



Partnership Agent Manual

**Indiana Long Term Care Insurance Program
Indianapolis, IN**

866-234-4582

www.longtermcareinsurance.IN.gov

(Updated 10-2009)

Indiana Long Term Care Insurance Program Staff Directory

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LONG TERM CARE INSURANCE IN INDIANA

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The Indiana Department of Insurance (IDOI)
311 West Washington Street, Indianapolis, IN 46204-2787

www.in.gov/idoi

Agency Services: 317-232-2389 (Licensing and Continuing Education)

The Indiana Department of Insurance (IDOI):

- Supervises the organization, regulation, examination, rehabilitation, liquidation, and conservation of all insurance companies residing in (*domiciled*) or authorized to do business in Indiana. The IDOI issues a *certificate of authority* to a company licensed to do business in Indiana.
- Enforces, administers, and executes the insurance laws of Indiana.
- Regulates insurance agent licensing requirements

LTC Licensing Requirements:

Resident

1. Be licensed to sell health insurance; **AND**
2. Complete an initial 8-hour basic long term care insurance course; **AND**
3. Complete 5 hours of LTCI continuing education every 2 years to maintain eligibility to sell LTCI. Course work can be in long term care insurance or Medicaid. The 5 hours can be any combination of hours (i.e. 5, 4/1, 3/2, 5 one hour classes). If the 5 hours renewal requirement is not maintained, the basic 8 hour class must be retaken; **AND**
4. If selling **Partnership** policies, complete a one-time 7 hour **IN Partnership** specific course.

Non-Resident

1. The basic 8 hour LTC CE and 5 hour LTC renewal CE are waived if the non-resident agent's state has continuing education reciprocity with Indiana.
2. Non-resident agent **MUST** complete the 7 hour IN Partnership specific course. The course **is not waived** and not reciprocal with other Partnership states.

Continuing Education Hours (CE):

1. IDOI requires self-reporting of CE hours. The Department **does not** keep copies of CE certificates. It is an agent's responsibility to maintain proper license credentials.
2. Agent should keep **original** certificates for at least 4 years after the end of a renewal period in case of an IDOI audit.

3. It is recommended that LTCI CE certificates be kept permanently. Insurance companies strictly monitor agent compliance with LTCI continuing education. Companies cannot accept applications or pay commissions to any agent who has not met LTCI continuing education requirements (760 IAC 2-10-1).

IN License Renewal Requirements (for the 2 year license):

1. Complete 20 hours of CE in the 2 year licensing period.
2. Same CE course number cannot be counted more than once in the 2 year period.
3. LTC CE courses can count toward satisfying the 20 hour general CE requirement.
4. Renewal invoices are mailed to agent residence address 60 days prior to expiration.
5. Mail renewal invoice and fee payment to the address on the invoice. Renewals can also be completed online thru SIRCON, (www.sircon.com), with a credit card payment.

Change of Name and/or Address:

1. Agents have 30 days to notify IDOI of a new address (residence and business) and/or name change in writing. Failure to comply can result in a \$100 fine.
2. Use the **Service Request Form** (available on IDOI website), www.in.gov/idoi, to submit changes.

Late License Renewal: An agent who is late renewing an Indiana insurance license is subject to a penalty of three times the renewal fee in addition to the license renewal fee. An agent who is more than 30 days late in renewing a license must pay the fine plus successfully complete the laws portion of the licensing exam.

Sircon Data Base (www.sircon.com): Agents can now renew licenses on line through Sircon using a credit card. Additional services are also available such as tracking CE classes taken since 1/1/2007, printing a paper copy of license, and updating personal information.

Continuing Education Providers:

The Partnership website, www.longtermcareinsurance.in.gov lists various Continuing Education providers that offer long term care classes. Additional CE providers and classes can also be located on the SIRCON website, www.sircon.com.

State Health Insurance Assistance Program (SHIP)

714 W. 53rd Street

Anderson, Indiana 46013

765-608-2310

1-800-452-4800

www.medicare.in.gov

The State Health Insurance Assistance Program (SHIP) provides free health insurance information for seniors and pre-retirees. SHIP is part of a federal network of State Health Insurance Assistance Programs located in every state. In Indiana, SHIP is sponsored by the Centers for Medicare and Medicaid Services (the federal agency which administers Medicare) and IDOI.

SHIP is not affiliated with any insurance company or agency and does not sell insurance.

SHIP is staffed by a crew of volunteer counselors who have completed an intensive four-day training course and are certified by the IDOI. Regular training updates keep them current with the most recent changes in Medicare and other health care insurance options.

SHIP counselors are committed volunteers who offer free and objective assistance in complete confidence. There are SHIP locations located across the state where consumers can meet one on one with a counselor. A listing of local SHIP sites is available on the following pages.

SHIP:

- Provides educational materials and brochures.
- Helps explain the Medicare program.
- Educates how to file Medicare claims and how to appeal Medicare decisions.
- Explains how to make informed decisions about health care policies.
- Informs a Medicare beneficiary or health insurance policyholder of their rights.
- Shows how to evaluate the various prescriptions, Medicare supplement, and long term care insurances available.
- Refers to appropriate agencies for additional help.
- Provides a speaker for presentation to a group, club, or senior center, etc.

SHIP maintains a toll-free 800 helpline. Consumers can receive free informational brochures and booklets as well as information about their local SHIP site upon request. SHIP staff will also provide presentations for the general public by request. Additional resources are available on the SHIP website at www.medicare.in.gov

Local State Health Insurance Assistance Program (SHIP) Sites

County	Organization	Telephone Number
Adams	Adams County Memorial Hospital-Healthy Lifesteps	260-724-2145; ext. 4352
Allen	Parkview Hospital--Senior Health Services	260-373-7952
Bartholomew	Aging & Community Services of South Central IN. (AAA XI)	812-372-6918
Blackford	LifeStream Services (AAA)	800-589-1121; ext. 152
Boone	Boone County Senior Services, Inc.	765-482-5220
Cass	Cass County Senior Center	574-722-2424
Clark	Medical Center of Southern Indiana (Community Relations)	812-256-7409
Daviess	Generations (Area Agency on Aging)	800-742-9002
DeKalb	DeKalb County Council on Aging/Heimach Center	260-572-0680
Delaware	High Street United Methodist Church	765-747-8500
Delaware	LifeStream Services (AAA)	800-589-1121; ext. 152
Dubois	Generations (Area Agency on Aging)	800-742-9002
Elkhart	Council on Aging of Elkhart County	574-295-1820
Fulton	RSVP of Fulton County	574-223-3716
Gibson	Purdue Cooperative Extension	812-385-3491
Gibson	SWIRCA, Area Agency on Aging	800-253-2188
Grant	Marion-Grant County Senior Center	765-662-6772
Greene	Generations (Area Agency on Aging)	800-742-9002
Hamilton	Prime Life Enrichment, Inc.	317-815-7000; ext. 209
Hancock	Hancock County Senior Services, Inc.	317-462-3758
Hancock	Hancock Memorial Hospital-Social Services	317-468-4531
Harrison	Community Services	812-738-8143
Hendricks	Hendricks County Senior Services	317-745-4303
Henry	Raintree Square	765-521-3491
Howard	St. Joseph Hospital & Health Center	765-456-5313
Huntington	Huntington County Council on Aging	260-356-3006
Jasper	Jasper County Hospital	219-866-5141; ext. 2130
Jay	Jay County Hospital	2601-726-1844
Johnson	Johnson Memorial Hospital	317-346-3184
Knox	Generations (Area Agency on Aging)	800-742-9002
Kosciusko	Kosciusko Community Senior Services	574-267-2012
LaGrange	LaGrange County Council on Aging	260-463-4161
Lake	St. Anthony Medical Center	219-864-2653
Lake	St. Catherine Hospital	219-392-7777
Lake	St. James Less Church	219-838-4873
Lake	St. Margaret Mercy Health Care Centers-Dyer	219-864-2653
Lake	St. Margaret Mercy Health Care Centers-Hammond	219-864-2653
Lake	St. Mary Medical Center	219-947-6581
LaPorte	LaPorte Hospital and Health Services	219-326-2338
LaPorte	Michigan City Senior Center	219-873-1504
Madison	Community Hospital of Anderson-Education Center	765-298-2536
Marion	Community Hospitals of Indianapolis	317-887-7989

County	Organization Name	Telephone Number
Marion	Heritage Place of Indianapolis, Inc.	317-283-6662
Marion	Indianapolis Senior Center	317-263-6272
Marion	Robin Run Village	317-293-5500
Marion	St. Vincent Hospital & Health Care Services	317-338-2198
Marshall	Marshall County Council on Aging (Older Adult Services)	574-936-9904
Monroe	Bloomington Hospital-Community Health Education	812-353-9300
Morgan	Barbara B. Jordan YMCA	765-342-6688
Noble	Noble County Council on Aging	260-347-4226
Owen	Bloomington Hospital-Community Health Education	812-353-9300
Perry	SWIRCA, Area Agency XVI Agency on Aging	800-253-2188
Porter	RSVP of Porter County	219-464-1028
Posey	SWIRCA, Area Agency XVI Agency on Aging	800-253-2188
Putnam	Putnam County Hospital	765-653-5121
Randolph	LifeStream Services (AAA)	800-589-1121; ext. 152
Ripley	Margaret Mary Community Hospital, Inc.	812-934-6624; ext. 5208
Scott	Life Span Resources	812-752-5457
Shelby	Shelby Senior Services	317-392-9727
Spencer	SWIRCA, Area Agency XVI Agency on Aging	800-253-2188
St. Joseph	REAL Services – South Bend	574-251-2592
St. Joseph	SJRMC Community Outreach	574-239-5299
Starke	Starke County Council on Aging	574-772-7070
Steuben	Steuben County Council on Aging	260-665-9856
Sullivan	Area VII Agency on Aging and Disabled	800-489-1561
Tippecanoe	Hanna Community Council	765-742-0191
Vanderburgh	SWIRCA, Area Agency XVI Agency on Aging	800-253-2188
Vigo	Area VII Agency on Aging and Disabled	800-489-1561
Vigo	Union Hospital	812-238-7000
Wabash	Wabash County Council on Aging	260-563-4475
Warrick	SWIRCA, Area Agency XVI Agency on Aging	800-253-2188
Wayne	Centerville Senior Center	765-855-5651
White	White County Council on Aging	800-913-3582
Whitley	Whitley County Council on Aging	260-248-8944

(03/09)

Long Term Care Insurance in Indiana

Two (2) categories of long term care insurance are approved by IDOI for sale in Indiana:

- (1) Indiana Long Term Care Insurance Program policies (*Partnership*) and
- (2) Traditional Long Term Care insurance policies.

Asset Protection

Only long term care insurance policies approved under the Indiana Long Term Care Insurance Program (*Partnership* program) provide Medicaid Asset Protection.

To identify if a LTC policy is a Partnership policy (qualifies for asset protection), special wording is on 1) Outline of Coverage, 2) application, and 3) front page of the policy. Look for this information:

Indiana Long Term Care Insurance Program (*Partnership*) Policy:

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 ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE PROGRAM.

Traditional LTCI Policy:

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 STATE HEALTH ASSISTANCE PROGRAM (SHIP) AT 1-800-452-4800.

Traditional LTCI and Partnership LTCI Comparison

Features/Requirements	Traditional LTCI Policies	ILTCIP <i>Partnership</i> Policies
Agent License Requirements	<p>Initial: Health insurance license + 8-hr CE in LTC to sell LTCI</p> <p>Maintenance: 5 hrs CE in LTC every 2 years for license renewal</p>	<p>Initial: Health insurance license + 8-hr CE in LTC to sell LTCI + 7-hr CE on the ILTCIP <u>before</u> selling or talking about the policies</p> <p>Maintenance: 5 hrs CE in LTC every 2 years for license renewal</p>
Asset Protection	These policies do <i>not</i> provide permanent asset protection	The State of Indiana adds the <i>Medicaid Asset Protection</i> benefit only to policies approved for the ILTCIP.
Benefit Triggers (what has to occur before the policy starts paying benefits)	The <i>insurance company</i> decides which benefit triggers to use and how to define the terms within the triggers.	The <i>State</i> determines and defines the benefit triggers that all insurers participating in the ILTCIP must use and how to define the terms within the triggers.
Benefit Amounts	Consumer can choose any amount of daily and maximum benefits from the options the insurance <i>company</i> offers in the policy.	<p>Consumer can choose any amount of daily and maximum benefits from the options the insurance <i>company</i> offers in the policy.*</p> <p>*A minimum daily facility benefit is required by the State and is set each January. (Based on 75% of the average daily nursing home daily benefit in Indiana).</p> <p>*Policy must offer an option of a maximum benefit of one year (365 days).</p>
Inflation Protection	Inflation protection must be <i>offered</i> , but is not required.	Inflation protection is <i>mandatory</i> in all Indiana <i>Partnership</i> policies. Total Asset Protection policies <i>must</i> have 5% annual compound inflation. Dollar for Dollar policies could offer inflation options of 5% compound, CPI, or 5% simple inflation for issue ages 75 or older only.

Features/Requirements	Traditional LTCI Policies	ILTCIP <i>Partnership</i> Policies
Maximum Benefit Type	<p><u>Company decides</u> how the maximum benefit will be offered:</p> <ul style="list-style-type: none"> ■ in days ■ in dollars ■ money pool for all benefits ■ separate maximum benefit for nursing home and home health care 	<p><u>State decided</u> that maximum benefit will be one pool of money for all benefits available in the policy.</p>
Portability	<p>Policies pay insurance benefits in any state. Some pay worldwide.</p>	<p>Policies pay insurance benefits in any state. Some pay worldwide.</p> <p>The <u>State-added Medicaid Asset Protection</u> benefit could be honored by another State’s Medicaid program that has a reciprocal agreement with Indiana. Asset protection is honored on a dollar for dollar basis only with other states.</p>
Favorable Tax Status	<ul style="list-style-type: none"> ■ A federal tax deduction is available for tax-qualified LTCI policies. ■ There is <u>NO</u> Indiana state tax deduction for traditional LTC policies. 	<ul style="list-style-type: none"> ■ A federal tax deduction is available for tax-qualified ILTCIP policies ■ <u>Only</u> ILTCIP policies qualify for an Indiana <u>state tax deduction</u> (not credit).
Policy Types Available	<ul style="list-style-type: none"> ■ Facility Care Only ■ Comprehensive (Facility & home health care) ■ Home Health Care Only ■ Life Insurance that will pay a portion of the death benefit early for LTC. 	<ul style="list-style-type: none"> ■ Facility Care Only ■ Comprehensive (Facility & home health care) <p>All insurers participating in the ILTCIP must offer the comprehensive policy.</p>

Note: Indiana Law and Insurance Regulation require ALL types of long term care insurance policies offered for sale in Indiana to (1) offer a 30-day free look, (2) prohibit the requirement of prior hospitalization in order to receive benefits in policies sold after July 1991, (3) prohibit waiting periods of longer than 6 months for pre-existing conditions, and (4) require policies to be either guaranteed renewable or non-cancellable.

Favorable Tax Status for Certain LTCI Policies

State of Indiana

Indiana residents who pay premiums for policies approved under the Indiana Long Term Care *Partnership* Program can receive a *state tax deduction*. A taxpayer may take this deduction only for premiums paid (during the tax year) for an Indiana *Partnership* policy for himself/herself, a spouse, or both taxpayer and spouse. The law authorizing this deduction was signed by Governor O'Bannon on May 13, 1999.

To identify an Indiana *Partnership* policy, look for the following box of information on the outline of coverage, the application, or the front page of the policy:

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.

The tax break is a deduction, not a credit. The deduction is 100% of the premium paid during the tax year. Exception: Self-employed persons who take a federal tax deduction may only deduct the premium amount not deducted on their federal tax return. The deduction is taken on Schedule 1&2 under "Other Deductions – Code 608" on the Indiana state tax form.

Federal

The Health Insurance Portability and Accountability Act of 1996 is a federal law providing limited federal tax breaks for owners of long term care (LTC) insurance policies that meet specific standards. Policies meeting these standards are called tax-qualified. The Act went into effect on January 1, 1997. Policies purchased before January 1, 1997 were grandfathered under the law's provisions.

Tax breaks provided

- (1) **Premiums:** Premiums paid for federally tax-qualified LTC insurance policies are tax deductible as part of the standard deduction for medical expenses on a federal tax return (exceeding 7.5% of AGI). This deduction applies for each taxpayer who pays premiums, and began with the 1997 tax year. These deductions are limited according to the age of the taxpayer as indicated below (amounts listed are for tax year 2009 and change annually for inflation):

<u>Age</u>	<u>Maximum Amount of Premium Deduction</u>
40 or less	\$ 320
41 to 50	\$ 600
51 to 60	\$ 1,190
61 to 70	\$ 3,180
71 and over	\$ 3,980

Premiums for self-employed: For self-employed persons, for tax year 2009, 100% of premiums paid for federally tax-qualified LTC insurance policies are tax deductible in a similar manner as other health insurance policy premiums. This deduction is limited according to the age table listed previously. (Age table applies first; then percentage of premium.) Example: A 43-year old person who paid \$700 in premium in 2009 would get to deduct \$600 on the federal return.

- (2) **Benefits:** Benefits received from a federally tax-qualified LTC insurance policy are not considered income for tax purposes. (The federal government has not yet determined whether benefits from a “non-tax-qualified” policy would count as taxable income.)

How do I know if a policy is a federally tax-qualified LTC insurance policy?

Look for language on the outline of coverage and on the policy that is similar to the following: "This Policy is intended to be a Qualified Long Term Care Insurance Contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended."

What are some of the features included in federally tax-qualified LTC policies?

- (1) **Benefit Triggers:** A benefit trigger is the event that must occur in order for the policy to begin paying out its benefits. The policyholder must meet the criteria of one of the benefit triggers. Federally tax-qualified policies will contain the following benefit triggers: (a) needing substantial assistance with at least 2 of 5 (or 6) activities of daily living, or (b) needing substantial supervision due to a severe cognitive impairment. A licensed health care practitioner must certify that the triggering condition exists and, to the best of their knowledge, will continue to exist for the next 90 days. (Activities of daily living may include bathing, continence, dressing, eating, toileting, and transferring.)
- (2) **Non-forfeiture Benefit:** The applicant must be offered the chance to purchase a non-forfeiture benefit as part of their policy. A non-forfeiture benefit is a guarantee from the company that you will get some of the benefits in the policy you have bought, should you cancel the policy after a set period of time. This benefit increases the policy's price.
- (3) **Required Consumer Protection Standards:**
- To get benefits from the policy, the policy cannot require you to be in the hospital first.
 - To keep up with rising costs in health care, an inflation protection benefit must be offered to you.
 - The policy must be guaranteed renewable. This means the policy will continue as long as you keep paying the premium. Your premium cannot be raised because you get older or have used some of the benefits in your policy.

**INDIANA LONG TERM CARE
INSURANCE PROGRAM
(*PARTNERSHIP*)**

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HISTORY OF THE INDIANA LTC INSURANCE PARTNERSHIP PROGRAM

Legislative History. The General Assembly enacted enabling legislation for the Indiana Long Term Care Insurance Program in 1987. It was the first such legislation of its kind in the country. The Council of State Governments later recognized it as model state enabling legislation for public/private partnerships for financing long term care.

The enabling legislation mandated development of a program whereby persons who purchased approved long term care insurance policies could become eligible for Medicaid without having to become impoverished. The legislation directed the Department of Public Welfare to apply to the Health Care Financing Administration (HCFA) for a waiver which was needed to implement the Program. The objectives of the Program's enabling legislation were to:

- Stimulate the availability of high quality, affordable long term care insurance;
- Provide a method by which Indiana's seniors could plan to finance their own long term care needs without fear of impoverishment;
- Contain the growth of public expenditures for long term care by encouraging private initiatives;
- Improve public understanding of long term care financing and provide counseling services to persons in planning for their long term care needs.

Robert Wood Johnson Foundation Planning Grant: In May, 1988, the Robert Wood Johnson Foundation became interested in Indiana's pioneering efforts and invited the state to participate in its Grant Program to Promote Long Term Care Insurance for the Elderly. Indiana was successful in securing funding from the Foundation for the Program's planning phase.

While the Foundation was the primary funding source during this planning phase, private insurers and health care providers contributed \$50,000 to the Program, plus staff time for task forces and committees. The state of Indiana contributed significant staff time and other vital in-kind assistance to the Program.

Steering Committee and Task Force: A Steering Committee and several task forces were assembled from the public and private sectors to work on designing the Program. Participants included health care providers, insurers, five state agencies, the Governor's office, state legislators, interest groups, and Area Agencies on Aging. The task forces focused on minimum standards for qualifying policies, insuring fiscal neutrality of the Program design, and design of the consumer counseling component.

Program Design: The basic design of the Program was intentionally simple: for every dollar of qualified long term care insurance benefits used by persons age 65 or older to pay for Medicaid-eligible services, a dollar of their own assets would be protected from the asset spend-down requirements of Medicaid. This basic design:

- Ensures fiscal neutrality;
- Eases administration for the state and federal governments;
- Fosters flexibility and innovation in product design;
- Encourages development of affordable, high quality insurance policies; and
- Enhances consumer choice among an array of long term care insurance products.

Attempts at Federal Legislation: When HCFA was initially contacted by Indiana regarding the Program, it was determined that there were no existing waivers that would enable this public/private partnership to be approved. HCFA indicated that new federal legislation would be needed, authorizing either a demonstration program or new type of Medicaid waiver.

At that time, eight states were participating in similar planning efforts through Foundation funding and they decided to work together to obtain necessary federal legislation. Attempts were made for two years to obtain authorizing legislation.

Medicaid State Plan Amendment Submitted: When attempts at federal legislation appeared futile, the eight states considered other approaches. Connecticut's Medicaid attorneys felt that programs such as those proposed by Indiana and Connecticut could be approved administratively by HCFA under the spousal impoverishment provision of the Medicare Catastrophic Coverage Act.

