for the new qualified policy form or qualified rider.

(iii) The issuer pools the insureds of the existing qualified policy with the issuer's most current largest selling qualified policy for purposes of requesting future rate changes. In the event an issuer does not have another qualified policy in which to pool insureds of their existing qualified policy, the issuer shall pool insureds of the existing qualified policy with their most current largest selling nonqualified policy or with another of their nonqualified policies as determined by the commissioner for purposes of requesting future rate changes.

(C) An issuer who discontinues selling qualified policies or any insurer who assumes a qualified policy from another insurer **shall pool insureds of the existing qualified policies with one (1) of their nonqualified policies as determined by the commissioner for purposes of requesting future rate changes. In addition the insurer** must continue to comply with the reporting requirements and maintaining auditing information requirements set forth in this article.

(13) Provide assurances to the department ~~of insurance~~ that in the event a change is made to a qualified policy or certificate that is eligible for favorable tax status that may affect its favorable tax status, the issuer shall disclose this fact to the policyholder or certificate holder prior to the change being made, and, at a minimum, the issuer shall advise the policyholder or certificate holder that they should consult a tax advisor.

(Department of Insurance; 760 IAC 2-20-34; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 586)

SECTION 40. 760 IAC 2-20-35 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-35 Minimum benefit standards for qualifying policies, certificates, and riders
Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 35. No long term care insurance policy, certificate, or rider may be advertised, solicited, or issued for delivery in this state as a qualified long term care insurance policy, certificate, or rider ~~which~~ **that** does not meet the minimum benefit standards in this section and ~~which~~ **that** has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy, certificate, or rider. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, a long term care insurance policy, certificate, or rider shall meet the following:

(1) Provide that maximum benefits be available in dollars and not in days of care.

(2) Include a provision of inflation protection ~~which~~ **that** satisfies at least one (1) of the following criteria:

(A) The policy or certificate covers at least seventy-five percent (75%) of the average daily private pay rate.

(B) The policy or certificate provides for automatic increases in the per diem dollar level in accordance with either the consumer price index or at five percent (5%) each year over the previous year for each year that the contract is in force.

(C) For policyholders or certificate holders seventy-five (75) years of age or greater at time of purchase, the policy or certificate provides for automatic increases in the per diem dollar level at five percent (5%) each year that the contract is in force.

(3) Provide that the unused maximum benefit amount of the policy, certificate, or rider increase proportionately with the inflation protection requirements of subdivision (2).

(Department of Insurance; 760 IAC 2-20-35; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1151; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2649; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 589)

SECTION 41. 760 IAC 2-20-36.1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-36.1 Minimum benefit standards and required policy and certificate provisions for integrated policies
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.1. No long term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified integrated policy or certificate ~~which~~ **that** does not meet the minimum benefit standards and required policy and certificate provisions in this section and ~~which~~ **that** has not been approved by the commissioner of the department ~~of insurance~~ as a qualified long term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits ~~which~~ **that** are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, an integrated policy or certificate must meet the following:

(1) Contain a maximum benefit amount equivalent to at least three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3)(A).

(2) Offer a maximum benefit amount option equivalent to three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3)(A). Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

(3) At a minimum, upon the initial effective date, provide the following:

(A) A daily nursing facility benefit of at least seventy-five percent (75%) of the average daily private pay rate in nursing facilities rounded to the next highest five dollar ($5) or ten dollar ($10) increment. No policy or certificate shall pay benefits in excess of the actual charges.

(B) A daily home and community based benefit of at least fifty percent (50%) of the daily nursing facility benefit contained in the policy or certificate. No policy or certificate shall pay benefits in excess of the actual charges.

(C) The daily home and community based benefit shall not exceed the daily nursing facility benefit.

(4) If issued on an expense incurred basis, provide benefits ~~which~~ **that** are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(5) Include a provision that policy or certificate benefits can be used to purchase nursing facility care or home and community-based care. Home and community-based care shall include, at a minimum, but not be limited to, the following:

(A) Home health nursing.

(B) Home health aide services.

(C) Attendant care.

(D) Respite care.

(E) Adult day care services.

(6) All home and community-based services shall include case management services delivered by a case management agency. The issuer may establish a limit on case management benefits. This limit shall not be less than thirteen (13) times the daily nursing home benefit per year. Case management benefits shall not count toward the policy's or certificate's maximum benefit.

(7) Issuers may include benefits for residential care facilities, as defined in section 31.1 of this rule, in an integrated policy or certificate. These policies must:

(A) provide a daily residential care facility benefit of at least ~~fifty~~ **seventy-five** percent ~~(50%)~~ **(75%)** and no more than the daily nursing facility benefit contained in the policy or certificate;

(B) if issued on an expense incurred basis, provide a daily residential care facility benefit ~~which~~ **that** does not exceed ~~fifty~~ **seventy-five** percent ~~(50%)~~ **(75%)** of the per diem cost incurred by the insured; and

(C) include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or residential care facility.