An opinion of a Washington law firm specializing in Medicaid law was sought and the firm's favorable opinion was shared with senior HCFA officials. In March 1991, Indiana was encouraged by HCFA to submit a state plan amendment authorizing an asset disregard under Section 1902(r)(2) of the Social Security Act.

In April 1991, the Indiana General Assembly enacted amendments to the Indiana Program, primarily to ensure that the language was consistent with appropriate sections of federal law. Based on this legislation, a Medicaid state plan amendment was submitted to HCFA on June 17, 1991.

Robert Wood Johnson Foundation Implementation Grant: In May 1991, Indiana applied to the Foundation for a grant to support the start-up costs of implementing and administering the Program. In August of 1991, the Foundation announced the approval of a three-year grant award of \$1.26 million, subject to Indiana obtaining HCFA approval to the state plan amendment.

Plan Amendment Approved: In December 1991, HCFA approved Indiana's Medicaid state plan amendment, permitting the state to proceed with implementation of the Program. This approval led to the finalization of the Foundation's grant award.

Program Implementation: The Program is administered by the Indiana Department of Insurance (IDOI) in conjunction with the Office of Medicaid Policy and Planning (OMPP) under the Indiana

Family and Social Services Administration office (IFSSA). The IDOI is responsible for promulgating regulations for setting standards applying to all long term care insurance plans and the company's participation in the Program. IFSSA is responsible for promulgating regulations regarding Medicaid eligibility under the Program.

ILTCIP provides technical assistance to insurers; oversees data collection and analysis; initiates policy and legislative recommendations; responds to insurer, agent, and public inquiries; monitors company compliance; and participates in an on-going public education and information effort.

Amendments: ILTCIP legislation and regulations were amended in 1994 to allow for the option of LTC Facility only policies. Prior to this, only comprehensive policies were available under the ILTCIP. Also included in this legislation was language allowing all benefits paid under ILTCIP policies, up to actual cost of care, to count towards asset protection.

ILTCIP regulations were amended in August 1997, to allow for tax-qualified ILTCIP policies. These changes to the regulation brought ILTCIP policy standards in compliance with the provisions of the federal Health Insurance Portability and Accountability Act of 1996.

ILTCIP legislation was amended in July, 1997, to (a) move the Program from the Division of Disability, Aging and Rehabilitative Services to the Office of Medicaid Policy and Planning (OMPP) and (b) to give OMPP, permission to establish reciprocity with other *Partnership* states' Medicaid programs.

In 1998, legislative amendments created the Combination Asset Protection feature, which adds the provision for total asset protection based on the amount of benefits initially purchased.

In 1999, legislation passed which authorized a state tax deduction for Indiana residents who pay premiums for ILTCIP *Partnership* policies.

In 2006, management of the Partnership Program was transferred to the Indiana Department of Insurance with coordination with OMPP.

Effective April 1, 2009, the Centers for Medicare & Medicaid Services (CMS) approved Indiana's State Plan Amendment to join in the National Reciprocity Compact for Medicaid asset protection with other states that offer Partnership LTC policies.

INDIANA LTC PARTNERSHIP PROGRAM FEATURES

INTRODUCTION

The following information highlights features and requirements unique to the Indiana Long Term Care Insurance Program (*Partnership*).

The term *policyholder* is used throughout this section to include both policyholders of individual long term care insurance policies and certificate holders of group long term care policies. The term *policy* includes insurance *certificates*.

Policy Requirements

1. One Year Policies: ILTCIP policies must offer an option of a maximum benefit amount of 365 times the minimum daily benefit, a figure determined annually by the State.
2. Minimum Daily Benefit: Companies may not offer a daily facility benefit below the State-set minimum. This figure is based upon 75% of the average daily private pay rate of nursing homes in Indiana. The minimum daily nursing facility benefit through 2010 is listed below:

<u>Year</u>	<u>Minimum Daily Benefit</u>
2003	\$100
2004	\$110
2005	\$110
2006	\$110
2007	\$110
2008	\$110
2009	\$110
2010	\$115

Companies are allowed to round up to the nearest \$5 or \$10 increment, if needed. Figures are effective on January 1 of each year.

3. Pot of Dollars (or Pool): The maximum lifetime benefits provided under an ILTCIP policy must be stated as a dollar value rather than days of care. This amount is considered one pot of dollars from which all benefits of the policy are paid. There are no separate maximum benefits for facility care and home care.
4. Inflation Protection: Inflation protection must be included as an integral part of the policy and not offered as an optional rider. The maximum lifetime benefits provided under the policy (minus any benefits used) must be increased proportionately with the inflation protection requirements as specified at 760 IAC 2-20-35 (3).

5. Pooled Risk: For purposes of approving any future premium adjustments, all individual qualified policies issued by the same issuer will be considered a single risk pool. All qualified group policies issued by the same insurer shall be considered a single risk pool, except a separate risk pool may be formed whenever there are at least 2,000 certificates in force for certain defined groups.
6. Comprehensive Policies: Companies must offer a comprehensive policy. A comprehensive policy includes coverage for both facility care and home and community based care. Home and community care services shall include, at a minimum:
 - a. home health nursing
 - b. home health aide services
 - c. attendant care
 - d. respite care
 - e. adult day care

The daily benefit for home and community-based services must be at least 50% of the daily nursing facility benefit contained in the policy.

7. Case Management: Case management must be included for all community and home care services.

The Indiana Department of Insurance has determined that the provision of case management services is to be considered an administrative cost, and therefore, are not to be charged against the benefits provided in the policy. Companies may include an annual limit for case management services in ILTCIP policies. The limit may not be less than 13 times the daily facility benefit.

8. Insured Event Determination: Policies qualified for participation in the ILTCIP must comply with the state's definition of the insured event found at 760 IAC 2-20-21.

a. Tax-Qualified ILTCIP policies: In order to qualify for insurance benefits, the beneficiary of a tax-qualified ILTCIP policy must be a chronically ill individual [as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA 1996)]. Chronically ill means the person meets the deficiencies in ADLs trigger or the cognitive impairment trigger as explained below.

- Deficiencies in Activities of Daily Living: When determining the loss of functional capacity, the chronically ill individual must be unable to perform – without substantial assistance from another individual – two (2) or more of six (6) activities of daily living (ADLs) for at least ninety (90) days. ADLs are:
 - Bathing – means washing oneself by sponge bath in a tub or shower, including the task of getting into or out of the tub or shower.

- *Continence* -- means the ability to maintain control of bowel and bladder function or when unable to maintain control of bowel or bladder function the ability to perform associated personal hygiene, including care for catheter or colostomy bag.
- *Dressing* – means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- *Eating* – means feeding oneself by getting food into the body from a receptacle, feeding tube, or intravenously.
- *Toileting* -- means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- *Transferring* – means moving into or out of a bed, chair, or wheelchair.

Substantial assistance means both hands-on and standby assistance in *Partnership* policies. *Hands-on assistance* means the physical assistance of another person without which the individual would be unable to perform the ADL. *Standby assistance* means the presence of another person within arm's reach of the individual which is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

For at least 90 days means that the licensed health care practitioner who is prescribing a plan of care must certify the person meets the ADL trigger now and will continue to meet the trigger for the next 90 days. The chronically ill person is not penalized if her/his health improves in less than 90 days such that care is no longer needed.

Cognitive Impairment: The individual requires *substantial supervision* to protect such individual from threats to health and safety due to *severe* cognitive impairment.

- *Substantial supervision* means continual supervision. This may include cueing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect the individual from threats to her/his health or safety. *Severe* cognitive impairment means a loss or deterioration in intellectual capacity that is (a) comparable to Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory; orientation as to person, place, or time; and deductive or abstract reasoning.

b. Non-tax-qualified ILTCIP Policy: The beneficiary of a non-tax-qualified ILTCIP policy must meet **one** of the following three (3) criteria to qualify for insurance benefits:

- Deficiencies in activities of daily living
- Cognitive impairment
- Complex, unstable medical condition

Deficiency in two of five activities of daily living (ADLs): ILTCIP policies must pay benefits if the insured has deficiencies in two or more of the following ADLs:

Bathing
 Dressing
 Eating
 Toileting/continence
 Transferring

Direct Assistance means a person cannot perform a particular ADL safely or appropriately without continual help or oversight. This assistance can range from totally performing the activity for the person, to helping the person set-up the activity, or physically standing by while the activity is being performed.

Cognitive impairment: ILTCIP policies must pay benefits and assets will be protected when a policyholder has a cognitive impairment. Cognitive impairment is defined as *confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer’s disease or similar forms of senility or irreversible dementia.*

Complex, Unstable Medical Condition: For non-tax-qualified policies, the ILTCIP has established an additional insured event trigger for persons needing skilled levels of care due to medical conditions which may not result in deficiencies of ADLs or be the result of a cognitive impairment. Policyholders are determined to have met this insured event trigger if they:

- Require twenty-four (24) hour a day professional nursing observation in a setting other than an acute care wing of a hospital; or
- Require professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital.

9. Measuring cognitive impairment for Indiana Long Term Care Insurance Program policies.

The regulations require that cognitive impairment be established through use of a standardized test which reliably measures impairment in:

- short term or long term memory;
- orientation as to person, place, or time;
- deductive and abstract reasoning.

For purposes of determining eligibility for benefits, cognitive impairment is established if at least one of the following is met:

When using the SPMSQ as the primary assessment tool:

- (1) (a) The individual has been assessed using the Short Portable Mental Status Questionnaire (SPMSQ) and has failed to correctly answer at least seven of the ten questions on the test;
or
- (b) The individual exhibits specific behavior problems requiring daily supervision, including but not limited to: wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, extreme or bizarre personal hygiene habits; AND has taken the SPMSQ and failed to correctly answer at least four questions. If the individual passes the SPMSQ, then the Folstein Mini-Mental examination is to be administered. A score of 23 or lower, along with the specific behavior problems mentioned earlier would result in the individual being eligible for benefits.

Or When using the Folstein Mini-Mental examination as the sole assessment tool:

- (2) (a) The individual has been assessed using the Folstein Mini-Mental examination and has scored 20 or lower; or
- (b) The individual exhibits specific behavioral problems requiring daily supervision, including but not limited to: wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, extreme or bizarre personal hygiene habits; AND has taken the Folstein Mini-Mental examination and achieved a score of 23 or lower.

10. Issue Age: Premiums must be based on the issue age of the applicant and remain level for the life of the policy. Premiums may **not** be based on the policyholder's attained age. Issue age premiums can be increased for an entire class of policyholders upon approval of the Commissioner of the Department of Insurance. This requirement does not preclude an insurer from using a paid-up premium option.

11. 30-Day Free Look: All ILTCIP policies must include a provision providing a 30-day "free look" period during which the applicant can return the policy (for full refund) for any reason.

12. Step-Down Coverage Provision: Insurers must offer the policyholder the option to reduce coverage to a lower benefit amount, in the event the policy is about to lapse. However, the reduced coverage cannot be for a period of less than 365 days of coverage inclusive of any benefits that may have been used to date. This provision does not apply to policies where the existing coverage is already at the minimum required for a policy to participate in the ILTCIP (that is, 365 days x the minimum daily nursing home benefit amount).

13. Contact Designee: Insurers must offer the policyholder the opportunity to designate an individual who can be contacted in the event the policy is about to lapse. If the policyholder declines to designate

someone, the insurer shall obtain a signed statement that the policyholder has been offered this opportunity and declined. The policyholder has the right to periodically update her/his authorized designee.

14. Minimum Reinstatement Period: The policy shall also provide, at a minimum, a 90-day reinstatement period for policyholders who have lapsed due to nonpayment of premium, who have a cognitive impairment and who have made past payments. The reinstated policy must provide the same benefits, terms, and premiums as the policy that lapsed.

15. Coordination of Benefits: The policy will contain a provision that all other forms of health insurance that cover long term care benefits must pay first before the ILTCIP policy will pay benefits. This extends the life of the maximum benefits. If an individual owns more than one ILTCIP policy, the policy with the earliest effective date will pay first.

16. No Policy Change Without Acceptance: The participating ILTCIP policy will contain a provision that the policy form shall not be changed without the signed acceptance of the policyholder.

17. Assisted Living Facility Benefit: Policies in the ILTCIP (facility-only and comprehensive) may include benefits for assisted living facilities. However, assisted living facilities are not defined in the ILTCIP regulation or State law. The term used in State law and regulation which most closely coincides with an assisted living facility is a *residential care facility*. *An ALF in Indiana may or may not be licensed as a residential care facility*. A residential care facility is defined at 760 IAC 2-20-31.1.

There may or may not be a requirement that the facility be licensed in an ILTCIP policy. However, the facility must meet the following standards:

1. provides twenty-four hour a day care and services sufficient to support needs resulting from 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.

18. Riders: In order to offer any type of rider to an ILTCIP policy, the following standards must apply:

- a. An approved rider can only be attached to an ILTCIP policy sold by the same insurer.
- b. An approved rider may not be attached to a long term care policy that has not been approved for participation in the ILTCIP

Deficit Reduction Act of 2005 (DRA of 2005)

President Bush signed this important legislation affecting Medicaid and the long term care industry on February 8, 2006. Most provisions were effective on this date based on individual state approval. Following are key DRA provisions specific to LTC Partnership plans.

Expansion

Section 6021 of the DRA expands Long Term Care Partnerships to additional states. The programs for the four “original” states (IN, CT, CA, NY) are grandfathered under the DRA. Their programs will remain as originally submitted.

New states are authorized to adopt “qualified” state long term care insurance partnerships by amending their Medicaid plans. Asset protection under new partnership programs is on a dollar for dollar basis.

Inflation protection requirements are different under new DRA Partnership plans. For purchasers –

- Under 61 years old – Compound inflation required (amount not stipulated)
- 61 to 76 years old – Some level of inflation protection required
- 76 years or older – Inflation may be offered, but is not required

Reciprocity for Medicaid Asset Protection

New states under the DRA will have reciprocity with each DRA state for Medicaid asset protection on a dollar for dollar basis unless they opt out. Reciprocity allows an individual with a partnership policy to have asset protection under another State’s Medicaid program. The four “original” states must opt in to have reciprocity with the DRA states. Connecticut’s reciprocity with the DRA states was effective January 1, 2009. Indiana joined the National Reciprocity Compact effective April 1, 2009. Connecticut and Indiana’s existing reciprocity agreement remains in effect.

To qualify for asset protection, a LTC Partnership policyholder must qualify and be approved under the other state’s Medicaid program **and** both states must have a reciprocity agreement with each other **at the time** of application to the other state’s Medicaid program.

Medicaid Eligibility

All transfers of assets (gift or trust) have been extended from 3 years to a 5 year period.

The Penalty period for asset transfer begins on the date one becomes eligible for Medicaid. (Previous date was the date assets were transferred.)

Home equity in excess of \$500k is a countable asset and Medicaid coverage of nursing home care is denied to any person with home equity exceeding \$500k.* Annuities purchased during the 5 year look-back period must name the state as a remainder beneficiary.*

*Indiana Partnership policyholders are exempted

Asset Protection

Medicaid Asset Protection is a special state-added benefit found only in long term care insurance policies approved by the Indiana Long Term Care Insurance Program (*Partnership*). The Medicaid Asset Protection benefit does not add to the cost of the policy because the insurance company does not provide the benefit. Medicaid Asset Protection is a free benefit provided by the state of Indiana.

The Medicaid asset protection feature with a Partnership LTC policy provides additional financial protection if a policyholder applies for Medicaid eligibility. In addition, assets protected with a Partnership policy are exempt from Medicaid asset recovery.

The State has approval from the federal government to offer asset protection only. This program does not offer income protection.

Payments made from *Partnership* LTC policies will count toward asset protection for purposes of determining eligibility for Medicaid, thereby resulting in an asset disregard. Asset disregard *means*

the total equity value of personal property, assets, and resources not exempt under Medicaid regulations which at a minimum are equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured in determining eligibility for Medicaid under IC 12-15-2.

Under the Indiana Long Term Care Insurance Program an asset disregard may be achieved either on a dollar-for-dollar basis or on a total basis as described below under Combination Asset Protection.

Combination Asset Protection

Public Law 1-1998 was passed during the 1998 state legislative session (as Senate Bill 101, Sections 39, 40 and 41) and took effect March 12, 1998. This law created the “combination asset protection model under the ILTCIP. This law expanded the asset protection under the ILTCIP such that both dollar-for-dollar and – with the new law – total asset protection could be available to persons buying and using ILTCIP policies.

The law required the office of Medicaid Policy and Planning to amend the state’s Medicaid plan to allow for combination asset protection. Federal approval was received on June 12, 1998, with a retroactive effective date of March 12, 1998. Regulations to implement this law were subsequently promulgated (See Revised Statute and Regulation).

The law refers to *qualified policies*. In Indiana law *qualified policies* means ILTCIP policies **only**. As denoted in state statute, the term *qualified policies* has no relationship to tax-qualified policies as designated pursuant to HIPAA 1996.

Total asset protection means the amount of the disregard is equal to the total sum of assets owned by the qualified insured once the *Partnership* policy benefits have been exhausted.

The amount of coverage initially purchased (in effect on the policy’s effective date) and then later used will determine whether the policyholder will receive dollar-for-dollar or total asset protection.

Initial Purchases: To receive **Total asset protection, the policyholder must *initially purchase Partnership coverage equal to or greater than the State-set dollar*** amount in effect during the calendar year of the policy’s effective date. State-set dollar amounts through 2023 are listed below:

<u>Year</u>	<u>State-Set Dollar Amount</u>	<u>Year</u>	<u>State-Set Dollar Amount</u>
1998 or before	\$140,000	2011	\$263,990
1999	\$147,000	2012	\$277,190
2000	\$154,350	2013	\$291,050
2001	\$162,068	2014	\$305,603
2002	\$170,171	2015	\$320,883
2003	\$178,679	2016	\$336,927
2004	\$187,613	2017	\$353,773
2005	\$196,994	2018	\$371,462
2006	\$206,884	2019	\$390,035
2007	\$217,186	2020	\$409,537
2008	\$228,045	2021	\$430,014
2009	\$239,447	2022	\$451,515
2010	\$251,419	2023	\$474,091

The *State-set* dollar amount increases by 5% compounded annually (beginning January 1), and is rounded to the nearest one dollar increment.

The annual increase in the *State-set* dollar amount applies only to new policies effective during that year.

Partnership policyholders that purchased their policies prior to March 12, 1998, with initial coverage of \$140,000 or more were grandfathered under the new law. This means these policies can provide total asset protection when policy benefits are exhausted.

Policyholders who initially purchase less than the State-set dollar amount in coverage in effect during that calendar year will earn dollar-for-dollar asset protection.

Policy Effective Date: Companies are required by regulation to offer the applicant the option of having her/his effective date as the application date for the policy being issued. (There is an exception for certificates under a group policy.)

Why the offer is important: A person applied for a policy in November, purchasing the current applicable state-set dollar amount. But due to the time involved in the underwriting process, the policy wasn’t issued until January of the next year. A new state-set dollar amount now applies. This applicant will not earn total asset protection because the coverage initially purchased was less than the State-set dollar amount in the new year, when the policy was actually issued.

This provision allowing the applicant the option of selecting the effective date is designed to avoid the scenario above.

Benefits Used: In order to earn Total Asset Protection, the policyholder must **exhaust** the benefits in their policy. Situations affecting benefit amounts available to the policyholder, such as a reduction of coverage or sharing of benefits in a policy by a husband and wife could result in dollar-for-dollar asset protection instead of total asset protection.

1. **Reduction of Coverage:** If a policyholder reduces coverage during the term of the policy, the individual will earn total asset protection if the coverage, *at the time the reduction goes into effect*, is equal to or greater than the State-set dollar amount in effect during the calendar year of the occurrence of the reduction minus any claims the policyholder may have already received under the policy.

Example: In 1999, T. J. Foster bought an Indiana *Partnership* policy with an unlimited maximum benefit. In 2003, Mr. Foster reduced his maximum benefit from unlimited to \$180,000. The State-set dollar amount in 2003 was \$178,679. Since his new maximum benefit is slightly more than the state-set dollar amount in effect when he made the reduction, his policy will provide total asset protection when the benefits have been exhausted paying for his care.

2. **Policies with Shared Benefits:** If a married couple purchases a policy (or policies with riders) which allow them to share a maximum benefit, then total asset protection occurs if:
 - a) Only one spouse uses and exhausts the maximum benefit available; or
 - b) If both spouses use benefits, the second spouse will earn total asset protection if at the time the first spouse permanently stops using benefits, the coverage at that time is equal to or greater than the State set dollar amount in effect during that calendar year minus any claims the second spouse may have already received under the policy.

Important Note: Asset protection does not transfer from the person who earned it to another person, including a spouse.

3. The following do not earn asset protection:
 - a. Benefits paid in excess of actual charges.
 - b. Benefits paid that are not based upon insured event criteria (example—return of premium).
 - c. Home and community care benefits paid without the use of case management.
 - d. Regulations (as of 1998) do not allow policy benefits to be paid in instances of (a) and (c). However, some first generation *Partnership* policies did include benefits similar to (a) and (c).

Growth of Assets: The amount of assets Medicaid will disregard during eligibility determination will equal the amount of asset protection the person earned (benefits paid out by the policy) by using the *Partnership* policy.

Example #1 – Dollar for Dollar Asset Policy

Bob initially purchased a \$150,000 Partnership policy that qualified as dollar for dollar asset protection. Over the years the policy benefits have increased to \$174,000 due to the 5% inflation factor. Bob has been diagnosed with early Alzheimer's disease and has needed long term care services. His Partnership policy has paid out \$174,000. Bob continues to need care, but he (or his family) does not have the financial resources to pay for ongoing long term care services. Bob decides to apply for Medicaid assistance. When Medicaid evaluates Bob's eligibility, \$174,000 of his countable assets will be disregarded because of his Partnership LTC policy (dollar for dollar). If Bob's assets are more than \$174,000, he will have to spend-down to remain eligible for Medicaid assistance.

Example #2 – Total Asset Policy

Same scenario except Bob initially purchased a \$240,000 Partnership policy that qualified as total asset protection. Over the years with 5% inflation protection, the policy benefits are now \$278,000. If Bob still needs care after all of his policy benefits have been paid out and does not have the financial resources to pay for continued care, he may have to apply for Medicaid assistance. When Medicaid evaluates Bob's eligibility, **all** of his countable assets would be disregarded because of his total asset Partnership policy.

Income: If in a nursing facility and eligible for Medicaid, Bob's income, except for \$52 a month for personal needs plus money for health insurance premiums, taxes, and/or medical expenses not covered by Medicaid, will go towards paying his nursing facility bill. Both earned income (social security checks, pensions, IRA payments) and unearned income (interest on savings, dividends from stocks, etc.) are counted in determining his contribution towards his care.

Protected assets may generate income equal to (or greater than) the cost of nursing facility care, resulting in the person not accessing Medicaid benefits. If a person is interested in protecting everything he/she owns; the goal should be to not access Medicaid. This can be done by the purchase and use of a long term care insurance policy WITH automatic 5% compounded annually inflation protection with an unlimited maximum benefit.

NOTE: Once assets are protected by using an ILTCIP policy, the person can then do anything she/he wants with those protected assets.

Reciprocity with Other States for Medicaid Asset Protection

Effective April 1, 2009, Indiana was approved by the federal government to join the National Reciprocity Compact for granting of Medicaid asset protection with other states that have Partnership long term care programs.

Questions Regarding Reciprocity

What does this mean for Indiana Partnership policyholders?

Indiana Partnership policyholders who relocate to another state may be eligible to receive **dollar for dollar asset protection** if applying to that state's Medicaid program.

The insurance policy benefits are payable in any state where you reside. But now with Indiana participating in the Reciprocity Compact, the asset protection benefit in your Indiana Partnership policy could also be honored by other states.

Does this change my Partnership policy if I remain in Indiana?

No. If you are applying to Indiana Medicaid, your Partnership policy could still provide either total asset or dollar for dollar asset protection depending on your policy type. The Reciprocity Agreement provides portability for asset protection and **does not** change benefits or premiums with your current policy.

If my Partnership policy was effective before April 1, 2009, am I covered under this reciprocity agreement?

Yes. All Indiana Partnership policyholders, regardless of the effective date of their policy, are covered under the Reciprocity Agreement.

What requirements have to be met to qualify for asset protection in other states?

Two requirements must be met:

1) A Partnership policyholder must qualify and be approved under the other state's Medicaid program,

AND

2) Both Indiana and the other state must be members of the Reciprocity Compact (or have a separate reciprocity agreement) **at the time** a policyholder applies to the other state's Medicaid program. The reciprocity agreement between Indiana and Connecticut remains in effect.

Does this Reciprocity Agreement guarantee that I will have asset protection with other states in the future?

No. Indiana and another state must have reciprocity with each other **at the time of Medicaid application**. States can opt in and out of the reciprocity agreement with 60 days notice. If a state opts out of Reciprocity, individuals who have already accessed Medicaid would be grandfathered. If Indiana's Partnership program would be discontinued, an Indiana resident who

purchased a Partnership policy prior to the date the program was discontinued, would still be eligible to receive earned asset protection under Indiana's Medicaid program.

How can I find a list of states participating in the National Reciprocity Compact Agreement?

Click here: <http://www.dehpg.net/lcpartnership/StateReciprocity.aspx> or call the Indiana Partnership office, toll free 1-866-234-4582, or 317-232-2187.

***Important Message from
the Indiana Long Term
Care Insurance Program***



Please read this message now. Then, keep it with your insurance policy.

Medicaid Asset Protection

Medicaid asset protection is a feature found in Indiana Long Term Care Insurance Program insurance policies (better know as “Indiana Partnership policies”). Medicaid asset protection allows you, the policyholder, to keep more assets than is normally allowed when, and if, you need help with long term care from the Indiana Medicaid Program. ***Only assets---not income---are protected.***

There are two types of asset protection—**Total** and **Dollar-for-Dollar**.

“**Total asset protection**” means all of your assets will be disregarded during the Indiana Medicaid eligibility process, should you choose to apply for help from Indiana Medicaid.

“**Dollar-for-dollar asset protection**” means that you will be allowed to retain one dollar of your assets for every one dollar of benefits used in your Partnership policy. However, any remaining assets will be considered (unless otherwise protected by law) during the Indiana Medicaid eligibility process.

Whether you receive total or dollar-for-dollar asset protection depends on:

- The amount of Partnership insurance you initially bought, and
- The amount of benefits you use under your policy, and
- The inflation feature in your policy.

The following steps will help you know whether you will receive total asset protection or dollar-for-dollar asset protection from your Indiana Partnership policy.

Step 1.

Make sure you purchased an Indiana Partnership policy. Check the front page of your policy for information that appears as follows:

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

Step 2.

Amount of Coverage Initially Purchased. Turn to the schedule page in your policy. The schedule page shows the policyholder's name, the policy's effective date, the policy number, and the specific amount of benefits you purchased.

- If the maximum benefit (total amount of dollars your policy will pay out) when you first bought your Partnership policy equals or exceeds the State-set dollar amount for the calendar year of your policy's effective date (see chart below), you may earn **total asset protection**.
- If the maximum benefit you initially purchased is less than the State-set dollar amount for the calendar year of your policy's effective date (see chart below), you will earn **dollar-for-dollar asset protection**.

Chart for State-Set Dollar Amount

<u>If the effective date of your policy is:</u>	<u>The State-set dollar amount is:</u>
1998 or before	\$140,000
1999	\$147,000
2000	\$154,350
2001	\$162,068
2002	\$170,171
2003	\$178,679
2004	\$187,613
2005	\$196,994
2006	\$206,844
2007	\$217,186
2008	\$228,045
2009	\$239,447
2010	\$251,419
2011	\$263,990
2012	\$277,190
2013	\$291,050
2014	\$305,603
2015	\$320,884

Step 3.

Policy Benefits Used. If you purchased coverage that equals or exceeds the State-set dollar amount (see Step 2) and used All of the coverage to which you had access, you may earn total asset protection.

Notes: (1) If you bought an unlimited maximum benefit, you will earn dollar-for-dollar asset protection because you will not use all the policy benefits as it will continue to pay benefits as long as you need care. (With an unlimited maximum benefit, your odds of ever needing Medicaid assistance are reduced.)

(2) A policy that begins as total asset protection could turn into one earning dollar-for-dollar asset protection in the following situations:

- (a) Reduction in Benefits. If you choose to reduce your policy benefits to an amount less than the State-set dollar amount for the calendar year of your reduction's effective date, you will earn dollar-for-dollar asset protection. (If you used policy benefits, subtract this amount from the State-set dollar amount when calculating.)
- (b) Sharing Benefits. If you and your spouse purchased Partnership coverage that allows you to share your maximum benefit (through one policy that you both own jointly or through two individual policies with a rider that allows you to access each other's benefits):
 - (1) One spouse may use all of the benefits, leaving no coverage or asset protection for the other spouse.
 - (2) If one spouse uses benefits (but not all of them), and the amount of remaining benefits for the second spouse is less than the State-set dollar amount for the year when the first spouse stopped using benefits, the second spouse will earn dollar-for-dollar asset protection. (If the second spouse used policy benefits, subtract this amount from the State-set dollar amount when calculating.)

Step 4.

Inflation Feature. The inflation factor in your policy also determines the type of asset protection.

- (1) Total Asset policies must have a 5% compound inflation factor.
- (2) Dollar For Dollar policies could have 5% compound, CPI, or 5% simple inflation - (Only for Purchasers age 75 or older at time of purchase.)

Partnership policies not qualifying for total asset protection will earn dollar-for-dollar asset protection.

How will you know how much asset protection you have earned?

When you are using benefits from your Indiana Partnership policy, your insurance company will send you quarterly reports showing how much asset protection you have earned. When you have used all of your policy benefits, the company will send you a final Service Summary Report. You will need the Service Summary Report if you choose to apply for Indiana Medicaid assistance. **Keep these asset protection reports with your policy.** Remember: Once you have earned asset protection, you may then do anything you wish with your protected assets.

What happens if you use all of your Indiana Partnership policy benefits and still need long term care services?

If you continue to need care after you have used your policy benefits, you may choose to apply for help from Indiana Medicaid. During the eligibility process, Indiana Medicaid will disregard (not consider) your asset amount equal to the amount of asset protection you have earned. By using an Indiana Partnership policy, you have earned asset protection, **not** income protection.

What is Indiana Medicaid?

Medicaid is a federal and state-funded medical assistance program. It pays for long term care services for persons who meet certain guidelines.

Eligibility

Eligibility for Medicaid is not automatic. You, or someone on your behalf, must apply for Medicaid. You must be living in Indiana at the time you apply for help from Indiana Medicaid. You must also meet Indiana Medicaid eligibility criteria in effect at that time. You will need to bring your **Service Summary Report** with you when you apply. This report will indicate the amount of asset protection you have earned by using your Indiana Partnership policy.

Once You Are Eligible

Once you are eligible to receive Indiana Medicaid benefits, you must continue to live in Indiana while receiving this assistance. The types of services you receive under Indiana Medicaid may be different from the services you received under your Partnership policy. You may receive more services under Indiana Medicaid than you did under your Partnership policy (example: coverage for prescriptions). However, there may be some services you received under your Partnership policy which are not available under Indiana Medicaid. Medicaid may require that part of your income be used toward your care. Medicaid determines the amount of your income contribution based upon your individual circumstances (i.e. living in your own home or a nursing home, single or married, etc...).

Important Information

- Premiums paid for Indiana Long Term Care Insurance Program (Partnership) policies may be deducted on your Indiana tax return. Please read your Indiana Tax Return Instruction Booklet for more details or consult with your tax advisor.
- A reciprocity agreement exists between Indiana and Connecticut Medicaid programs. This means that each of these states' Medicaid programs can honor the asset protection earned under the other state's Partnership policies. Asset protection honored under a reciprocal agreement will be on a dollar-for-dollar basis only.
- For an application or more information on **Indiana Medicaid**, contact the office of the Division of Family Resources in the county where you live.
- For more information about the **Indiana Long Term Care Insurance Program**, or for the **State-set dollar amount** for any given year, contact the Indiana Long Term Care Insurance Program office at 1-866-234-4582, or visit our website at www.longtermcareinsurance.in.gov, or write to: Indiana Long Term Care Insurance Program, 311 W. Washington St., Suite 300, Indianapolis, IN 46204.
- For **information about the particular policy you own**, contact either the insurance company listed on your policy or the insurance agent who sold you the policy.

Thank you for purchasing an Indiana Partnership policy!

**Keep this Message with your
Indiana Partnership insurance policy.**

Frequently Asked Questions

Q. Why would I want to purchase a long term care policy?

A. We cannot predict the future – our future medical needs, financial resources, and family support environment. As a population, we are living longer and healthier, but we are aging and disabling accidents can occur at any age. Our ability to perform normal activities of daily living could be hindered due to a medical or mental condition. For the same reasons we purchase auto and home insurance – to help offset the financial risk of a loss – we would purchase a long term care insurance policy. A LTC policy gives you the control over long term care needs and helps protect financial resources. Two types of long term care policies are available in Indiana – traditional policies and Partnership policies.

Q. Doesn't Medicare pay for long term care services?

A. Yes, but very limited and on a restricted basis. The maximum number of days Medicare Part A will cover is 100 – the first 20 days are covered at 100% and the next 80 days require a substantial copayment. Also, Medicare provides limited coverage for skilled care (services provided to improve the patient's health) if in a Medicare approved facility and a 3 day prior hospitalization requirement has been met.

Q. What is the Indiana Long Term Care Insurance Program (also known as the “Partnership Program”)?

A. The Partnership Program is a working collaboration between insurance companies and State/Federal governments to promote awareness of long term care. The Program's purpose is to help Hoosiers understand and make good decisions regarding their long term care needs.

Q. Since the program is called Indiana Long Term Care Insurance Program, doesn't the State of Indiana sell policies under the Partnership Program?

A. No, the State does not sell insurance policies. Insurance companies sell the policies. The Partnership Program, as an agency within the Department of Insurance, works with the insurance companies and agents to promote long term care and has oversight over the program. The Department of Insurance reviews and approves policies to make sure they comply with required regulations.

Q. What is the difference between a traditional long term care policy and a Partnership policy?

A. Both policies provide benefits for long term care services up to the policy limits. Partnership policies require several consumer benefits to be included which may be options with a traditional policy. A Partnership policy provides additional financial protection if you have to apply to Medicaid. You would not have to “spend down” your assets to be eligible for Medicaid. Protected assets under a Partnership policy are also exempt from Medicaid estate recovery.

Q. What is asset protection?

A. Asset protection is a financial consumer benefit included in Partnership policies provided by the State at no charge. For example – An individual has a long term care insurance policy (either a traditional or Partnership policy) and is receiving benefits. The policy pays out all benefits and the

policy is exhausted. However, this individual still needs care and now must pay for services with their own money or their family's money.

If the individual cannot afford care, he may have to apply for government assistance called Medicaid. To qualify for Medicaid, an individual's income must be at or below certain income guidelines or he must "spend down" his income and assets to that level. With a Partnership policy, an individual can protect or will not have to "spend down" his assets. Assets that are protected include such items as cash, savings and checking accounts, IRA's, certificates of deposit, and real property. Income, such as social security and interest income, is not protected.

The asset protection feature is a benefit only in Partnership policies and is not included in traditional long term care policies.

Q. Does a Partnership policy cost more than a traditional long term care policy?

A. No. The cost of a long term care policy is based on 4 factors: 1) your age at time of purchase; 2) benefits selected; 3) your health status; and 4) the insurance company you select. If all of these factors are identical, there is no difference in price to purchase a Partnership policy. Asset protection is a benefit provided by the State of Indiana **at no charge** and is not an insurance company benefit.

Q. How do I purchase a Partnership long term care policy?

A. Policies are available through insurance companies. Some companies offer both traditional and Partnership policies. The State of Indiana does not sell Partnership policies. A list of companies participating in the Partnership Program is listed on the Home Page on the website.

Q. How do I know if I have a Partnership policy?

A. Partnership policies were first sold in Indiana in May 1993. The first page of the policy, the Outline of Coverage, and the application will contain language in bold print and boxed stating if the policy is a Partnership policy (has asset protection). Look for this language:

<p>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.</p>
--

If the policy is not a Partnership policy, it will also have the boxed language stating "**This policy does not qualify**"

Q. If my policy is not a Partnership policy, can I add asset protection?

A. No. A policy is either a traditional policy or Partnership. In addition to asset protection, Partnership policies are required to include other consumer benefits that may be offered as options with a traditional policy. Asset protection is not available under a traditional policy.

Q. I bought a long term policy after 1993, but my agent did not discuss a Partnership policy with me. Is this illegal?

A. No. Agents are required to have 8 hours of long term care training plus an additional 7 hours of Partnership specific training to sell Partnership policies. Your agent may not have taken this training or may represent a company that does not offer Partnership long term care policies.

Q. How much asset protection will my Indiana Partnership policy provide?

A. There are two types of asset protection – dollar for dollar and total asset protection. The type of asset protection your policy provides depends on the amount of coverage you initially purchased and the inflation factor.

A **Total Asset** policy protects all of your assets if applying for Medicaid eligibility. **All of your assets** are protected from Medicaid spend down. To receive **Total Asset** protection, the policy must: 1) have 5% compound inflation; 2) have a total benefit amount equal to or more than the State set minimum for the year purchased; 3) exhaust all benefits; and 4) not have reduced the total benefit lower than the State set minimum for the year of reduction. **All of your assets** regardless of their value are protected if applying to Medicaid.

A **Dollar for Dollar** Partnership policy will provide asset protection **equal** to the amount paid out in benefits up to the policy maximum.

Q. How do I find out how much coverage is required for total asset protection?

A. A chart is provided under “Consumer Information” and the Home Page. The minimum amount is increased by 5% each year.

Q. Is my income protected under an Indiana Partnership policy?

A. No. If you need to apply to Medicaid because you do not have the financial resources to pay for long term care, assets are protected under a Partnership policy, but not income.

Q. Is my long term care policy good if I move to another state?

A. Yes. A long term care policy, whether it is a traditional or a Partnership policy, is portable and will pay for services in other states regardless of where you purchased it. If you purchased an Indiana Partnership long term care policy and are applying to Medicaid in another state, you may also have asset protection (**Reciprocity**) with that state. Asset protection under a Reciprocity Agreement with another state is on a dollar for dollar basis.

Q. Can I take a tax deduction for my long term care policy?

A. Yes. You may be able take a portion of the premium paid as a deduction for a tax qualified long term care policy on your Federal form. In addition, if you have a Partnership LTC policy, you can take the premium paid as a deduction on your state form using Form IT-40, Schedule 1&2, under other deductions, Code 608.

Q. Since I have a Partnership LTC policy, am I automatically eligible for Medicaid?

A. No. The decision to purchase of a long term care policy is because of concern over future health care services needed due to a mental or medical condition and the financial cost of that care. A long

term care policy gives you the control over those decisions and will help offset the costs involved. In the event, you would have to rely on the government's Medicaid program to cover the costs of your long term care and to make your healthcare decisions, a Partnership policy with asset protection would provide financial protection for your assets.

(Oct 2009)

Companies with Indiana Partnership Long Term Care Insurance Policies (3/2009)

INSURANCE COMPANY	TELEPHONE NUMBER	*POLICY TYPES	AM BEST	MOODY'S	STANDARD & POOR'S
Allianz Life Insurance Company	800-950-7372	TQ Comprehensive	A	A2	AA
Bankers Life and Casualty Co.	888-282-8252	TQ Comprehensive TQ Facility-only	B	Baa3	BB-
Genworth Life Insurance Co.	800-456-7766	TQ Comprehensive TQ Facility-only	A	A1	A
John Hancock Life Insurance Co.	800-377-7311	TQ Comprehensive	A++	Aa1	AA+
Massachusetts Mutual Insurance Co.	800-277-2216	TQ Comprehensive TQ Facility-only	A++	Aa1	AAA
Metropolitan Life Insurance Co.	800-308-0179	TQ Comprehensive TQ Facility-only	A+	Aa2	AA-
The Prudential Insurance Co. of America	800-732-0416	TQ Comprehensive	A+	Aa3	AA-
State Farm Mutual Automobile Insurance Co.	866-855-1212	TQ Comprehensive	A++	Not Rated	AA
United Teacher Associates Insurance Co. (Group policies only)	800-258-7041	TQ Comprehensive	A-	Not rated	Not rated

TQ = meets standards for federal tax breaks

Comprehensive = includes coverage for nursing facility care & home and community care

Your best resource for specific policy information is your local certified Indiana Partnership agent. When calling the insurance companies, you will be referred to a local Indiana Partnership agent.

A.M. Best

A++	Superior
A+	
A	Excellent
A-	
B++	Very Good
B+	
B	Fair
B-	
C++	Marginal
C+	
C-	
D	Poor
E	Under State supervision
F	In liquidation
S	Rating suspended

Moody's Investment Service

Aaa	Exceptional
Aa	Excellent
A	Good
Baa	Adequate
Ba	Questionable
B	Poor
Caa	Very Poor
Ca	Extremely Poor
C	Lowest

Standard & Poor's

Secure Range:	
AAA	Superior
AA	Excellent
A	Good
BBB	Adequate
Vulnerable Range:	
BB	May be adequate
B	Vulnerable
CCC	Extremely vulnerable

Rating Modifiers:

G	Group
p	Pooled
v	Reinsurance
u	Under review

Modifiers:

1	=High end generic category
2	=Middle of generic category
3	=Low end generic category

Modifiers:

Plus (+) or Minus (-): Relative standing within major rating category

Since company ratings can change, you are encouraged to check your local library or the internet for the most current ratings.

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INDIANA MEDICAID

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Indiana Medicaid

General

Medicaid is a federal/state funded medical assistance program that pays for approved and needed medical care for persons who meet specific eligibility requirements. Applications for Medicaid assistance are taken at the County office of Family and Children.

In Indiana persons who apply and are eligible for Medicaid assistance, may receive services from the list that follows:

- | | |
|---|--|
| Physician's services | Nurse practitioners' services |
| Inpatient hospital care | Outpatient hospital and clinic services |
| Other clinic, laboratory, and x-ray services | Nursing facility services – skilled and intermediate |
| Dental services | Eyeglasses and prosthetic devices |
| Medical supplies and equipment | Prescription drugs |
| Home health care services | Chiropractic services |
| Physical, occupational, speech and respiratory therapies | Medical social workers' services |
| Nurse midwife services | Psychologists' services |
| Optometry services | Family planning services |
| Rural health clinic services | Private duty nursing |
| Podiatry services | Rehabilitative services |
| Christian Science sanitariums and Christian Science nurses | Hospice services |
| Preventive care for all medical recipients under age 21 | |
| Inpatient psychiatric care for recipients under age 21 and ages 65+ | |
| Transportation to Medicaid covered services | |
| Early periodic screening diagnosis and treatment for those under age 21 | |

Eligibility:

(1) Applicants must be in one of the following categories:

- | | |
|---|-----------------------------|
| •Low income families with dependent children | •Individuals age 18, 19, 20 |
| •Pregnant women | •Children under 19 |
| •Newborns (up to age 1 if born to Medicaid recipient) | •Blind |
| •Age 65 or older | •Refugees |
| •Disabled | |

AND

(2) Meet medical criteria,

AND

(3) Meet the financial criteria:

	<u>Individual</u>	<u>Married Couple</u>
Income:	\$690 or less monthly	\$1,027 or less monthly
Countable Assets:	\$1,500 or less	\$2,250 or less

Spousal Impoverishment Protection Law applies when one spouse needs nursing home care and the other spouse will remain in the community.