(Department of Insurance; 760 IAC 2-20-36.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2651; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1994; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 589)

SECTION 42. 760 IAC 2-20-36.2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-36.2 Minimum benefit standards and required policy and certificate provisions for long term care facility policies

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.2. No long term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified long term care facility policy or certificate ~~which~~ **that** does not meet the minimum benefit standards and required policy and certificate provisions in this section, and ~~which~~ **that** has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits ~~which~~ **that** are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, a long term care facility policy or certificate must meet the following:

(1) Contain a maximum benefit amount equivalent to at least three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3).

(2) Offer a maximum benefit amount option equivalent to three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3). Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

(3) At a minimum, upon the initial effective date, provide a daily nursing facility benefit of at least seventy-five percent (75%) of the average daily private pay rate in nursing facilities rounded to the next highest five dollar ($5) or ten dollar ($10) increment. No policy or certificate shall pay benefits in excess of the actual charges.

(4) If issued on an expense incurred basis, provide daily nursing facility benefits ~~which~~ **that** are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(5) Issuers may include benefits for residential care facilities, as defined in section 31.1 of this rule, in a long term care facility policy or certificate. Policies and certificates ~~which~~ **that** include residential care facility benefits must:

(A) provide a daily residential care facility benefit of at least ~~fifty~~ **seventy-five** percent ~~(50%)~~ **(75%)** and no more than the daily nursing facility benefit contained in the policy or certificate;

(B) if issued on an expense incurred basis, provide a daily residential care facility benefit ~~which~~ **that** does not exceed ~~fifty~~ **seventy-five** percent ~~(50%)~~ **(75%)** of the per diem cost incurred by the insured; and

(C) include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or a residential care facility.

(Department of Insurance; 760 IAC 2-20-36.2; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2652; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1995; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 590)

SECTION 43. 760 IAC 2-20-37.2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-37.2 Reporting of insurance producer data

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2; IC 12-15-39.6

Sec. 37.2. Issuers of qualified policies or certificates shall submit ~~agent~~ **insurance producer** sales data to OMPP two (2) times per year for purposes of creating and maintaining a directory of ~~agents~~ **insurance producers** for consumers. The format, time frame of reporting periods, and due date for data will be specified by OMPP. *(Department of Insurance; 760 IAC 2-20-37.2; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1997; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 590)*

SECTION 44. 760 IAC 2-20-37.3 IS ADDED TO READ AS FOLLOWS:

760 IAC 2-20-37.3 Reporting of sales data
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 37.3. Issuers of qualified policies or certificates shall submit Indiana sales data for qualified and nonqualified long term care insurance policies or certificates annually to OMPP. The format and time frame for reporting this data will be specified by OMPP. *(Department of Insurance; 760 IAC 2-20-37.3; filed Oct 7, 2004, 1:00 p.m.: 28 IR 590)*

SECTION 45. 760 IAC 2-20-38.1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-38.1 Determining asset protection
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 38.1. (a) Total asset protection for an individually owned qualified policy or certificate is earned when:
(1) the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate;
(2) the policy or certificate includes an inflation protection benefit of five percent (5%) compounded annually;
~~(2)~~ **(3)** the maximum benefit was not reduced by the request of the policyholder or certificate holder during the term of the policy or certificate; and
~~(3)~~ **(4)** all of the qualified policy or certificate benefits have been exhausted.

(b) Total asset protection for a qualified policy or certificate that has had a reduction of coverage during the term of the policy or certificate is earned when:
(1) the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate;
(2) the maximum benefit was reduced at the request of the policyholder or certificate holder during the term of the policy or certificate, and, at the time of the reduction, the new maximum benefit was equal to or greater than the state-set dollar amount in force during the calendar year in which the reduction took place disregarding any qualifying insurance benefits the policyholder or certificate holder may have already received from the policy or certificate being reduced; and
(3) all of the qualified policy or certificate benefits have been exhausted.

(c) Total asset protection for a qualified policy, certificate, or rider that allows spouses to share the benefits is earned when the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate, and either:
(1) only one (1) spouse uses the policy or certificate benefits and exhausts all of the qualifying insurance benefits; or
(2) both spouses use the policy or certificate benefits and the remaining maximum benefit at the time the first spouse has permanently stopped using benefits is equal to or greater than the state-set dollar amount in force during that calendar year disregarding any qualifying insurance benefits the second spouse may have already received, and the second spouse exhausts the remaining qualifying insurance benefits.

(d) Dollar-for-dollar asset protection is earned for all other situations ~~which~~ **that** differ from **subsections** (a) ~~(b), and~~ **through** (c).

(e) A qualified long term care insurance policy or certificate owned by an Indiana resident ~~which~~ **that** was purchased as part of another state's Partnership for Long Term Care Program will earn dollar-for-dollar asset protection for the qualified insured if the other state's program is similar to the Indiana long term care program and OMPP has a reciprocity agreement with the other state's Medicaid program.

(f) Benefits paid in excess of the actual charges do not earn asset protection.

(g) Benefits paid that are not based upon the insured event criteria do not earn asset protection.

(h) Home and community care benefits paid without case management do not earn asset protection. *(Department of Insurance;*

760 IAC 2-20-38.1; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1998; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 590)

SECTION 46. 760 IAC 2-20-42 IS AMENDED TO READ AS FOLLOWS:

760 IAC 2-20-42 Auditing and correcting deficiencies in issuer record keeping
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 42. (a) Within one (1) year of the first date that any policyholder or certificate holder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner or OMPP deems necessary thereafter, OMPP as representative of the commissioner shall conduct a systems audit of that company's records. The issuer shall be responsible for advising OMPP and the department of insurance when this one (1) year period has begun. OMPP shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation. It is the responsibility of the issuer to make any necessary corrections.

(b) OMPP shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. OMPP shall have the final decision concerning sample sizes and other auditing methods. OMPP shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. OMPP shall also notify the issuer of any obligations described in this subsection to hold clients harmless.

(c) The assistant secretary of OMPP or other authorized individual may enter into voluntary arrangements with issuers of qualified long term care insurance policies and certificates under which the assistant secretary would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificate holders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the assistant secretary of OMPP or other authorized individual concerning whether services qualify for asset protection shall be binding upon OMPP in all subsequent actions, and OMPP shall not make any assertion contradicting these determinations in any action arising in this subsection:

(1) All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the assistant secretary of OMPP or other authorized individual in writing. These requests may include, but are not limited to, requests for determinations in the following areas:
   (A) Whether the insured event has occurred and has been adequately documented.
   (B) Whether a care plan is required.
   (C) Whether a revision of a care plan is required.
   (D) Whether a service or services are in accord with the care plan.
   (E) Whether a service is of such a nature as to qualify for asset protection.
   (F) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

(2) The assistant secretary of OMPP or other authorized individual may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:
   (A) Assessments.
   (B) Care plans.
   (C) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information are *[sic., is]* later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on OMPP or any other person or entity in subsequent actions. In the case of a policyholder or certificate holder for whom a determination has been invalidated because information provided was determined to be inaccurate, ~~the provisions of~~ subsections (f) and (g) will apply in the same manner as for any other policyholder or certificate holder.

(3) The assistant secretary of OMPP or other authorized individual shall render his or her determination on each request in writing. Each determination of the assistant secretary of OMPP or other authorized individual shall state the reason for his or her determination, including the following:
   (A) Relevant facts.
   (B) Documentation of facts.
   (C) Statutes.

(D) Regulations.
(E) Policies.
(4) A copy of all determinations of the assistant secretary of OMPP or other authorized individual shall be kept on file at OMPP, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency that originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificate holder or the policyholder's or certificate holder's authorized ~~agent.~~ **insurance producer.**

(d) When an audit or other review by OMPP reveals deficiencies in the record keeping procedures of an issuer, OMPP will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by OMPP within a reasonable period of time, OMPP will notify the department ~~of insurance~~ of the deficiencies.

(e) The commissioner of the department, ~~of insurance,~~ upon consultation with OMPP, shall reserve the right to remove qualification status of long term care insurance policies and certificates when deemed necessary. Failure to comply with ~~any of the provisions of~~ this article can be grounds for the removal of qualification status. If the department of insurance removes qualification status from a long term care insurance policy or certificate, a policyholder or certificate holder who purchased his or her policy or certificate while the policy or certificate was qualified will retain his or her right to asset protection. A policyholder or certificate holder who purchases his or her policy or certificate after the removal of qualification status will have no right to asset protection. Any issuer who has their qualification status removed must continue to comply with the reporting requirements and maintaining auditing information requirements set forth in this article.

(f) If an issuer prepares a service summary ~~which~~ **that** is used in a Medicaid application for a policyholder or certificate holder and the client is found eligible for Medicaid, and the policyholder or certificate holder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, OMPP may require the issuer to pay for services counting towards asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's errors, after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

(g) If OMPP determines that an issuer's records pertaining to a policyholder or certificate holder who has received Medicaid benefits are in such condition that OMPP cannot determine whether the policyholder or certificate holder qualifies for asset protection, OMPP may require the issuer to pay for services counting towards asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's error, after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

(h) OMPP shall serve as the representative of the commissioner for all audits and examinations that may be required to determine compliance with this article.

(i) Compliance with subsections (f) and (g) is a requirement for a policy or certificate to retain qualification. *(Department of Insurance; 760 IAC 2-20-42; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1157; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2000; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 7, 2004, 1:00 p.m.: 28 IR 591)*

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