Examples of Exempt and Non-Exempt Resources Under Indiana's Medicaid Program

Exempt (not counted)

- **Burial and Funeral Trusts** if irrevocable AND the amount is tied to specific funeral or burial services.
- **Home** if any of the following live there: spouse, child under age 18, disabled or blind child, or if the recipient is expected to return home.
- **Household furnishings**
- **Income-Producing Property** if income is greater than expenses of ownership
- **Life Insurance** if term insurance OR it has cash value and the face value is \$10,000 or less AND the beneficiary is the recipient's estate or the funeral home
- **Personal Effects** (excluding collections)
- **Real Property in the sole name of the community spouse**
- **Vehicle** -- one of any value if used for the recipient's employment, medical treatment, has been modified to accommodate a disability, or is for the community spouse; otherwise, \$5,000 of the current market value.

Non-Exempt (counted)

- **Annuities**
- **Cash**
- **Cash value of life insurance (not meeting criteria to be exempt)**
- **Certificates of Deposit**
- **IRAs**
- **Series EE Bonds**
- **Money Market Funds**
- **Mutual Fund Shares**
- **Pension Funds** (if option exists to withdraw a lump sum AND as long as employment doesn't have to end to receive the withdrawal)
- **Real Property** (if criteria for the home to be exempt is not met, then it must be offered for sale or rent at fair market value)
- **Stocks and Bonds**

Note: The asset protection earned by using *Partnership* policies is meant to protect the countable assets of the policyholder (since the exempt assets are not counted by Medicaid).

Indiana Medicaid's Perspective of Assets and Income

The Medicaid program uses the term *resources* to mean assets. The Medicaid program distinguishes resources and income in determining eligibility and calculating the amount that a Medicaid recipient must contribute to medical expenses. The Indiana *Partnership* policy asset disregard applies to resources. Whether a resource or income is counted, and how it affects eligibility, depends on many factors. The information below is general in nature. It is intended to give examples of certain types of resources and income. There are many other types of resources and income that might affect Medicaid eligibility. The listing of an item below does not necessarily mean that it will count toward Medicaid eligibility; depending on an individual's circumstances, some resources and income might be exempt or unavailable for Medicaid purposes.

- **Annuities:** Prior to being annuitized, the balance is a resource. After it is annuitized, the payments are income in the month received.** Withdrawals prior to annuitization are considered resources.
- **Bank Accounts and Certificates of Deposit:** The balance on the *first day of the month is a resource. Interest earned is income in the month received.
- **IRAs:** Balance in the account on the *first day of the month (minus any penalty the person would incur for early withdrawal if under age 59 1/2) is a resource. Dividends and interest earned is income in the month received. Withdrawals are considered resources.
- **Life Insurance with Cash Value:** The cash value is considered a resource.
- **Mutual Funds:** Balance in the account on the *first day of the month is a resource. Dividends or interest are income in the month received. Capital gains distributions to the fund's shareholders are income. Shares that are redeemed are resources.
- **Retirement Plans:** Whether it is considered a resource or income depends upon multiple factors. Each retirement plan would need to be reviewed and considered separately.
- **Stocks and Bonds:** Balance on the *first day of the month, based on current share prices, is a resource. Dividends are income during the month received. Shares that are redeemed are considered resources.

***First day of the month** – Medicaid is concerned about the applicant's financial picture as of the first moment of the first day of the month in which the applicant would be receiving benefits. For more information about how the date of application affects the date benefits begin, contact your local office of Family and Children.

**Income earned from resources is counted as income regardless of whether it is paid directly to the recipient or reinvested into the resource.

INCOME

The information below is an abbreviated overview of individual income taken into account for eligibility under Medicaid. For married couples, both incomes are considered when determining eligibility. When the income is distributed jointly to both spouses, it is assumed that each spouse shares an equal interest. Actual income contributions to the cost of care for the Medicaid eligible spouse, however, depend on the personal income of each spouse.

1. What is Income?

Total monthly income is the gross amount received by the individual or generated by his/her assets. This includes but is not limited to:

- **Pensions**
- **Social Security**
- **Income from Annuities/IRAs:** (See #3 - Annuities/IRAs: How are payments treated?)
- **Net income from rental property**
- **Interest on loans and mortgages**
- **Dividends and/or interest from stocks, bonds (see exception below), bank accounts, CDs, etc.,** whether or not the individual actually received the monies. Rollovers and reinvested income are still income.
- **Capital gain distributions,** (e.g., from mutual funds, other regulated investment companies, or real estate investment trusts), noted on “Internal Revenue Form 1099-DIV, Dividends and Distributions,” whether paid as cash or reinvested.

Some exceptions and items of note:

- **Series E/EE Savings Bonds:** Interest is **NOT** considered income.
- **I Bonds:** Interest is **NOT** considered income.
- **Zero Coupon Bonds:** Upon maturity, Medicaid considers interest as income.
- **Capital Gains:** Capital gains (e.g., from the sale of mutual fund or real estate) are considered an increase in the value of the resource and are exempt under Medicaid Extended Coverage.*Note, however, that capital gain distributions (e.g., from mutual funds), annotated on Internal Revenue Form 1099-DIV, are considered unearned income. (Refer to #3 for treatment of payments from annuities and IRA's).

- **Capital Appreciation:** This is NOT considered income.
- **Life Insurance:** When a person becomes the beneficiary of benefits under a life insurance policy, the monies are considered income in the month in which they are received. Dividends from life insurance are NOT considered income, but interest on dividends from a life insurance policy IS considered income.
- **Spousal income or “OTHERWISE AVAILABLE INCOME”:** The income of the spouse at home may be adjusted by certain permissible deductions. The net result of this calculation is called “**otherwise available income**”. Although other specialized deductions exist, the most common permissible deductions from the spouse at home’s gross income are:
 - Health insurance premiums (including premiums for long term care insurance);
 - Incapacitated adult/child care costs (actual); and
 - Court ordered support (Paid Out).

2. How is income treated in the eligibility determination process?

Income eligibility for Medicaid is determined on a monthly basis. Because of this, Medicaid differentiates between periodic income and non-periodic income. Periodic income is received on a regular schedule, for example, once a month, once a quarter, once a year, etc. Some examples of periodic income are pensions, annuities, and IRA withdrawals. Non-periodic income is income received on an irregular schedule such as an inheritance, or an award.

Non-periodic income is counted in the month in which become available. After that, it is considered a resource. This means that if the individual were to receive monies that would cause his/her income to exceed the cost of his/her care, he/she would be ineligible for Medicaid for that month only, regardless of whether the money is all spent by the end of the month. For example, needed care is \$5,000/month and a CD matures, when the CD’s interest is combined with regular monthly income, it gives the individual \$7,000 that month. In this instance, the individual would be ineligible for Medicaid in that month but eligible in the following month even if he/she merely deposits the extra amount.

Periodic income is applied on a monthly basis regardless of how often it is received during the year. For example, if an annuity paid out once a year, the amount paid would be divided by twelve (12) to establish total monthly income.

3. Annuities and IRAs: How are payments treated?

All monies received on a periodic basis from an annuity or IRA, whether received monthly, quarterly, semi-annually, or annually, are considered income regardless of whether such monies represent a payout of interest or principal. However, if the total principal were to be withdrawn in a lump sum, the money would be considered a resource.

4. May I transfer income?

When the transfer or conversion of protected resources results in the transfer or loss of income that was earned by those protected assets, no transfer penalty shall apply. However, income transfer other than through the transfer of income attached to protected resources may result in penalties.

Medicaid Look-Back Period (during eligibility determination)

Medicaid will look back 5 years from the time of application to determine whether the applicant transferred any assets for less than fair market value in order to be eligible for Medicaid. A transfer for less than fair market value is an “illegal transfer. The look back period for the establishment of trusts is 5 years.

If the applicant is an in-patient at a nursing facility and it is determined that the applicant performed an illegal transfer, the applicant will be subject to a penalty. During the penalty period, Medicaid will not provide assistance for a period of time equal to the dollar amount of assets transferred. The penalty period would begin on the date of Medicaid eligibility.

Closing Medicaid Eligibility Loopholes

During 2002, Indiana Medicaid adopted regulations to close some of the common eligibility loopholes used to shelter assets.

Annuities (405 IAC 2-3-1.2). The purchase of an annuity within the 3 year look back period will result in a transfer penalty unless the annuity is:

- Actuarially sound (repays purchase price within life expectancy)
- Issued by a commercial entity or a nonprofit organization
- Structured to have substantially equal monthly payments (vary by 5% or less per year)

The intent of this regulation was to stop the practice of purchasing an annuity with a minimal monthly payout with a large lump sum final payment. This regulation applies to annuities purchased or annuitized on or after June 1, 2002.

Transfer of Income (405 IAC 2-3-1.1). This regulation applies to transfers taking place, or leases entered into or renewed, on or after June 1, 2002. Transfers between spouses are allowed.

- A penalty will be imposed for renting property for less than fair market value.
- A penalty will be imposed for transferring income streams, including income-producing property if the transferor doesn't retain the income.
- *Partnership* policy protected assets may be transferred, once protected, without penalty.

Transfer Penalty for Inaction (405 IAC 2-3-1.1). Failing to take action to receive assets to which an individual is entitled is considered a transfer. Example: failing to elect to take the spousal share of an estate. No penalty will be imposed if:

- the individual is unaware of her/his right to receive assets,
- the individual is not competent and has no guardian to act on her/his behalf,
- taking action is not cost-effective,
- if the deceased spouse made other equivalent arrangements to provide for the surviving spouse.

U. S. Savings Bonds (405 IAC 2-3-23). Effective November 2002, savings bonds are considered to be available and thus countable resources for Medicaid purposes, beginning on the date of purchase.

Deficit Reduction Act of 2005 (DRA of 2005)

President Bush signed this important legislation affecting Medicaid and the long term care industry on February 8, 2006. Most provisions were effective on this date based on individual state approval.

Deficit Reduction Act of 2005 – Key Medicaid Asset Provisions

- **Penalty Period Changes:** Requires states to lengthen the look back period from 3 to 5 years and changes start of penalty date from date of transfer to date of Medicaid eligibility.
- **Hardship Waiver:** Creates an exception from penalty in cases when health or life is endangered
- **Treatment of Annuities:** Requires annuities to be disclosed and the state named as a remainder beneficiary; *IN Partnership policyholders are exempt; 405 IAC 2-3-1.2(d)(3)*
- **Mandatory “Income-First” Rule:** Requires states to consider all income of institutionalized spouses to meet the minimum monthly maintenance needs allowance for community spouses.
- **Excluded Coverage for Substantial Home Equity:** Persons become ineligible with home equity in excess of \$500,000 (IN) - \$750,000, as set by state; *IN Partnership policyholders are exempt; 405 IAC 2-3-15(c)(3)*

Deficit Reduction Act of 2005 – Key Partnership Provisions

- **Expansion** – Section 6021 of the DRA expands Long Term Care Partnerships to other states. Partnership policy features for new DRA states can vary from state to state. The programs for the 4 “original” states are grandfathered.
- **Reciprocity** – Provides for portability of asset protection in Partnership policies with other state Medicaid programs. If a Partnership policyholder from one state applies to another state’s Medicaid program, asset protection can be honored on a **dollar for dollar** basis. To qualify for asset protection, a LTC Partnership policyholder must qualify and be approved under the other state’s Medicaid program. Also, both states must have a reciprocity agreement with each other **at the time** of application to the other state’s Medicaid program.

The 4 original states have to opt in to join the National Reciprocity Compact. Indiana was effective April 1, 2009 and Connecticut on January 1, 2009. The separate reciprocity agreement between Indiana and Connecticut remains in effect. Indiana Partnership policyholders could have either dollar for dollar or total asset protection depending on their policy when applying to Indiana Medicaid.

Medicaid Estate Recovery

Medicaid estate recovery is required by federal law (Social Security Act – 42 USC 1396p) as well as by State law (IC 12-15-9).

In cases where a Medicaid recipient dies and has an estate, the State is to file a claim against the recipient's estate in order to be reimbursed for services it paid on behalf of the recipient when the recipient was age 65 or older. In addition, the claim includes payments for services provided to a recipient age 55 or older if the services were provided on or after October 1, 1993. The claim includes the cost of all types of Medicaid services provided to the recipient.

Assets subject to recovery. All assets in the recipient's probate estate are subject to recovery. (Probate is the process by which the real and personal property of a deceased person is distributed to heirs [if there is no will] or to beneficiaries named in the will). Assets that were exempt (not counted) for Medicaid eligibility purposes may be subject to estate recovery. Further, some assets outside of the recipient's probate estate are subject to recovery.

Assets not subject to recovery.

- Proceeds of a life insurance policy or annuity.
- Personal effects, keepsakes, and ornaments of the deceased.
- *Assets protected by the use of an Indiana Partnership long term care insurance policy.*

Filing of a Claim. There is no time limit as to when the State has to file its claim. However, it is important for claims to be filed in a timely manner. Most estate recovery efforts do not involve court proceedings. Court proceedings usually occur for estates valued at \$25,000 or more.

The State may waive its claim against a deceased recipient's estate if enforcement of the claim would result in undue hardship for the survivors. "Undue hardship" means the survivors would become eligible for public assistance if the State enforced its claim.

Liens (IC 12-15-8.5). Effective, July 1, 2003, Indiana Medicaid has authority to place a lien on the real property of a Medicaid recipient who is in a nursing facility or other institution and is not expected to return home. The lien is enforced if the property is sold or upon the death of the Medicaid recipient. No lien is permitted if any of the following people reside on the property:

- Recipient's spouse
- Recipient's child who is under age 21
- Recipient's disabled child
- Recipient's sibling who has lived in the home for 12 months and has an ownership interest
- Recipient's parent

A lien may not be enforced while the recipient is survived by a spouse, a minor or disabled child, or a parent, even if those individuals do not live on the property.

Spousal Impoverishment Protection Law (Updated 7/2009)

The Spousal Impoverishment Protection Law applies for nursing home admissions occurring on or after September 30, 1989. The purpose of the law is to allow the community spouse to keep some of the couple's income and assets while still qualifying the nursing home spouse for Medicaid.

A "snapshot" is taken of the couple's assets to determine the community spouse's share. "Snapshot" involves the couple's assets at the time of the Medicaid applicant's FIRST date of continuous (minimum 30 days) institutionalization (nursing facility or hospital).

When a nursing home spouse is applying for Medicaid, the couple will need to complete a resource assessment tool based upon the resources (assets) owned at the "snapshot" date AND an application for Medicaid (which asks for information about current resources). The community spouse's share is calculated from the resource assessment tool. The nursing home spouse's eligibility is determined from the application. Assets of a married couple are generally considered to be jointly-owned no matter in whose name they have been placed.

ASSETS:

The community spouse is allowed to keep a maximum of **HALF** of the non-exempt assets up to a total of **\$109,560** (1/2009) or least a minimum of **\$21,912**. (1/2009).

The nursing home spouse is allowed only **\$1,500** in non-exempt assets to be eligible for Medicaid.

INCOME:

The community spouse is allowed to keep all income that is solely in his/her name, plus half (1/2) of all jointly-owned income. If his/her income does not equal at least **\$1,823 per month**, he/she may keep some of the nursing home spouse's income to get up to the minimum level of **\$1,823** (7/2009) each month. If the community spouse has high living expenses, he/she may appeal to keep more of the nursing home spouse's income – bringing his/her total minimum monthly income up to **\$2,739** (1/2009).

The nursing home spouse must contribute all of his/her income towards the nursing home cost except for \$52 per month for personal needs and any dollar amounts for health insurance premiums, taxes, and medical expenses not covered by Medicaid. This contribution of income towards his/her care is called his/her "liability."

INDIANA LAWS AND REGULATIONS

Traditional Long Term Care Insurance Statute (IC 27-8-12)	P. 61
Traditional Long Term Care Insurance Regulation (760 IAC 2)	P. 70
Indiana Long Term Care Insurance Statute (IC 12-15-39.6)	P. 116
Indiana Long Term Care Insurance Regulation (760 IAC 2-2)	P. 120

Traditional Long Term Care Insurance Statute

IC 27-8-12

Information Maintained by the Office of Code Revision Indiana Legislative Services Agency
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IC 27-8-12

Chapter 12. Long Term Care Insurance

IC 27-8-12-1

"Applicant" defined

Sec. 1. As used in this chapter, "applicant" means:

(1) an individual who applies for long term care insurance through an individual insurance policy;
or

(2) a prospective holder of a certificate issued under a group long term care insurance policy.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-2

"Certificate" defined

Sec. 2. As used in this chapter, "certificate" means a document issued to a member of the group covered under a group insurance policy, which policy has been delivered or issued for delivery in Indiana, to signify that the individual named in the certificate is covered under the policy.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-3

"Certificate holder" defined

Sec. 3. As used in this chapter, "certificate holder" means an individual to whom a certificate is issued.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-4

"Insurance policy" defined

Sec. 4. As used in this chapter, "insurance policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in Indiana by an insurer, a fraternal benefit society, a nonprofit corporation, a health maintenance organization (as defined in IC 27-13-1-19), a limited service health maintenance organization (as defined in IC 27-13-34-4), a preferred provider arrangement, or any other organization.

As added by P.L.275-1987, SEC.1. Amended by P.L.26-1994, SEC.16.

IC 27-8-12-4.5

"Long term care facility" defined

Sec. 4.5. As used in this chapter, "long term care facility" has the meaning set forth in IC 12-15-39.6-2.

As added by P.L.75-1994, SEC.9. Amended by P.L.24-1997, SEC.63.

IC 27-8-12-5

"Long term care insurance policy" defined

Sec. 5. (a) As used in this chapter, "long term care insurance policy" means an insurance policy providing coverage for at least twelve (12) consecutive months for each covered person on an

expense incurred, indemnity, prepaid, or other basis for one (1) or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care wing of a hospital.

(b) The term includes the following:

(1) A policy advertised, marketed, or offered as long term care insurance.

(2) A group or individual annuity, a life insurance policy, or riders that provide directly or supplement long term care insurance.

(3) A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(c) The term does not include the following:

(1) An insurance policy that is offered primarily to provide basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, comprehensive coverage, catastrophic coverage, or limited benefit health coverage.

(2) A life insurance policy that accelerates the death benefit specifically for terminal illness, a medical condition requiring extraordinary medical intervention, or a permanent institutional confinement, and that provides the option of a lump sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care.

(3) An insurance policy that is offered primarily to provide basic Medicare supplemental coverage (as defined under IC 27-8-13).

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.9.

IC 27-8-12-6

Compliance with statutory requirements

Sec. 6. An insurance policy may be marketed, advertised, offered, or sold in Indiana as long term care insurance only if that policy complies with the requirements of this chapter.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-7

Policy disclosure standards; marketing practices; continuing education; penalties; reporting practices; rules

Sec. 7. (a) The insurance commissioner shall adopt rules under IC 4-22-2 establishing standards of full and fair disclosure concerning long term care insurance policies. The standards must require disclosure of information concerning the following:

(1) The sale of the policies.

(2) Terms of renewability.

(3) Initial and subsequent terms of eligibility.

(4) Non-duplication of coverage provisions.

(5) Coverage of dependents.

(6) Preexisting conditions.

- (7) Termination of insurance coverage.
- (8) Probationary periods.
- (9) Limitations on coverage.
- (10) Exceptions to coverage.
- (11) Reductions from coverage.
- (12) Elimination periods.
- (13) Requirements for replacement.
- (14) Recurrent conditions.
- (15) Definitions of terms.
- (16) Continuation or conversion of coverage.

(b) The insurance commissioner shall adopt rules under IC 4-22-2 to establish minimum standards concerning:

- (1) marketing practices;
- (2) insurance producer continuing education;
- (3) penalties; and
- (4) reporting practices;

for long term care insurance.

(c) Rules adopted by the insurance commissioner under this section must:

- (1) recognize the unique, developing, and experimental nature of long term care insurance; and
- (2) where necessary or appropriate, recognize the distinctions between group insurance policies and individual insurance policies.

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.10; P.L.178-2003, SEC.65.

IC 27-8-12-7.1

Qualification of long term care policies; rules

Sec. 7.1. The department of insurance shall adopt rules under IC 4-22-2 that establish standards for the qualification of a long term care policy under IC 12-15-39.6. The rules must include the following:

- (1) The standards adopted under section 7 of this chapter.
- (2) The requirement that an insurer or other person who issues a qualified long term care policy must at a minimum offer to each policyholder or prospective policyholder a policy that provides both:
 - (A) long term care facility coverage; and
 - (B) home and community care coverage.
- (3) A provision that an insurer or other person who complies with subdivision (2) may elect to also offer a qualified long term care policy that provides only long term care facility coverage.
- (4) The submission of data by insurers that will allow the department of insurance, the office of Medicaid policy and planning, and the division of aging to administer the Indiana long term care program under IC 12-15-39.6.
- (5) Other standards needed to administer the Indiana long term care program.

As added by P.L.114-1991, SEC.11. Amended by P.L.9-1991, SEC.94; P.L.2-1992, SEC.786; P.L.4-1993, SEC.260; P.L.5-1993, SEC.273; P.L.75-1994, SEC.10; P.L.24-1997, SEC.64; P.L.141-2006, SEC.109.

IC 27-8-12-8

Loss ratio standards rule

Sec. 8. The insurance commissioner may not adopt a rule establishing loss ratio standards that apply

to long term care insurance policies unless the rule exclusively concerns long term care insurance.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-9

Termination of policy on grounds of age or deteriorated health

Sec. 9. An insurer that issues a long term care insurance policy may not cancel, decline to renew, or otherwise terminate the policy solely on the grounds of the age or deterioration in mental or physical health of the insured individual or certificate holder.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-10

"Preexisting condition" defined; exclusion of coverage; limitations

Sec. 10. (a) As used in this section, "preexisting condition" means the existence of:

(1) either:

(A) symptoms that would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or

(B) a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services; within

(2) a period not to exceed either:

(A) twelve (12) months preceding the effective date of coverage of an insured person who is sixty-five (65) years of age or older on the effective date of coverage; or

(B) twenty-four (24) months preceding the effective date of coverage of an insured person who is less than sixty-five (65) years of age on the effective date of coverage.

(b) A long term care insurance policy may exclude coverage for a loss or confinement that is the result of a preexisting condition only if that loss or confinement begins within:

(1) twelve (12) months following the effective date of coverage of an insured person who is sixty-five (65) years of age or older on the effective date of coverage; or

(2) twenty-four (24) months following the effective date of coverage of an insured person who is under sixty-five (65) years of age on the effective date of coverage.

(c) The insurance commissioner may extend the limitation periods set forth in subsections (a)(2)(A), (a)(2)(B), and (b), concerning specific age group categories in specific policies upon a finding that the extension is in the best interest of the public.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-10.5

Loss or confinement resulting from a preexisting condition; exclusion of coverage; limitation period; rules

Sec. 10.5. (a) As used in this section, "preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six (6) months preceding the effective date of coverage of an insured individual.

(b) A long term care insurance policy may not use a definition of preexisting condition that is more restrictive than the definition contained in subsection (a).

(c) Except for a group long term care policy under IC 27-8-5-16(1) or IC 27-1-12-37, a long term care insurance policy may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of

coverage of an insured individual.

(d) The commissioner may extend the limitation period under subsections (a) and (c) concerning a specific age group category in a specific policy form upon a finding by the commissioner that the extension is in the best interest of the public.

(e) This section does not prohibit an insurer from doing any of the following:

(1) Using an application form designed to elicit the complete health history of an applicant.

(2) Based on an application, underwriting in accordance with the insurer's established underwriting standards.

(f) Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether the condition is disclosed on the application, need not be covered until after the waiting period described in subsection (c).

(g) A long term care insurance policy may not exclude or use a waiver or rider to exclude, limit, or reduce coverage or benefits for a specifically named or described preexisting disease or physical condition beyond the waiting period described in subsection (c).

As added by P.L.114-1991, SEC.12.

IC 27-8-12-10.6

Conditions on eligibility for benefits; restrictions

Sec. 10.6. (a) A long term care insurance policy may not be delivered or issued for delivery in Indiana if the policy:

(1) conditions eligibility for any benefits on a prior hospitalization requirement;

(2) conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) conditions eligibility for a benefit other than:

(A) a waiver of premium;

(B) postconfinement;

(C) postacute care; or

(D) recuperative benefits;

on a prior institutionalization requirement.

(b) A long term care insurance policy containing a postconfinement, postacute, or recuperative benefit must clearly label in a separate paragraph of the policy a statement entitled "limitations or conditions on eligibility for benefits". Under the statement, the policy must outline any limitations or conditions for benefits.

(c) A long term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care must not require a prior institutional stay of more than thirty (30) days.

(d) A long term care insurance policy or rider that provides benefits only following institutionalization may not condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

As added by P.L.114-1991, SEC.13.

IC 27-8-12-11

Establishment of new waiting period

Sec. 11. (a) A long term care insurance policy may not:

(1) contain a provision establishing a new waiting period if an existing policy is converted to or

replaced by a new form issued by the same insurer, except in the case of an increase in benefits voluntarily selected by the insured individual or group policyholder;

(2) be canceled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(3) provide coverage for skilled nursing care only; or

(4) provide significantly more coverage for skilled care than coverage for a lower level of care.

(b) Subsection (a) does not prohibit an insurer from voluntarily waiving any authorized waiting period.

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.14.

IC 27-8-12-12

No obligation return period; notice

Sec. 12. (a) An individual long term care insurance policyholder may return the policy within thirty (30) days of its delivery and have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(b) Each individual long term care insurance policy must have prominently printed on, or attached to, its first page a notice setting forth in substance the provisions of subsection (a).

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.15.

IC 27-8-12-13

Direct response solicitation issued policies; no obligation return period; notice

Sec. 13. (a) A person insured under a long term care insurance policy or certificate issued under a direct response solicitation may return the policy or certificate within thirty (30) days of its delivery and have the premium refunded if the insured person is not satisfied for any reason.

(b) Each long term care insurance policy or certificate issued under a direct response solicitation must have printed on, or attached to, its first page a notice setting forth in substance the provisions of subsection (a).

As added by P.L.275-1987, SEC.1.

IC 27-8-12-14

Outline of coverage; contents

Sec. 14. (a) The insurer shall deliver an outline of the coverage provided by an individual long term care insurance policy to the prospective applicant at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and the document's purpose.

(b) The commissioner shall prescribe a standard format regarding:

(1) style;

(2) arrangement;

(3) overall appearance; and

(4) content;

for an outline of coverage.

(c) An insurance producer who solicits a long term care insurance policy shall deliver the outline of coverage before the presentation of an application or enrollment form.

(d) The outline of coverage must be presented in conjunction with any application or enrollment form when there is a direct response solicitation of long term care insurance.

- (e) An outline of coverage required under this section must include the following:
- (1) A description of the principal benefits and coverage provided in the policy.
 - (2) A statement of the principal exclusions, reductions, and limitations set forth in the policy.
 - (3) A statement of the policy's renewal provisions, including any reservation by the insurer of a right to change premiums.
 - (4) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine the exact terms of the coverage provided by the policy.
 - (5) A description of the terms under which the policy may be returned and the premium refunded.
 - (6) A brief description of the relationship of the cost of care and benefits.
 - (7) A statement of the terms under which the policy or certificate may continue or be discontinued, including any reservation in the policy of the right to change the premium.
 - (8) A specific statement of the provisions for continuation or conversion of group coverage.
- As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.16; P.L.178-2003, SEC.66.*

IC 27-8-12-14.5

Policy summary; requirements

Sec. 14.5. (a) A policy summary shall be delivered, at the time of policy delivery, for an individual life insurance policy that provides long term care benefits within the policy or by a rider.

(b) The insurer shall deliver the policy summary upon the applicant's request when there is a direct response solicitation. If there is no request, the insurer shall deliver the policy summary not later than when the policy is delivered.

(c) The policy summary must include the following:

(1) An explanation of how long a long term care benefit interacts with other components of the policy, including deductions from a death benefit.

(2) An illustration of the amount of a benefit, the length of a benefit, and the guaranteed lifetime benefits for each covered person.

(3) Any exclusion, reduction, and limitation on benefits of long term care.

(d) A policy summary required under this section must also include the following information if applicable:

(1) A disclosure of any effect of exercising rights under the policy other than rights referred to in subsection (c).

(2) A disclosure of any guarantee related to long term care costs of insurance charges.

(3) Current and projected maximum lifetime benefits.

As added by P.L.114-1991, SEC.17.

IC 27-8-12-14.6

Benefits funded through life insurance by acceleration of death benefits; benefit payment status report; contents

Sec. 14.6. If a long term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report containing the following shall be provided to the policyholder:

(1) Any long term care benefit paid out during the month.

(2) An explanation of any change in the policy, including a change in death benefit or cash value due to long term care benefits being paid.

(3) The amount of long term care benefits remaining under the policy.

As added by P.L.114-1991, SEC.18.

IC 27-8-12-15

Group policy certificate; contents

Sec. 15. A certificate issued under a group long term care insurance policy that is delivered or issued for delivery in Indiana must include the following:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the principal exclusions, reductions, and limitations set forth in the policy.

(3) A statement that the group master policy should be consulted to determine the exact terms of the coverage provided by the policy.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-16

Application of general insurance law

Sec. 16. All other applicable provisions of IC 27 not in conflict with the provisions of this chapter apply to insurance policies issued under this chapter. A long term care insurance policy issued under this chapter is not subject to any rule adopted under IC 27-1-3-7(c).

As added by P.L.275-1987, SEC.1.

IC 27-8-12-17

Group policies issued in another state; requirements

Sec. 17. Group long term care insurance may not be offered to a resident of Indiana under a group policy issued in another state unless the commissioner determines that the group long term care insurance policy substantially complies with insurance requirements similar to those established under this chapter.

As added by P.L.114-1991, SEC.19.

IC 27-8-12-18

Insurance producer commissions

Sec. 18. (a) An insurer or other entity that provides a commission to an insurance producer or other representative for the sale of a long term care insurance policy may not violate the following conditions:

(1) The amount of the first year commission for selling or servicing the policy may not exceed two hundred percent (200%) of the amount of the commission paid in the second year.

(2) The amount of commission provided in years after the second year must be equal to the amount provided in the second year.

(3) A commission must be provided each year for at least five (5) years after the first year.

(b) If an existing long term care policy or certificate is replaced, the insurer or other entity that issues the replacement policy may not provide, and its insurance producer may not accept, a commission in an amount greater than the renewal commission payable by the replacing insurer on renewal policies, unless the benefits of the replacement policy or certificate are clearly and substantially greater than the benefits under the replaced policy or certificate.

(c) This section does not apply to the following:

(1) Life insurance policies and certificates.

- (2) A policy or certificate that is sponsored by an employer for the benefit of:
 - (A) the employer's employees; or
 - (B) the employer's employees and their dependents.

As added by P.L.114-1991, SEC.20. Amended by P.L.178-2003, SEC.67; P.L.173-2007, SEC.29.

IC 27-8-12-19

Violations; civil penalty; amount

Sec. 19. (a) In addition to any other sanction provided under this article, the commissioner may impose a civil penalty against an insurer who has violated this chapter or rules adopted under this chapter. A penalty imposed under this section must be the greater of:

- (1) three (3) times the amount of the commissions paid for each policy involved in the violation; or
- (2) ten thousand dollars (\$10,000).

(b) In addition to any other sanction provided under this title, the commissioner may impose a penalty against an insurance producer who has violated this chapter or rules adopted under this chapter. The penalty must be the greater of:

- (1) up to three (3) times the amount of the commissions paid to that insurance producer for each policy involved in the violation; or
- (2) twenty-five hundred dollars (\$2,500).

As added by P.L.114-1991, SEC.21. Amended by P.L.178-2003, SEC.68.

Traditional Long Term Care Insurance Regulation 760 IAC 2

ARTICLE 2. LONG TERM CARE INSURANCE COVERAGE

Rule 1. General Provisions

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)*

Rule 2. Definitions

760 IAC 2-2-1 Policy definitions

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 1. (a) No long term care insurance policy, certificate, or subscriber agreement delivered, or issued for delivery, in Indiana shall contain the terms set forth in this rule, unless the terms are defined in the policy and the definitions satisfy the requirements in this section.

(b) All providers of services, including, but not limited to:

- (1) skilled nursing facility;
- (2) extended care facility;
- (3) intermediate care facility;
- (4) convalescent nursing home;
- (5) personal care facility; and
- (6) home care agency;

shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

(c) The definitions in this rule apply throughout this article. *(Department of Insurance; 760 IAC 2-2-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-2-2 "Acute condition" defined

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status. *(Department of Insurance; 760 IAC 2-2-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-2-3 "Adult day care" defined

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 3. "Adult day care" means a program for six (6) or more individuals, of social and health related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly, or other adults with disabilities who can benefit from care in a group setting outside the home. *(Department of Insurance; 760 IAC 2-2-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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 or 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-2-4 "Home health care services" defined

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 4. "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. Such services may include, but are not limited to, the following:

- (1) Home health nursing services.
- (2) Home health aide services.
- (3) Homemaker services.
- (4) Assistance with activities of daily living.
- (5) Respite care services.

(Department of Insurance; 760 IAC 2-2-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-2-5 "Medicare" defined

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 5. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import. *(Department of Insurance; 760 IAC 2-2-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-2-6 "Mental or nervous disorder" defined

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 6. "Mental or nervous disorder" includes only neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. *(Department of Insurance; 760 IAC 2-2-6; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-2-7 "Personal care" defined

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 7. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring, and toileting). *(Department of*

Insurance; 760 IAC 2-2-7; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*)

Rule 3. Policy Practices and Provisions

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) 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-3-3 Termination; extension of benefits

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 3. Termination of long term care insurance shall not prejudice any benefits payable for institutionalization if the institutionalization began while the long term care insurance was in force and which institutionalization continues without interruption after termination. The extension of benefits beyond the period the long term care insurance was in force may be limited to the following:

- (1) The duration of the benefit period, if any.
- (2) Payment of the maximum benefits, if any.

Further, such extension of benefits may be subject to any policy waiting period and all other applicable provisions of the policy. (*Department of Insurance; 760 IAC 2-3-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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, "basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when such coverage would otherwise terminate and that is subject only to the continued timely payment of premium. Group policies that contain incentives to use certain providers or facilities, or both, and group policies that provide a restricted list of providers or facilities, or both, shall provide continuation of benefits 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, "basis for conversion of coverage" means a policy provision 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 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 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

(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 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 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 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-3-5 Replacement

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 5. If a group long term care policy, certificate, or subscriber agreement is replaced by another group long term care policy, certificate, or subscriber agreement issued to the same policyholder or to the members of the previous policyholder's group, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long term care services.

(Department of Insurance; 760 IAC 2-3-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 859; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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 sixty-five (65) years of age or beyond; or

(2) the duration the insured has been covered under the policy.

(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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

Rule 4. Required Disclosure Provisions

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;
- (2) appear on the first page of the policy; and
- (3) clearly state the duration of:
 - (A) renewability, where limited;
 - (B) the term of coverage for which the policy is issued; and
 - (C) the term of coverage for which the policy may be renewed.

This section shall not apply to policies 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 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 that increases benefits or coverage that also increases the premium during the policy term must be accepted in writing signed by the insured 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 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 that provide an accelerated benefit for long term care are required to include a disclosure statement at the time:

- (1) of application for the policy or rider; and
- (2) 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*)

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*)

Rule 5. Prohibition Against Post-Claims Underwriting

760 IAC 2-5-1 Application; medication

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 1. (a) All applications for long term care insurance policies, certificates, or subscriber agreements except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(c) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy, certificate, or subscriber agreement shall not be rescinded for that condition. (*Department of Insurance; 760 IAC 2-5-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-5-2 Language of application; supplemental information

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 2. Except for policies, certificates, or subscriber agreements which are guaranteed issue, the following apply:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long term care insurance policy, certificate, or subscriber agreement: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your [policy] [certificate] [subscriber agreement].".

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long term care insurance policy, certificate, or subscriber agreement at the time of delivery: "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] [certificate] [subscriber agreement]. 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].".

(3) Prior to issuance of a policy, certificate, or subscriber agreement to an applicant eighty (80) years of age or older, the insurer shall obtain one (1) of the following:

- (A) A report of a physical examination.
- (B) An assessment of functional capacity.
- (C) An attending physician's statement.
- (D) Copies of medical records.

(*Department of Insurance; 760 IAC 2-5-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-5-3 Completed application or enrollment form

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 3. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy, certificate, or subscriber

agreement unless it was retained by the applicant at the time of application. (*Department of Insurance; 760 IAC 2-5-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-5-4 Records

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 4. Every insurer or other entity selling or issuing long term care insurance benefits shall maintain a record of all policy, certificate, or subscriber agreement rescissions, both statewide and country wide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners. (*Department of Insurance; 760 IAC 2-5-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

Rule 6. Home Health Care Benefits in Long Term Care Insurance Policies

760 IAC 2-6-1 Minimum standards for home health and community care benefits

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 1. (a) A long term care insurance policy, certificate, or subscriber agreement shall not, if it provides benefits for home health and community care services, limit or exclude benefits as follows:

(1) By requiring that the insured/claimant need skilled care in a skilled nursing facility if home health care services were not provided.

(2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community, or institutional setting before home health care services are covered.

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses.

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

(5) By requiring that the insured/claimant have an acute condition before home health care services are covered.

(6) By limiting benefits to services provided by Medicare-certified agencies or providers.

(7) By excluding coverage for personal care services provided by a home health aide.

(8) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.

(9) By excluding coverage for adult day care services.

(b) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy, certificate, or subscriber agreement.

(c) A long term care insurance policy, certificate, or subscriber agreement, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy, certificate, or subscriber agreement, at the time covered home health or community care services are being received. This requirement shall not apply to policies, certificates, or subscriber agreements issued to residents of continuing care retirement communities. (*Department of Insurance; 760 IAC 2-6-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

Rule 7. Inflation Protection Offer

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 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 does not include a maximum specified indemnity amount or limit.

(b) Inflation protection benefit increases under a policy 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 that provides for automatic benefit increases shall include an offer of a premium 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-7-2 Group policy; exception

Authority: IC 27-8-12-7

Affected: IC 27-8-5-17; IC 27-8-12

Sec. 2. Where the policy is issued to a group, the required offer under section 1 of this rule shall be made to the group policyholder; except, if the policy is issued to a group defined in IC 27-8-5-17 other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder. *(Department of Insurance; 760 IAC 2-7-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-7-3 Accelerated long term care benefits

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 3. The offer under section 1 of this rule shall not be required of life insurance policies or riders containing accelerated long term care benefits. *(Department of Insurance; 760 IAC 2-7-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-7-4 Outline of coverage

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 4. Insurers shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at seventy-five (75) and eighty-five (85) years of age for benefit increases.

(3) An insurer may use a reasonable hypothetical or a graphic demonstration, for the purposes of this disclosure.

(Department of Insurance; 760 IAC 2-7-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

Rule 8. Application Forms and Replacement Coverage

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 insurance producer, except where the coverage is sold without an 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*)

760 IAC 2-8-2 Any other health insurance policies

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 2. Insurance producers shall list the following:

- (1) Any other health insurance policies they have sold to the applicant.
- (2) Policies sold which are still in force.
- (3) Policies sold in the past five (5) years 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*)

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 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 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 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 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 Insurance producer,
Broker, or Other Representative)

[Typed Name and Address of
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)

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 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 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)

760 IAC 2-8-5 Replacement; notification

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 5. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy, certificate, or subscriber agreement shall be identified by the insurer, name of the insured, and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy, certificate, or subscriber agreement is issued, whichever is sooner. *(Department of Insurance; 760 IAC 2-8-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 864; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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)*

Rule 9. Reporting Requirements

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 insurance producer of that insurance producer's amount of replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

(b) Each insurer shall report annually by June 30 the ten percent (10%) of its 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 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.

(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.

(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*)

Rule 10. Licensing

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 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 unless the insurance producer doing so has met all of the following criteria:

(1) The insurance producer has successfully passed eight (8) hours of approved continuing education courses in long term care and long term care insurance. An 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) Continuing education courses completed under this section may be used to satisfy the continuing education requirements set forth in IC 27-1-15.7-2. (*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*)

Rule 11. Discretionary Powers of Commissioner

760 IAC 2-11-1 Modification or suspension

Authority: IC 27-8-12-7

Affected: IC 4-21.5; IC 27-8-12

Sec. 1. The commissioner may, upon written request and after a hearing under IC 4-21.5, issue an order to modify or suspend a specific provision or provisions of this article with respect to a specific long term care insurance policy, certificate, or subscriber agreement upon a written finding of the following:

- (1) The modification or suspension would be in the best interest of the insureds.
- (2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension.
- (3) Any of the following are necessary:
 - (A) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long term care.
 - (B) The policy, certificate, or subscriber agreement is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community.
 - (C) The modification or suspension is necessary to permit long term care insurance to be sold as part of, or in conjunction with, another insurance product.

(Department of Insurance; 760 IAC 2-11-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

Rule 12. Reserve Standards

760 IAC 2-12-1 Reserves for policies, certificates, and riders

Authority: IC 27-8-12-7

Affected: IC 27-1-12-10; IC 27-8-12

Sec. 1. (a) When long term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies or certificates, policy reserves for such benefits shall be determined in accordance with IC 27-1-12-10(2)(h). Claim reserves must also be established in the case when such policy, certificate, or rider is in claim status. Reserves for policies, certificates, and riders subject to this section should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long term care benefits. However, in no event shall the reserves for the long term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long term care benefit.

(b) In the development and calculation of reserves for policies, certificates, and riders subject to this section, due regard shall be given to the applicable policy, certificate, or rider provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (1) Definition of insured events.
- (2) Covered long term care facilities.

- (3) Existence of home convalescence care coverage.
- (4) Definition of facilities.
- (5) Existence or absence of barriers to eligibility.
- (6) Premium waiver provision.
- (7) Renewability.
- (8) Ability to raise premiums.
- (9) Marketing method.
- (10) Underwriting procedures.
- (11) Claims adjustment procedures.
- (12) Waiting period.
- (13) Maximum benefit.
- (14) Availability of eligible facilities.
- (15) Margins in claim costs.
- (16) Optional nature of benefit.
- (17) Delay in eligibility for benefit.
- (18) Inflation protection provisions.
- (19) Guaranteed insurability option.

(c) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

(d) When long term care benefits are provided other than as in subsections (a) and (b), reserves shall be determined using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner. (*Department of Insurance; 760 IAC 2-12-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

Rule 13. Loss Ratio

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 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)

Rule 14. Filing Requirements

760 IAC 2-14-1 Approval by commissioner
Authority: IC 27-8-12-7

Affected: IC 27-8-12-17

Sec. 1. (a) Prior to an insurer or similar organization offering group long term care insurance to a resident of this state under IC 27-8-12-17, it shall file for approval with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long term care insurance requirements substantially similar to those adopted in this state.

(b) The commissioner shall review the policy or certificate to determine whether the policy or certificate complies with the requirements of this rule. (*Department of Insurance; 760 IAC 2-14-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 866; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-14-2 Advertising

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 2. (a) Every insurer, health care service plan, or other entity providing long term care insurance or benefits in Indiana shall provide a copy of any long term care insurance advertisement intended for use in Indiana whether through written, radio, or television medium to the commissioner of insurance of this state for review and approval by the commissioner. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three (3) years from the date the advertisement was first used.

(b) The commissioner may exempt from subsection (a) any advertising form or material when, in the commissioner's opinion, subsection (a) may not be reasonably applied. (*Department of Insurance; 760 IAC 2-14-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

Rule 15. Marketing

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 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 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 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*)

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)

Rule 16. Purchase or Replacement

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 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*)

760 IAC 2-16-2 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 2. If a long term care insurance policy, certificate, or subscriber agreement replaces another long term care policy, certificate, or subscriber agreement, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long term care policy, certificate, or subscriber agreement for similar benefits to the extent that similar exclusions have been satisfied under the original policy, certificate, or subscriber agreement. (*Department of Insurance; 760 IAC 2-16-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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*)

Rule 17. Outline of Coverage

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 12-point type.

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

(c) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means 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 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] 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.]

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.]

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 insurance producers] Neither [insert company name] nor its 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.

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.]

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.]

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 that limit, exclude, restrict, reduce, delay, or, in any other manner, operate to qualify payment of the benefits described in (9) above.]

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

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.]

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 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.]

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 that provides preconditions to the availability of policy benefits for such an insured.]

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 that corresponds to each benefit option.]

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)

Rule 18. Shopper's Guide

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) For insurance producer solicitations, an insurance producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) 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)*

Rule 19. Penalties

760 IAC 2-19-1 Civil penalties

Authority: IC 27-8-12-7

Affected: IC 27-8-12

Sec. 1. In addition to any other penalties provided by the laws or rules of this state, the commissioner may impose a civil penalty against an insurer which has violated the laws or rules. A penalty imposed under this section shall be the greater of:

(1) three (3) times the amount of the commissions paid for each policy involved in the violation; or

(2) ten thousand dollars (\$10,000).

(Department of Insurance; 760 IAC 2-19-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 869; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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 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.
- (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)

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
90 and over

11%
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)

Indiana Long Term Care Insurance Program Statute IC 12-15-39.6

IC 12-15-39.6

Chapter 39.6. Long Term Care Program

IC 12-15-39.6-1

"Long term care" defined

Sec. 1. As used in this chapter, "long term care" means the provision of the following services in a setting other than an acute care wing of a hospital to enable individuals whose functional capacities are chronically impaired to be maintained at their maximum level of health and well-being:

- (1) Physician's services.
- (2) Nursing services.
- (3) Diagnostic services.
- (4) Therapeutic services, including physical therapy, speech therapy, and occupational therapy.
- (5) Rehabilitative services.
- (6) Maintenance services.
- (7) Personal care services, including companion services and assistance in bathing, dressing, and other skills of daily living.
- (8) Transportation services.
- (9) Day care services.
- (10) Home health care services.
- (11) Respite care services.
- (12) Services provided in a facility licensed under IC 16-28.
- (13) Services provided by chiropractors, podiatrists, and optometrists.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-2

"Long term care facility" defined

Sec. 2. As used in this chapter, "long term care facility" means a facility licensed under IC 16-28.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-3

"Long term care insurance" defined

Sec. 3. (a) As used in this chapter, "long term care insurance" means insurance coverage for at least twelve (12) consecutive months for each covered person on an expense incurred, indemnity, or prepaid basis for one (1) or more necessary long term care services provided in a setting other than an acute care wing of a hospital.

(b) The term does not include payment:

- (1) of coinsurance, deductibles, or premiums for other insurance policies;
- (2) for services covered by other insurance policies; or
- (3) for services covered by Parts A and B of the Medicare program (42 U.S.C. 1395 et seq.).

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-4

"Health maintenance organization" defined

Sec. 4. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-5

"Qualified long term care policy" defined

Sec. 5. As used in this chapter, "qualified long term care policy" means an insurance policy that:

- (1) provides long term care insurance;
- (2) meets:
 - (A) the definition set forth in IC 27-8-12-5; and
 - (B) the standards established under IC 27-8-12-7.1; and
- (3) is issued by an insurer or other person who complies with section 9(a) of this chapter.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-6

Establishment and administration of program

Sec. 6. (a) The Indiana long term care program is established to do the following:

- (1) Provide incentives for individuals to insure against the costs of providing for their long term care needs.
- (2) Provide a mechanism for individuals to qualify for coverage of the costs of their long term care needs under the Medicaid program without first being required to substantially exhaust all their resources.
- (3) Assist in developing methods for increasing access to and the affordability of a long term care policy.
- (4) Provide counseling services to individuals in planning for their long term care needs.
- (5) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(b) The office of Medicaid policy and planning and the department of insurance shall administer the program. The department of insurance may contract with a local office of aging services, an area agency on aging, or other nonprofit organization to provide counseling services under the program. The department of insurance shall develop and coordinate a plan to provide counseling services under the program.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-7

Information on program; availability; assistance

Sec. 7. (a) The department of insurance or the agency with which the department of insurance has contracted under section 6(b) of this chapter shall make available to any individual interested in participating in the Indiana long term care program information concerning the following:

- (1) The Indiana long term care program.
- (2) Long term care insurance policies.
- (3) Medicare supplement insurance policies.
- (4) Parts A and B of the Medicare program (42 U.S.C. 1395 et seq.).
- (5) Health maintenance organizations under IC 27-13 that are contracted with the Medicare program.

(6) The Medicaid program.

(b) If an individual elects to pursue any of the options under subsection (a), the department of insurance shall assist the individual in doing so.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-8

Eligibility

Sec. 8. An individual who is either:

(1) the beneficiary of a qualified long term care policy approved by the department of insurance; or

(2) enrolled in a health maintenance organization that both provides long term care services and meets the requirements under sections 4 and 5 of this chapter; is eligible for assistance under the Medicaid program using the asset disregard under section 10 of this chapter.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-9

Policy provisions

Sec. 9. (a) An insurer or other person who issues a qualified long term care policy under this chapter must at a minimum offer to each policyholder or prospective policyholder a policy that provides both:

(1) long term care facility coverage; and

(2) home and community care coverage.

(b) An insurer or other person who complies with subsection (a) may also elect to offer a qualified long term care policy that provides only long term care facility coverage.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-10

Asset disregard adjustment

Sec. 10. (a) As used in this section, "asset disregard" means one (1) of the following:

(1) A one dollar (\$1) increase in the amount of assets an individual who:

(A) purchases a qualified long term care policy; and

(B) meets the requirements under section 8 of this chapter;

may retain under IC 12-15-3 for each one dollar (\$1) of benefit paid out under the individual's long term care policy for long term care services.

(2) The total assets an individual owns and may retain under IC 12-15-3 and still qualify for benefits under IC 12-15 at the time the individual applies for benefits if the individual:

(A) is the beneficiary of a qualified long term care policy that provides maximum benefits at time of purchase of at least one hundred forty thousand dollars (\$140,000) and includes a provision under which the daily benefit increases by at least five percent (5%) per year, compounded at least annually;

(B) meets the requirements under section 8 of this chapter; and

(C) has exhausted the benefits of the qualified long term care policy.

(b) When the office determines whether an individual is eligible for Medicaid under IC 12-15-3, the office shall make an asset disregard adjustment for any individual who purchases a qualified long term care policy. The asset disregard must be available after benefits of the long term care policy have been applied to the cost of long term care as required under this chapter.

(c) The qualified long term care policy an individual must purchase to be eligible for the asset disregard under subsection (a)(2) must have maximum benefits at time of purchase equal to at least one hundred

forty thousand dollars (\$140,000) plus five percent (5%) interest compounded annually beginning January 1, 1999.

As added by P.L.24-1997, SEC.53. Amended by P.L.2-1998, SEC.39.

IC 12-15-39.6-11

Application of asset disregard to determination of individual's assets

Sec. 11. A public program administered by the state that:

(1) provides long term care services; and

(2) bases eligibility upon the amount of the individual's assets;

must apply the asset disregard under section 10 of this chapter in determining the amount of the individual's assets.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-12

Discontinuation of program

Sec. 12. If the Indiana long term care program is discontinued, an individual who purchased a qualified long term care policy prior to the date the program is discontinued is eligible to receive an asset disregard as defined under section 10 of this chapter.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-13

Reciprocal agreements to extend asset disregard

Sec. 13. The office of Medicaid policy and planning may enter into reciprocal agreements with other states to extend the asset disregard under section 10 of this chapter to Indiana residents who had purchased qualified long term care policies in other states.

As added by P.L.24-1997, SEC.53.

IC 12-15-39.6-14

Rules

Sec. 14. The secretary of family and social services may adopt rules under IC 4-22-2 necessary to implement this chapter.

As added by P.L.24-1997, SEC.53.

Indiana Long Term Care Insurance Program Regulation

760 IAC 2-20

Rule 20. Indiana Long Term Care Program

760 IAC 2-20-1 Authority

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-8-12-7.1. (*Department of Insurance; 760 IAC 2-20-1; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-2 Purpose

Authority: IC 27-8-12-7.1

Affected: IC 12-10-12; IC 12-15-2

Sec. 2. The purpose of this rule is to:

- (1) establish minimum standards for long term care insurance policies, certificates, and riders to qualify for participation in the Indiana long term care program;
- (2) establish documentation and reporting requirements for issuers of policies, certificates, or riders to qualify under the Indiana long term care program;
- (3) provide full disclosures in the sale of long term care insurance policies, certificates, and riders which qualify under the Indiana long term care program; and
- (4) facilitate public understanding regarding long term care insurance and long term care insurance policies, certificates, and riders which qualify under the Indiana long term care program.

(*Department of Insurance; 760 IAC 2-20-2; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-3 Applicability

Authority: IC 27-8-12-7.1

Affected: IC 12-10-12; IC 12-15-2

Sec. 3. The requirements of this rule apply to any long term care insurance policy, certificate, or rider authorized for sale by the commissioner of the department of insurance as qualifying under the Indiana long term care program under IC 27-8-12-7.1. (*Department of Insurance; 760 IAC 2-20-3; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-4 "Activities of daily living" defined

Authority: IC 27-8-12-7.1

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

Sec. 4. (a) As used in this rule, "activities of daily living" include each of the following items:

(1) Eating.

(2) Transferring.

(3) Dressing.

(4) Bathing.

(5) Toileting or continence.

(b) The following definitions apply throughout this section:

(1) "Eating" means feeding oneself by getting food into the body from a receptacle, feeding tube, or intravenously.

(2) "Transferring" means moving into or out of a bed, chair, or wheelchair.

(3) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(4) "Bathing" means washing oneself by sponge bath in a tub or shower, including the task of getting into or out of the tub or shower.

(5) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(6) "Continence" means the ability to maintain control of bowel and bladder function or when unable to maintain control of bowel or bladder function the ability to perform associated personal hygiene, including care for catheter or colostomy bag.

(Department of Insurance; 760 IAC 2-20-4; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-5 "Asset disregard" defined

Authority: IC 27-8-12-7.1

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

Sec. 5. As used in this rule, "asset disregard" means the total equity value of personal property, assets, and resources not exempt under Medicaid regulations which at a minimum are equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured in determining eligibility for the Medicaid program under IC 12-15-2. The following are the two (2) types of asset disregard:

(1) "Dollar-for-dollar asset disregard" means the amount of the disregard is equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured.

(2) "Total asset disregard" means the amount of the disregard is equal to the total sum of assets owned by the qualified insured once the qualified insured has exhausted all qualifying insurance benefits.

(Department of Insurance; 760 IAC 2-20-5; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-6 "Asset protection" defined

Authority: IC 27-8-12-7.1

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

Sec. 6. As used in this rule, "asset protection" means the right extended by IC 12-15-39.6 to beneficiaries of qualified long term care insurance policies and certificates to an asset disregard under the Indiana long term care program. (*Department of Insurance; 760 IAC 2-20-6; 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-7 "Authorized designee" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 7. As used in this rule, "authorized designee" means any person designated in writing to the insurance company by the policyholder or certificateholder of a qualified long term care policy or certificate for purposes of notification under section 36(8) of this rule. (*Department of Insurance; 760 IAC 2-20-7; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-8 "Average daily private pay rate" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 8. As used in this rule, "average daily private pay rate" means the average daily rate charged by nursing facilities for persons not qualifying for federal or state reimbursement, established annually on a calendar year basis by OMPP for the period immediately preceding the effective date or renewal date of a policy or certificate. (*Department of Insurance; 760 IAC 2-20-8; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-9 "Case management" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 9. As used in this rule, "case management" includes, but is not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services. (*Department of Insurance; 760 IAC 2-20-9; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-11 "Certificate" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 11. As used in this rule, "certificate" means any certificate delivered or issued for delivery in this state under a group long term care policy. (*Department of Insurance; 760 IAC 2-20-11; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-12 "Certificate form" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 12. As used in this rule, "certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer. (*Department of Insurance; 760 IAC 2-20-12; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-13 "Certificateholder" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 13. As used in this rule, "certificateholder" means an owner of a qualified long term care insurance certificate or the beneficiary of a qualified long term care certificate. (*Department of Insurance; 760 IAC 2-20-13; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-14 "Cognitive impairment" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 14. As used in this rule, "cognitive impairment" means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer's disease or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

- (1) Short term or long term memory.
- (2) Orientation as to person, place, and time.
- (3) Deductive or abstract reasoning.

Cognitive impairment must result in an individual requiring twenty-four (24) hour a day supervision or direct assistance to maintain his or her safety. (*Department of Insurance; 760 IAC 2-20-14; filed Nov 20,*

1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-15 "Complex, unstable medical condition" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 15. As used in this rule, "complex, unstable medical condition" means that the individual requires twenty-four (24) hour a day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital. (*Department of Insurance; 760 IAC 2-20-15; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-16 "DDARS" defined

Authority: IC 27-8-12-7.1

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

Sec. 16. As used in this rule, "DDARS" means the Indiana division of disability, aging, and rehabilitative services. (*Department of Insurance; 760 IAC 2-20-16; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-17 "Deficiency in activities of daily living" defined (*Repealed*)

Sec. 17. (*Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001*)

760 IAC 2-20-18 "Direct assistance" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 18. As used in this rule, "direct assistance" means that the individual cannot perform an activity of daily living safely or appropriately without continual help or oversight. Direct assistance may vary from requiring a person to physically stand by or set up the activity to the activity being totally performed by others. (*Department of Insurance; 760 IAC 2-20-18; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-18.1 "Eligible long term care services" defined (*Repealed*)

Sec. 18.1. (*Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001*)

760 IAC 2-20-19 "Indiana long term care program" defined

Authority: IC 27-8-12-7.1

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

Sec. 19. As used in this rule, the "Indiana long term care program" means the program authorized in IC 27-8-12-7.1 and IC 12-15-39.6. (*Department of Insurance; 760 IAC 2-20-19; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-20 "Indiana preadmission screening program" defined (*Repealed*)

Sec. 20. (*Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001*)

760 IAC 2-20-21 "Insured event" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 21. (a) Except as specified in subsection (b), as used in this rule, "insured event" means, for the purposes of determining eligibility for benefits under a qualified policy, or certificate, or rider and for determining whether these benefits result in an asset disregard for a qualified insured, that any one (1) of the following criteria is met:

(1) The individual has a deficiency in two (2) or more activities of daily living.

(2) The individual has a cognitive impairment.

(3) The individual has a complex, unstable medical condition.

(b) For qualified policies eligible for favorable tax status, "insured event" means when the policyholder has become a "chronically ill individual" as that term is defined in the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, Sections 321 through 327, hereinafter referred to as "HIPAA 1996". When determining the loss of functional capacity, the policyholder must be unable to perform (without substantial assistance from another individual) two (2) or more of six (6) activities of daily living (as set forth in HIPAA 1996) for a period of at least ninety (90) days. (*Department of Insurance; 760 IAC 2-20-21; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3369; errata, 21 IR 111; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-21.1 "Integrated policy" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-10-12; IC 12-15-2

Sec. 21.1. As used in this rule, "integrated policy" refers to any qualified long term care insurance policy or certificate which provides coverage for both long term care facilities and home and community care services. (*Department of Insurance; 760 IAC 2-20-21.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-22 "Issuer" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 22. As used in this rule, "issuer" means:

- (1) insurance companies;
- (2) fraternal benefit societies;
- (3) prepaid health care delivery plans;
- (4) health care service plans;
- (5) health maintenance organizations; and
- (6) any other entity;

delivering or issuing for delivery in this state, long term care policies or certificates. (*Department of Insurance; 760 IAC 2-20-22; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-22.1 "Long term care facility" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-10-12; IC 12-15-2; IC 16-28

Sec. 22.1. As used in this rule, "long term care facility" means a facility licensed under IC 16-28, including nursing facilities and residential care facilities. (*Department of Insurance; 760 IAC 2-20-22.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-22.2 "Long term care facility policy" defined

Authority: IC 27-8-12-7.1

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

Sec. 22.2. As used in this rule, "long term care facility policy" refers to any qualified long term care insurance policy or certificate which provides coverage primarily for care in a long term care facility and does not provide coverage for home and community care. (*Department of Insurance; 760 IAC 2-20-22.2; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-23 "Medicaid eligible long term care services" defined (*Repealed*)

Sec. 23. (*Repealed by Department of Insurance; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2653*)

760 IAC 2-20-24 "Medicaid waiver" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 24. As used in this rule, "Medicaid waiver" refers to the home and community based services waiver for the aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act which allows Indiana to provide certain community and in-home services not covered in the state Medicaid plan, which are instrumental in the avoidance or delay of institutionalization. Indiana's Medicaid waiver services include:

- (1) case management;
- (2) homemaker;

- (3) respite care;
- (4) attendant care;
- (5) adult day care; and
- (6) other services which, independent of the preceding home and community based services, are essential to prevent institutionalization.

(Department of Insurance; 760 IAC 2-20-24; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-24.1 "Minimum inflation adjusted daily benefit" defined (*Repealed*)

Sec. 24.1. (Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)

760 IAC 2-20-25 "OMPP" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 25. As used in this rule, "OMPP" means the Indiana office of medicaid policy and planning. *(Department of Insurance; 760 IAC 2-20-25; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-20-26 "Plan of care" defined

Authority: IC 27-8-12-7.1

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

Sec. 26. As used in this rule, "plan of care" means a written individualized plan of services developed by a case management agency which specifies the type and frequency of all services required by the individual, the service providers, and the cost of services. *(Department of Insurance; 760 IAC 2-20-26; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-20-26.5 "Policy eligible for favorable tax status" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2; IC 27-8-12-7

Sec. 26.5. As used in this rule, "policy eligible for favorable tax status" means any long term care insurance policy or certificate meeting federal standards of HIPAA 1996, including clearly disclosing in the policy and in the outline of coverage that such policy is intended to be a long term care insurance contract eligible for favorable tax status under Section 7702B(b) of Chapter 79 of the Internal Revenue Code of 1986. *(Department of Insurance; 760 IAC 2-20-26.5; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-20-27 "Policy form" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 27. As used in this rule, "policy form" means the form on which the policy is delivered or issued for delivery by the issuer. (*Department of Insurance; 760 IAC 2-20-27; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-28 "Policyholder" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 28. As used in this rule, "policyholder" means an owner of an individual qualified long term care insurance policy or a beneficiary of a qualified individual long term care insurance policy. (*Department of Insurance; 760 IAC 2-20-28; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-29 "Qualified insured" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 29. As used in this rule, "qualified insured" means the following:

(1) An individual who is either:

(A) the beneficiary of a qualified long term care policy, certificate, or rider approved by the department of insurance; or

(B) enrolled in a prepaid health care delivery plan that provides long term care services and qualifies under this rule.

(2) An individual who is eligible for an asset disregard under a qualified long term care policy, certificate, or rider.

(*Department of Insurance; 760 IAC 2-20-29; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-30 "Qualified long term care insurance policy or certificate" defined
Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6; IC 27-8-12-7

Sec. 30. As used in this rule, "qualified long term care insurance policy or certificate" means:

(1) any long term care insurance policy or certificate qualified for sale to Indiana residents by the department of insurance as meeting standards promulgated under IC 27-8-12-7 and IC 27-8-12-7.1; or

(2) any long term care insurance policy or certificate owned by an Indiana resident purchased under another state's Partnership for Long Term Care Program 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.

(Department of Insurance; 760 IAC 2-20-30; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-30.1 "Qualified rider" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2; IC 27-8-12-7

Sec. 30.1. As used in this rule, "qualified rider" means any long term care insurance rider qualified for sale to Indiana residents by the department of insurance as meeting standards promulgated under IC 27-8-12-7 and IC 27-8-12-7.1. *(Department of Insurance; 760 IAC 2-20-30.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-20-31 "Quarterly/annually" defined

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 31. As used in this rule, "quarterly/annually" refers to periods aligning with the state fiscal year of July 1 to June 30. *(Department of Insurance; 760 IAC 2-20-31; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-20-32 "Service summary" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 32. As used in this rule, "service summary" means a written summary, prepared by an issuer for a qualified insured, which identifies the following:

- (1) The specific qualified policy or certificate.
- (2) The total benefits paid for services to date.
- (3) The amount of benefits qualifying for asset protection.

(Department of Insurance; 760 IAC 2-20-32; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-32.5 State-set dollar amount

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 32.5. As used in this rule, "state-set dollar amount" means the least amount of maximum benefit a policyholder or certificateholder must initially purchase in a qualified policy or certificate to be eligible for a total asset disregard. The state-set dollar amount begins at one hundred forty thousand dollars (\$140,000) for qualified policies with an effective date of 1998 or earlier. The state-set dollar amount will increase each year on January 1 by five percent (5%) compounded annually, rounded to the nearest one dollar (\$1) increment, and applies to new policies effective during each calendar year. *(Department of Insurance; 760 IAC 2-20-32.5; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-20-33 Qualification of long term care insurance policies, certificates, and riders

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 33. (a) No long term care insurance policy, or certificate, or rider shall qualify for participation in the Indiana long term care program unless the long term care insurance policy, or certificate, or rider complies with this rule.

(b) The commissioner of the department of insurance may not approve a long term care facility policy or certificate as a qualified policy or certificate for participation in the Indiana long term care program unless the issuer has an approved qualified integrated policy or certificate.

(c) The commissioner of the department of insurance may not approve a long term care facility policy or certificate eligible for favorable tax status as a qualified policy or certificate for participation in the Indiana long term care program unless the issuer has an approved qualified integrated policy or certificate eligible for favorable tax status.

(d) Long term care insurance policies, and certificates, and riders in force at the effective date of this rule may, with the signed acceptance of the policyholder or certificateholder, be amended to meet the requirements for qualification. *(Department of Insurance; 760 IAC 2-20-33; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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

Sec. 34. 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 that does not meet the requirements of this article and has not been approved by the commissioner of the department as a qualified long term care insurance policy, certificate, or rider. Each issuer seeking to qualify a long term care policy, 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 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 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.

(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) 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 that procedures are in place to assure that no 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 insurance producer or telemarketer has completed fifteen (15) hours of 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 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 boldface type and prominently displayed that states: LONG TERM CARE FACILITY POLICY [CERTIFICATE].

(9) Include a statement on the qualified rider in 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 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 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.

(B) The ceding issuer remains responsible for complying with all requirements of sections 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 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 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 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 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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 that does not meet the minimum benefit standards in this section and 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 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-36 Required policy, certificate, and rider provisions

Authority: IC 27-8-12-7.1

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

Sec. 36. All qualified policies, certificates, and riders shall meet the following requirements:

- (1) Have premiums:
 - (A) based on the issue age of the applicant; or
 - (B) level for the life of the policy or certificate.

Nothing in this subdivision shall preclude an issuer from reducing premiums of a policy or certificate or using a policy form or certificate form in which the premiums are no longer required to be paid after a specified period of time.

- (2) Include a provision that the policy, certificate, or rider will utilize the insured event criteria, defined in section 21 of this rule, for determining eligibility for benefits and for determining the amount of asset disregard.
- (3) Include a provision which, in the event the qualified policy or certificate is about to lapse, offers the policyholder or certificateholder the option to reduce his or her coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, cannot be less than the minimum benefit amount requirement specified in section 36.1(l) or 36.2(l) of this rule. The issuer need only allow this offer to be exercised one (1) time. Premiums shall be based on the age of the policyholder or certificateholder at the time of the issuance of the original qualified policy or certificate.
- (4) Include a provision that, upon sale of a qualified long term care insurance policy or certificate, the issuer shall do the following:

- (A) Offer to collect and store the name and address of an individual designated as an authorized designee by the purchaser to be notified when a policy or certificate lapse is imminent. The issuer must obtain a signed statement from purchasers who do not choose to designate an authorized designee that they have been offered this opportunity and declined. It shall be the issuer's responsibility to notify such designee prior to canceling a policy or certificate due to lack of premium payment. The designee notification shall occur no later than fifteen (15) days after the beginning of the thirty (30) day grace period for premium

payments. The issuer shall permit the policyholder or certificateholder to periodically update the authorized designee.

(B) Provide at least a ninety (90) day guaranteed reinstatement period for a policyholder or certificateholder whose policy or certificate has lapsed due to nonpayment of premium, who meets the insured event criteria, and who has paid all due and unpaid premiums. The reinstated policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

(5) Include a provision that benefits shall only be paid after the payment of all other benefits to which the policyholder or certificateholder is otherwise entitled, excluding Medicaid. The issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare.

(6) Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate form issued under a group long term care policy shall not be changed or otherwise modified without the signed acceptance of the certificateholder.

(7) For purposes of approving any future premium adjustments, all individual qualified policies issued by the same issuer shall be considered a single risk pool and all group qualified policies issued by the same issuer shall be considered a single risk pool, except a group issuer may form a separate risk pool whenever at least two thousand (2,000) certificates are in force for:

(A) a single employer, labor organization, or trust established by a single employer or labor organization;

(B) a single nonprofit association composed of individuals who are or were actively engaged in the same profession, trade, or occupation and organized in good faith for purposes other than obtaining insurance; and

(C) a single nonprofit association created and maintained in good faith for the benefit of its members and not for the purposes of obtaining insurance, in active existence for at least five (5) years, and with a constitution and bylaws and a board with member representation.

Nothing in this subdivision shall preclude an issuer from pooling their qualified and nonqualified policies, certificates, and riders to avoid or reduce the amount of any future premium increase that otherwise might have occurred to the risk pool of qualified policies, certificates, and riders.

(Department of Insurance; 760 IAC 2-20-36; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1152; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2650; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1993; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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 that does not meet the minimum benefit standards and required policy and certificate provisions in this section and that has not been approved by the commissioner of the department as a qualified long term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits 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 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 seventy-five percent (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 that does not exceed seventy-five percent (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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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 that does not meet the minimum benefit standards and required policy and certificate provisions in this section, and 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 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 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 that include residential care facility benefits must:

(A) provide a daily residential care facility benefit of at least seventy-five percent (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 that does not exceed seventy-five percent (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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-36.3 Minimum benefit standards and required policy and certificate provisions for qualified riders

Authority: IC 27-8-12-7.1

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

Sec. 36.3. (a) No long term care insurance rider may be advertised, solicited, or issued for delivery in this state as a qualified rider which does not meet the minimum benefit standards and required provisions in this section, and which has not been approved by the commissioner of the department of insurance as a qualified rider.

(b) An issuer may only attach a qualified rider to a qualified long term care policy sold by the same issuer.

(c) A qualified rider, which provides home and community based services, must provide benefits, at a minimum, but not be limited to, the following:

- (1) Home health nursing.
- (2) Home health aide services.
- (3) Attendant care.
- (4) Respite care.
- (5) Adult day care services.

(d) All home and community based services covered through the qualified rider 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 or certificate's maximum benefit.

(e) At a minimum, upon the initial effective date of the qualified rider, which provides home and community based services, the qualified rider must provide the following:

- (1) A daily home and community based benefit of at least fifty percent (50%) of the then current daily nursing facility benefit of the long term care facility policy or certificate. No policy or certificate shall pay benefits in excess of the actual charges.
- (2) The daily home and community based benefit shall not exceed the then current daily nursing facility benefit of the long term care facility policy or certificate.
- (3) If issued on an expense incurred basis, provide benefits which are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(f) At a minimum, upon the initial effective date of the qualified rider, which provides home and community based services, the qualified rider must provide a maximum benefit amount for the home and community care that:

- (1) is at least fifty percent (50%) of the then current maximum total benefit amount of the long term care facility policy or certificate; and
- (2) does not exceed the then current maximum benefit amount of the long term care facility policy or certificate.

(Department of Insurance; 760 IAC 2-20-36.3; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2652; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3373; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1996; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

760 IAC 2-20-37 Reporting requirements *(Repealed)*

Sec. 37. (Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)

760 IAC 2-20-37.1 Reporting requirements

Authority: IC 27-8-12-7.1

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

Sec. 37.1. Unless otherwise noted, the following requirements refer to issuer documentation and reporting requirements for qualified policies and certificates:

(1) The reporting requirements shall adhere to the specifications put forth in the Partnership for Long Term Care Insurance Uniform Data Set (UDS) Manual. A printed copy of the Indiana Long Term Care Program reporting requirements and documentation shall be provided, upon request, by OMPP. Reports shall adhere to the most recent UDS specifications, including, but not limited to:

(A) reporting frequencies;

(B) file structures;

(C) file triggers and formats;

(D) field definitions; and

(E) state specific requirements as noted in the Indiana Long Term Care Program section of the state specific appendices of the UDS manual.

(2) All reports are due to OMPP no later than thirty (30) days after the close of the reporting periods specified for the respective reports.

(3) The reporting requirements may vary over time and will adhere to the most current requirements as specified in the UDS Reporting Requirements and Documentation Manual.

(Department of Insurance; 760 IAC 2-20-37.1; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1996; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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 insurance producer sales data to OMPP two (2) times per year for purposes of creating and maintaining a directory of 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)*

760 IAC 2-20-38 Maintaining auditing information

Authority: IC 27-8-12-7.1

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

Sec. 38. (a) Each issuer shall maintain information as stipulated in subsection (f) on all policyholders or certificateholders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificateholder's condition which is not otherwise required by federal or state statute or regulation.

(b) When a policyholder or certificateholder who has received any benefits dies or when a policyholder or certificateholder who has received any benefits lapses his or her policy or certificate for any reason, the issuer must retain the stipulated information for a period of at least five (5) years after the time the policy or certificate ceases to be in force or after the documented death of the policyholder or certificateholder. Unless notified by the department of insurance to the contrary during this period, after the five (5) years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost effective method of record storage as alternatives to storage of paper copies of stipulated information.

(c) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificateholder of his or her right to request his or her service records as stipulated in subsection (f).

(d) The issuer shall also, upon request in writing, provide such policyholder or certificateholder or the policyholder's or certificateholder's authorized designee, if any, with a copy of the issuer's service records as required in subsection (f) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificateholder or the policyholder's or certificateholder's authorized designee, if requested, within sixty (60) days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

(e) The issuer shall enclose with the records a statement advising the former policyholder or certificateholder that it is in his or her interest to retain the records if he or she may ever wish to establish eligibility for Medicaid.

(f) The information to be maintained includes the following:

(1) Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(A) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(B) By an assessment conducted as part of the preadmission screening program of DDARS.

(C) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(D) For persons for whom clauses (A) through (C) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in clauses (A) through (C). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

(2) Description of services provided under the policy or certificate, including the following:

(A) Name, address, phone number, and license number, if applicable, of provider.

(B) Amount, date, and type of services provided, and whether the services qualify for asset protection.

- (C) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.
 - (D) The charges of the service providers, including copies of invoices for all services counting towards asset protection.
 - (E) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.
- (3) In order for home and community based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificateholder has received any benefits delivered as part of a plan of care, the issuer must retain the following:
- (A) A copy of the original plan of care.
 - (B) A copy of the plan of care required by DDARS.

(C) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count towards asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count towards asset protection if the revisions to the plan of care are made within ten (10) business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

(Department of Insurance; 760 IAC 2-20-38; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1155; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2653; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1997; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA)

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;
- (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
- (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 that differ from subsections (a) through (c).

(e) A qualified long term care insurance policy or certificate owned by an Indiana resident 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-39 Reporting on asset protection

Authority: IC 27-8-12-7.1

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

Sec. 39. (a) Each issuer shall send an asset protection report at least quarterly, with a copy sent to OMPP, to each policyholder or certificateholder who has received any benefits since the last asset protection report sent to the policyholder or certificateholder. Each asset protection report shall include the following information and shall appear in a format prescribed by OMPP:

(1) The amount of asset protection for which the policyholder or certificateholder had qualified prior to the quarter covered by the report.

(2) The total benefits paid by the issuer for services rendered during the quarter.

(3) A statement of the amount of benefits paid by the issuer for services rendered during the quarter which qualify for asset protection.

(4) A summary total of the amount paid to date under the policy or certificate that qualifies for asset protection.

(b) Asset protection reports shall be subject to audit by OMPP serving as representative of the commissioner of the department of insurance under the same requirements as specified in section 41(2) of this rule which covers the records in section 38 of this rule. (*Department of Insurance; 760 IAC 2-20-39; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1998; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-40 Preparing a service summary

Authority: IC 27-8-12-7.1

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

Sec. 40. (a) Each issuer shall prepare a service summary at the client's request specifically for the policyholder or certificateholder applying for Medicaid. The issuer shall also prepare a service summary when the policyholder or certificateholder has exhausted his or her benefits under the policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificateholder, whichever occurs first. The issuer shall send the service summary to the policyholder or certificateholder, with a copy sent to OMPP, within thirty (30) days of the date of final payment of qualifying insurance benefits by the issuer.

(b) The service summary shall include the following and shall appear in a format prescribed by OMPP:

- (1) The specific qualified policy or certificate.
- (2) The total benefits paid for services rendered to date.
- (3) The amount qualifying for asset protection.

This service summary is separate and in addition to the information requirement described in section 38 of this rule. (*Department of Insurance; 760 IAC 2-20-40; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-41 Plan of action

Authority: IC 27-8-12-7.1

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

Sec. 41. (a) Each issuer shall, prior to qualification by the department of insurance, submit to OMPP a plan for complying with the information maintenance and documentation requirements set forth in sections 37.1 and 38 of this rule. No policy or certificate shall be qualified until OMPP has approved the issuer's documentation plan for the policy or certificate. The documentation plan will include the following:

- (1) The location where records will be kept. Records required for purposes of the Indiana long term care program must be available at no more than three (3) locations, each of which shall be easily accessible to OMPP serving as representative of the department of insurance.
- (2) The issuer shall agree to give OMPP access to all information described in section 38 of this rule on an aggregate basis for all policyholders or certificateholders and on an individual basis for all policyholders or certificateholders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order to determine if an issuer's system for documenting asset protection is functioning correctly. The OMPP shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.
- (3) The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with OMPP and the department of insurance concerning the information.
- (4) Methods for determining when insurance benefits or prepaid benefits qualify for asset protection, including the following:
 - (A) Documentation of the insured event.
 - (B) Description of services.
 - (C) Documentation of charges and benefits paid.
 - (D) Documentation of plans of care, when required.
- (5) Description of electronic and manual systems which will be used in maintaining the required information.
- (6) Information that will be retained which is needed to comply with this rule.
- (7) Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium that will be used to report required information and a description of the relevant files.

(b) After OMPP reviews a plan of action, OMPP shall advise the department of insurance and the issuer in writing whether OMPP approves the plan of action. If OMPP disapproves a plan of action,

OMPP shall advise the department of insurance and the issuer of the shortcomings in the plan of action and shall instruct the issuer of the methods necessary to resolve them. (*Department of Insurance; 760 IAC 2-20-41; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

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, 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 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 the deficiencies.

(e) The commissioner of the department, 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 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 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; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

760 IAC 2-20-43 Separability

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2

Sec. 43. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid or unenforceable, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. (*Department of Insurance; 760 IAC 2-20-43; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1159; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA*)

APPENDIX

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This Indiana Long Term Care Partnership Agent Manual is produced as a reference for agents. The manual is periodically updated. All information contained in this manual may not be the most current. You can address any comments or questions to the Partnership Office at 866-234-4582 or 317-232-2187.

(October 2009)

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INSURANCE COMPANY LETTERHEAD

Dear [Policyholder's name, Family Member name or Power of Attorney name]

The enclosed Quarterly Asset Protection Report summarizes the amount of benefits paid and asset protection [policyholder's name or you] [has or have] earned during the quarter. A Quarterly Asset Protection Report will be sent to you for any quarter in which benefits are paid from [policyholder's name or your] Indiana Long Term Care Program insurance policy.

The Quarterly Asset Protection Report provides information on the total amount of insurance payments we have made to date, and the total amount of asset protection that has been earned under [policyholder's name or your] Indiana Long Term Care Program insurance policy. Please examine this report and carefully compare the current amount of assets [he, she, or you] own(s) with the total amount of asset protection earned as stated in the report. If [policyholder's name or your asset protection amount is close to the amount of the assets currently owned, then [he, she, or you] may be eligible for medical assistance from Indiana's Medicaid Program.

When the benefits under the insurance policy have reached the maximum limit, or if the policy has lapsed, a Service Summary Report will automatically be sent. This report will indicate the total amount of benefits paid by the policy and the total amount of asset protection that has been earned. In the event assistance from Indiana's Medicaid Program is needed before [policyholder's name or your] policy benefits have been fully used, a Service Summary Report may be requested specifically for the purpose of applying for Medicaid assistance.

To receive medical assistance from Indiana's Medicaid Program, [policyholder's name or you] must apply at the county office of the Division of Family Resources (DFR). Someone may apply on [policyholder's name or your] behalf. When you apply, a Medicaid caseworker will determine if and when [policyholder's name or you] [is or are] eligible for Medicaid. The DFR office can also provide you with information about other exclusions of assets, in addition to the protected amount listed in this report. The county office of the Division of Family Resources is usually listed in the blue pages of the telephone directory under the heading "County Government."

If [policyholder's or your] records don't agree with ours or if you have questions concerning the enclosed report, please write us at the above address, or call us at [insurance company phone number].

Sincerely,

QUARTERLY ASSET PROTECTION REPORT

Period Covered: _____ to _____ Date Prepared: _____

Insurance Co. Name that Issued the Policy: _____

Policy/Certificate #: _____

Insured's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

	Benefits Paid	Asset Protection Earned
Previous Amount	\$ _____	\$ _____
Amount this Quarter	\$ _____	\$ _____
Total:	\$ _____	\$ _____

Please retain this report for your records.

Preparer's Name and Title: _____

Company Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Insurance Company Letterhead

Dear [Policyholder's name, Family Member name, or Power of Attorney name]

Enclosed is a Service Summary Report with important information about [policyholder's name or your] long term care insurance policy.

The Service Summary Report provides information on the total amount of insurance payments we have made on [policyholder's name or your] behalf, and the total amount of asset protection [he, she, or you] [has or have] earned under [his, her, or your] Indiana Long Term Care Program insurance policy. Please examine this report and carefully compare the current amount of assets [policyholder's name or you] own(s), with the total amount of asset protection earned as stated in the report. If the asset protection amount is close to the amount of the assets [policyholder's name or you] currently own(s), [he, she, or you] may be eligible for medical assistance from Indiana's Medicaid Program.

To receive medical assistance from Indiana's Medicaid Program, [policyholder's name or you] must apply at the county office of the Division of Family Resources (DFR). Someone may apply on [policyholder's name or your] behalf. When you apply, a Medicaid caseworker will determine if and when [policyholder's name or you] [is or are] eligible for Medicaid. The county DFR office can also provide you with information about other exclusions of assets, addition to the protected amount listed on this report. The county office of the Division of Family Resources is usually listed in the blue pages of the telephone directory under the heading "County Government."

Please take this report with you at the time of applying for medical assistance from Indiana's Medicaid Program.

If [policyholder's name or your] records don't agree with ours, or if you have questions about the enclosed report, please write to us at the above address, or call us at [insurance company phone number].

Sincerely,

SERVICE SUMMARY REPORT

Period Covered: _____ to _____ Date Prepared: _____

Insurance Co. Name that Issued the Policy: _____

Policy/Certificate #: _____

Insured's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This Service Summary Report has been prepared due to the following:

_____ The report was requested.

_____ The policy benefits have been exhausted.

_____ The policy has lapsed.

	<u>Benefits Paid</u>	<u>Asset Protection Earned</u>
Total Amount	\$	\$ [\$ amount or the word "Total"]

Please retain this report for your records.

Preparer's Name and Title: _____ Telephone Number: _____

Company Name: _____

Address: _____

City, State, Zip Code: _____

To Medicaid Caseworker: This summary verifies that the amount appearing under the column labeled "Asset Protection Earned" was paid by [Company Name] on behalf of the above named individual for long term care services. The amount of "Asset Protection Earned" is an asset disregard for Medicaid eligibility as provided under Indiana Code at IC 12-15-39.6.

Indiana Long Term Care Insurance Program List of Participating Case Management Agencies

CHCS/National Care Management Partnership IN021

A long-term care case management agency.

Maureen Lillith
3050 Universal Blvd., Suite 150
Weston, FL 33331
Phone: (800)-370-7684 Fax: (954)-283-4887
Phone calls Carole Wright, Partnership Coordinator, with initial Partnership inquiries at (888)-232-4605 ext. 11.

Crawford and Company Health and Rehabilitation IN022

A national case management agency.

Contact Information:
Karen Fox
200 Glenridge Point Parkway
Suite 500
Atlanta, GA 30342
Phone: (800)-352-7359 or (888)582-3939 Fax: (404)-845-2418

Evercare Connections IN024

A national case management agency utilizing local certified home health agencies.

Contact Information:
Peggy Brandt
9900 Bren Road East
Minnetonka, MN 55343
Phone: (952)-936-3854 or (866)-728-9836
Fax: (952)-936-1947

Family Caring Network IN018

A national case management agency utilizing, in Indiana, the 13 Visiting Nurse Associations and various independent case management offices.

Contact Information:
Jocelyn Gordon
51 Sawyer Rd., Suite 340
Waltham, MA 02154
Phone: (800)-525-7279 Fax: (781)-891-8295

Long Term Solutions

IN025

A national case management agency.

Contact Information:

Noreen Guanci

182 West Central St.

Natick, MA 01760

Phone: (508)-907-6290

Fax: (508)-668-6478

Nation's Care Link

IN023

A national case management agency.

Contact Information:

Susan Toms, RN, MS, CCM

Director Clinical Services

5701 Shingle Creek Parkway, Suite 400

Minneapolis, MN 55430

Phone: (800)-560-1705

ILTCIP Materials Request Order Form

(Check payable to Department of Insurance (DOI))

Send the check and this completed form to:

Indiana Department of Insurance
Indiana Long Term Care Insurance Program
311 W. Washington St., #300
Indianapolis, Indiana 46204
(317) 232-4391

Please print legibly.

Name _____

Mailing Address _____

City, State, Zip _____

Send me ____ of the ILTCIP Booklet at \$1.00 each, Total \$ _____
"What You Should Know About Long Term Care" is an easy-to-read
overview of ILTCIP and Long Term Care insurance. (5/09 edition)

Send me ____ packs of the ILTCIP Brochure at \$7.50, Total \$ _____
(per pack of 50), "Your Peace of Mind," Provides an overview of the
Partnership Program in a tri-fold brochure format. (02/03 edition)

Send me ____ copies of the Agent Manual at \$7.00 each Total \$ _____
Contains ILTCIP, as well as regular LTC, regulations. (10/09 edition)

Send me ____ copies of the Partnership Guide for Agents Total \$ _____
at \$6.50 each. Comprehensive guide with marketing ideas and examples
to aid in being a successful agent partner. (11/06 edition)

Send me ____ packs of the "Your Future's So Bright" brochure Total \$ _____
at \$15.00 (per pack of 50). Bi-fold format geared to Baby-Boomers.
(09/03 edition)

Send me ____ "Nursing Home Resident with a Spouse at Home" Total \$ _____
brochure at .05 each. Explains the spousal impoverishment
protection law. (7/09 edition)

Send me ____ Shopper's Guide for Long Term Care for .75 each. Total \$ _____
(02/09 edition)

Grand Total _____

Partnership ID Card Request and/or Join the Mailing List

The **Agent ID Card** shows prospective clients that you are a “certified Indiana Partnership” agent. It confirms you have taken the necessary training required to sell Indiana Partnership policies.

The Agent ID Card signed by the Partnership Office will display your name, the issue date (date of completion of your 7-hour Partnership course), and the Partnership logo.

The initial card is available **free of charge**. Replacement cards will cost \$5.00 each. Check should be made payable to “Indiana Department of Insurance.”

Professionals on the **mailing list** will receive various Partnership mailings, including the quarterly newsletter. This is an ideal method to stay current on the Indiana Partnership Program and long term care issues.

Instructions: Complete the form below. Then fax, mail or e-mail the completed form, **ALONG WITH A COPY OF YOUR CERTIFICATE OF COMPLETION FOR THE 7-HOUR PARTNERSHIP COURSE** if requesting an Agent ID card to:

Danielle Fuller
Indiana Department of Insurance
311 W. Washington St., Suite 300
Indianapolis, IN 46204-2787
(317) 232-4391 Telephone
(317) 232-5251 Fax
dfuller@idoi.in.gov

____ Please send me an Indiana Partnership Agent ID Card

____ Initial Card or ____ Replacement Card

____ Please add me to the Partnership Mailing List

Please print clearly or type.

Date: _____

Name: _____

Agency Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ E-mail: _____

Please allow 30 working days for delivery of ID Card.

(8/09)

SERVICE REQUEST FORM

TO: INDIANA DEPARTMENT OF INSURANCE
 AGENT LICENSING DIVISION
 311 WEST WASHINGTON STREET, SUITE 300
 INDIANAPOLIS, IN 46204-2787

FROM:

 Name of Individual or Agency

 Mailing Address (Street, P.O. Box, etc.)

 City State Zip

Social Security or FEIN Number

OPTIONS (You may choose more than one)

1. Change of Residence Address and/or Phone Number	<input type="checkbox"/>	5. Request Letter(s) of Clearance	<input type="checkbox"/>
2. Change of address	<input type="checkbox"/>	6. Request Letter(s) of Certification AGENCIES ONLY	<input type="checkbox"/>
3. Correct Social Security	<input type="checkbox"/>	7. Request Duplicate License(s)	<input type="checkbox"/>
4. Change of Business Address and/or Phone Number	<input type="checkbox"/>		

NOTE: THE AGENT MUST SIGN THE BACK OF THIS FORM WHERE SHOWN

1. **CHANGE OF RESIDENT ADDRESS AND/OR PHONE NUMBER**

Note: State law requires you to notify the Department of a change of address or name within thirty (30) days of the change. Failure to do so will result in a \$100.00 penalty, revocation, suspension or other disciplinary action. If moving from one state to another a certification letter must be attached.

PRIOR ADDRESS	NEW ADDRESS
Street Address Required	Street Address Required
P.O. Box (If Applicable)	P.O. Box (If Applicable)
City State Zip	City State Zip
Phone Number	Phone Number

2. **CHANGE OF NAME**

Note: Attach copy of the change (legal documentation).

 Name as currently in our record (Last, First, Middle) New Name to appear in our Records (Last, First, Middle)

3. **CORRECT SOCIAL SECURITY NUMBER TO:**

Note: You must attach photocopies of at least 2 forms of identification confirming the number you provide below.

--	--	--	--	--	--	--	--	--	--

Social Security Number or FEIN _____

Agent's or Agency's Name _____

4. CHANGE OF BUSINESS ADDRESS AND/OR PHONE NUMBER

Note: State law requires you to notify the Department of a change of business address within thirty (30) days of the change. Failure to do so will result in a \$100.00 penalty, revocation, suspension or other disciplinary action.

PRIOR ADDRESS			NEW ADDRESS		
Street Address Required			Street Address Required		
P.O. Box (If Applicable)			P.O. Box (If Applicable)		
City	State	Zip	City	State	Zip
Phone Number			Phone Number		

5. REQUEST LETTER(S) OF CLEARANCE

Note: You must return original license(s) to the Department before a Letter of Clearance will be issued. Please enclose a stamped self-addressed envelope of sufficient size to hold the material requested.

I have moved from Indiana to the State of _____. Please cancel all my existing Indiana resident insurance licenses and send me a Letter of Clearance.

6. REQUEST LETTER(S) OF CERTIFICATION AGENCIES ONLY How many Copies? _____

Note: Please enclose a stamped self-addressed envelope of sufficient size to hold the material requested.

Providers must obtain letters of certification by logging onto www.sircon.com

7. REQUEST DUPLICATE LICENSE(S) (\$10.00 FEE REQUIRED)

License Type	Reason for Request

Note: The fee for a duplicate license is \$10.00 (personal check, cashiers check or money order). Do NOT send cash. Requests for a duplicate license(s) will not be processed unless a fee is received.

**8. ASSUMED BUSINESS NAME _____
*Must Notify the Department Before Using**

Signature of Agent or Officer/Principal of Agency

Date

Renewal Notice: The Department mails a renewal invoice to the producer's resident address on file. If for some reason the producer does not receive a renewal invoice, it is still the producer's responsibility to renew the license. Invoices are mailed to the producer approximately sixty (60) days before the license is due to expire. Contact the Department for a new invoice if an invoice is not received thirty (30) days prior to the license expiration date.

GLOSSARY FOR LONG TERM CARE

AAA (Area Agencies on Aging) – These local non-profit agencies answer consumer questions regarding benefits provided to aging and elderly persons. In Indiana, they are responsible for all federal and state funding for community and in-home long term care services.

Accelerated Death Benefit – A feature of a life insurance policy that lets the policy owner use some of the policy's death benefit prior to death.

Activities of Daily Living (ADLs) – Those things people need to do in order to live independently in their home. These skills can include: dressing, bathing, using the toilet, getting out of bed, eating and taking medicine. ADLs are often used to determine when one can get benefits from long term care insurance.

Acute Care – Care provided for patients who are not medically stable. These patients require frequent monitoring by health care professionals in order to maintain their health status. Care is usually short term. If patients are expected to remain sick, they are designated as chronically ill.

Adult Day Care – Care generally offered by a social agency or nursing home that is usually custodial in nature. It is a concept similar to children's day care centers, but catering to adult needs and interests.

Adult Foster Care – A live-in arrangement where one adult lives with, and is provided care and/or services, by an unrelated person or family. These arrangements may be certified by the state or managed individually.

Age Banding – The combining of age groups for premium purposes. Each age within the group pays the same amount. Age group examples: 65-69, 70-74, 75-79.

Age Limits – A requirement by the insurer that an applicant be older than a certain age (such as 65), or younger than a certain age (such as 85), before an application is accepted. The limit may also be a cutoff beyond which a person cannot purchase insurance.

Age Restrictions – LTC policies are generally sold to people between 50 and 79 years of age. Insurers which sell policies to those over 80 years of age will often offer reduced benefits compared to standard policy offerings.

Alternate Care Benefit – A policy provision which allows for a special arrangement of services specifically designed to allow the person to reside in a setting other than a nursing facility.

Alternate Care Facility – A licensed residence other than a nursing facility where care services are delivered. Examples include a hospice center, assisted living facility, Alzheimer's facility or Christian Science setting.

Alternate Plan of Care – Alternate plan of care benefit in a long term care insurance policy can include making improvements to a policyholder's home (such as ramps built for wheelchair access,

handrails in a bathroom, kitchen cabinets lowered) if the doctor, patient, and insurance company determine that this would be more appropriate and if it is at a lower or equal cost to the nursing home.

Alternative Care – A feature found in long term care insurance policies which can be defined in either a structured or unstructured way. It may include such items as care in group homes, home modification etc. It may be a definition unique to each policy form but generally allows the insurer to provide services not specifically covered in the policy to meet the unique needs of the individual.

Alzheimer's Disease – A form of organic dementia resulting in cognitive impairment first described in 1906 by German neurologist Alois Alzheimer. Specified levels of impairment trigger benefits under long term care insurance policy.

Alzheimer's Units – Special living units within nursing facilities or alternate care facilities specifically providing care for persons with Alzheimer's disease.

Assessment – An evaluation of physical and/or mental status by a health professional. The assessment is a central component in long term care insurance coverage and payment of claims. Upon the initiation of benefits – due either to deficiencies in two or more ADLs or a cognitive impairment – an assessment is performed by a healthcare professional. This assessment, together with the attending physician notes, determines the level of functional incapacity and plan of care to be followed in assisting the policyholder in performing ADLs. The form is sent to the company for their review and, if accepted, payments may begin after the elimination period.

Asset Disregard – The total equity value of personal property, assets, and resources not exempt under Medicaid regulations equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured in determining eligibility for the Medicaid Program.

Asset Protection – The right of beneficiaries of qualified long term care insurance policies and certificates to an asset disregard under the Indiana Long Term Care Insurance Program.

Assisted Living Facility – A residential living arrangement that provides individualized personal care and health services for people who require assistance with activities of daily living.

Attained Age – The age reached at an individual's last birthday. Premiums based on attained age do not change until the next birthday. Policies with premiums based on attained age may be more costly in the long run, because premiums may increase yearly with age. State law prohibits approved Indiana Long Term Care Insurance Program policies from using the attained age approach.

Authorized Designee – Any person designated in writing to the insurance by the policyholder of an ILTCIP long term care policy for purposes of notification in the event of policy lapse due to nonpayment of premium.

Bathing – One of the ADLs – Cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of a tub or shower and reaching head and body parts for soaping, rinsing and drying.

Bed Reservation Benefit – A bed reservation benefit may be paid if a policyholder’s covered stay is interrupted because the insured is hospitalized for any reason and a charge is made to reserve the policyholder’s nursing home or alternate care facility accommodations.

Benefit Maximum – The limit a health care insurance policy will pay for a certain loss or covered service. The benefit can be expressed as (1) Length of time (example: 2 years); (2) dollar amount (example: \$50,000); (3) percentage of the actual cost. The benefits may be paid to the policyholder or to a third party. This may refer to a specific illness, a specific time frame, or throughout the life of the policy.

Benefit Period (or Duration of Benefits) – This time period marks the time frame (or maximum amount of money) in which a policy will pay benefits.

Benefit Rider – A legal document which modifies the protection of an insurance policy by providing benefits for services not normally covered in an original policy. For example, a rider may add such benefits as nursing care, private rooms and hearing aids.

Benefit Trigger (or Insured Event) – The circumstances under which benefits will begin to be paid, such as, deficiencies in two (2) or more ADLs, cognitive impairment or complex, unstable medical condition.

Board and Care Homes – Living arrangements which provide seniors with a room, meals, help with ADLs, and some degree of protective supervision. They are not usually certified by Medicaid, but are usually licensed by the state. Board and Care Homes are also known as domiciliary care homes, personal care homes, community residence facilities, rest homes, or other similar terms.

Cancellation – An action by either the insurer or the policyholder that will terminate a policy. If the action occurs at the renewal time, it is called “nonrenewal”.

Case Management Agency – An agency or other entity approved by the Division of Disability, Aging and Rehabilitation Services (DDARS) as meeting DDARS case management standards contained in the DDARS community and home care services provider manual.

Case Management Services – Case management services include but are not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

Cash Surrender Value – The amount of money one is entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value will be determined as stated in the policy.

Centers for Medicare and Medicaid Services (CMS) – formerly the Health Care Financing Administration. The branch of the federal Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Certificate of Authority – The legal certificate issued by a state department of insurance, granting an insurance company the legal power and right to conduct business in that state.

Certificate of Insurance – With a group contract, there is only one master contract. Each covered member is given a document (the certificate of insurance) which states the benefits provided under the group contract.

Charges – Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

CHOICE – Community and Home Options to Institutional Care for the Elderly and Disabled – One of Indiana’s in-home services programs that is administered by the sixteen Area Agencies on Aging.

Chore Services – Services such as painting, yard work and heavy duty cleaning provided to the elderly and frail who are unable to do these tasks for themselves.

Chronic Illness – An illness with one or more of the following characteristics: permanency, residual disability, requires rehabilitation training, or requires a long period of supervision, observation, or care.

Chronically Ill – LTC policies that are tax-qualified require that a policyholder be certified as chronically ill by a licensed health care practitioner. This means that the policyholder is not able to perform without substantial assistance at least two (2) ADLs for a period of at least 90 days or that the policyholder requires substantial supervision to protect her/himself from threats to health and safety as a result of severe cognitive impairment. The 90-day requirement does not imply a waiting period for payment of benefits or a time during which services are not considered qualified long term care services. Tax-qualified policies, therefore, may pay benefits from the beginning of services, providing the services are expected to be needed for at least 90 days.

Class – In insurance, a group of insureds with the same general characteristics who are exposed to the same perils and are grouped together for rating purposes.

Cognitive Impairment – Confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer’s disease or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests that reliably measure impairment in the areas of short term or long term memory, orientation as to person, place and time, and/or deductive or abstract reasoning. Cognitive impairment must result in an individual requiring supervision or direct assistance twenty-four (24) hours a day in order to maintain safety.

Community-Based Services – Services that are provided through local agencies in order to maintain disabled individuals in the community. They may be provided in either the person’s own home or in settings to which the client travels (e.g. adult day care).

Congregate Housing – Multiple-unit housing with common dining room, shared common space, and services for those elderly/handicapped who are not totally independent but who do not need institutional care.

Continuing Care Retirement Community (CCRC) – A private facility located on one campus providing housing and care services, ranging from independent apartments to nursing home beds.

Complex, Unstable Medical Condition – A condition which requires twenty-four (24) hour a day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital.

Compound Interest – Interest earned on interest. First, interest is earned on the principal over a given period. It is then added to the original principal to become the new, higher principal, upon which interest is earned during the new period, and so on.

Conditionally Renewable – A clause that allows the insurer to refuse to renew the policy. The conditions under which the insurer can refuse to renew must be stated in the policy.

Convalescent Care or Rehabilitative Care – This is non-acute care which is prescribed by a physician and is received during the period of recovery from an illness or injury.

Co-pay (Co-Insurance) – A specified dollar amount or percentage of covered expenses which the policyholder is required to pay toward medical bills.

Coverage – What an insurance company offers in benefits toward covering an illness or injury. In long term care, companies offer three types of coverage: coverage of facility only stays, care provided in the home or community, and coverage for both facility and home care/community.

Custodial Care (Personal Care) – Care to help individuals meet personal needs such as bathing, dressing, and eating. Care may be provided by someone without professional training.

DDARS – The Indiana Division of Disability, Aging and Rehabilitative Services – The division of the Family and Social Services Administration responsible for services for the aged and disabled.

Deductible – The amounts payable by the policyholder for covered services before the insurer makes reimbursements.

Deficit Reduction Act of 2005 (DRA 2005) – Federal legislation signed on February 8, 2006 significantly impacting the Medicaid program and the long term care industry.

Durable Medical Equipment – Mechanical devices, equipment and supplies which enable a person to maintain functional ability. Examples include wheelchairs, walkers, and hospital beds.

Durable Power of Attorney – A person’s appointment of a representative to act on his or her behalf via a legal document that remains in effect in the event of incapacity of the grantor. This is specifically different than a regular power of attorney that ceases to act at the time of disability.

Duration of Benefits (Benefit Period) – Time period or maximum amount of dollars for which an insurance policy will pay benefits.

Elimination Period – Otherwise known as the “waiting period”, is the time period when an individual qualifies for benefits and before benefits are paid under the policy. Expenses incurred during the elimination period are paid by the policyholder as out-of pocket. An elimination period is similar to a deductible. Most long term care policies offer choices of elimination periods. The choices can be different for home/community care services and nursing home care. The shorter elimination period – the higher the cost.

Exclusion – An expense or condition that a policy does not cover. Common exclusions may include preexisting conditions such as heart disease, diabetes, or hypertension. Persons who have a serious condition or disease are often unable to secure insurance coverage either for general conditions or the particular disease. Excluded conditions could be covered after a stated period of time.

“Free Look” Period – A specified period of time during which an insurance policy may be examined by the buyer. If the buyer is not satisfied for any reason, the policy may be returned to the insurance company for a full refund.

FSSA – Family and Social Services Administration – The FSSA is the Indiana State agency responsible for human service programs including aging services and the Medicaid program.

Functionally Disabled – A functionally disabled person is one who has cognitive impairment or is unable to perform a prescribed number of activities of daily living (ADLs) as per the insurance policy. Additionally, some insurance policies require that the treatment must be medically necessary before they will pay any benefits.

Grace Period – A specified period after a premium payment is due on an insurance policy, in which the policyholder may make such payment and during which the provisions of the policy continue.

Group Insurance – A group policy that is a written contract between an insurer and another entity, usually an employer or group, which provides benefits to the insured persons holding individual certificates of insurance. These certificates state the provisions of coverage given to each insured individual or family.

Guaranteed Renewable – A provision whereby the insurance company agrees to continue insuring the policyholder as long as the premium is paid. (The policy cannot be cancelled by the company.) The premiums for the policy cannot be raised because of the benefits received. Premiums can only be raised for all policyholders on a class basis.

HCBLTC – Home and Community Based Long Term Care – Care that includes assistance with personal care, homemaker/chore assistance, transportation, meal preparation and adult day care.

Health Insurance Portability and Accountability Act (HIPAA) – Federal health insurance legislation passed in 1996 that allows, under specified conditions, long term care insurance policies to be qualified for certain tax benefits.

Home Equity Conversion Mortgages – These mortgages are loans available to persons who own the own homes. They allow homeowners to use the equity in their homes to generate income for meeting expenses, such as long term care costs.

Home Health Agency – A public or private agency that specializes in providing skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

Home Health Aide – A person who, under the supervision of a home health or social service agency, assists elderly, ill or disabled persons with household chores, bathing, personal care and other daily living needs.

Home Health Care – Services provided by a state licensed agency and includes services provided by a nurse, home health aide, nutritionist, or occupational, speech, respiratory, or physical therapist but does not require confinement in a nursing home. Services provided by family members, special companions or homemakers are not usually covered expenses in long term care policies.

Hospice – A public agency or private organization that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families in the home. In addition, a hospice can provide short-term inpatient care.

Hospital – A legally operated institution whose primary purpose is to provide acute medical care and treatment for sick or injured persons. This excludes nursing homes and drug and alcohol rehabilitation facilities.

IDOI – Indiana Department of Insurance – The IDOI is the state agency which regulates insurance in Indiana. The IDOI determines the standards that individual companies will meet in order to do business in the state.

ILTCIP – Indiana Long Term Care Insurance Program (Partnership Program) – An innovative program administered by DOI in conjunction with FSSA which provides an incentive and a means for Hoosiers to plan for their potential long term care. Through a partnership between the State Medicaid program and private insurers, the ILTCIP allows policyholders to protect their assets from Medicaid spend down requirements.

Indiana Preadmission Screening Program – The program which requires that persons seeking admission to nursing facilities be screened and approved for admission by DDARS.

Noncompliance can result in ineligibility for Medicaid reimbursement for a one (1) year period after admission.

Indemnity Policy – A type of health insurance policy that pays a fixed amount for each day of care received. Insurance agencies offer many options from which to choose. The higher the coverage amount per day, the more expensive the policy will be.

Individual Health Insurance – An individual policy of insurance that is a written contract between an insurance company and an insured person.

Inflation Protection – A benefit offered in many long term care policies that protects the consumer against the increasing cost of nursing home care and reduces the amount of income and assets the person must use to make any daily co-payment. This type of protection is highly recommended when purchasing a long term care policy. The Indiana Long Term Care Insurance Program mandates that inflation protection be offered to policyholders.

Institutionalization – Admission of an individual to an institution, such as a nursing home, where he/she will reside for an extended period of time or indefinitely.

Insured – The individual or group of people covered under the contract of an insurance policy.

Insured Event – An event that needs to occur for the policy to begin paying benefits. Terms such as medically necessary, injury or sickness, activities of daily living (ADLs), and cognitive impairment, are used to determine what is, or is not, an insured event.

Insurer – A company which, for a set premium, agrees to reimburse the insured for a loss covered by an insurance policy. The company underwrites the insurance and assumes the risk.

Integrated Policy – A qualified long term care insurance policy that provides coverage for both long term care facilities and home and community care services.

Intermediate Care – Care performed by licensed and trained health professionals but is not as intensive as skilled care.

Intermediate Care Facility – A facility which provides health related care and services to individuals who do not require the degree of care or treatment given in a hospital or skilled nursing facility, but who (because of their mental or physical condition) require care and services which are greater than custodial care and can only be provided in an institutional setting.

LTC – Long Term Care – The medical and social care given to individuals who have severe chronic impairments over a long period of time. Long term care can consist of care in the home by family members assisted with voluntary or employed help (such as provided by home health care agencies), adult day care, or care in institutions.

Lapse – A situation in which the policy becomes void or forfeited because the premium was not paid when due or during the grace period.

Length of Coverage – The maximum number of days or number of dollars that will be allowed by a policy for the insured.

Length of Stay – The amount of time a patient stays in a hospital or other health facility.

Level Premium – This means that the premium cannot be increased on an individual basis because the insured grows older. For example, if a person who is age 55 purchases a plan for \$300 per year, the premium will remain the same as the insured grows older. The only exception is the right of the insurer to raise the premium on a “class” basis.

Lifetime Maximum – The maximum dollar amount that a policy will pay in the policyholder’s lifetime.

Limitations – The exceptions or reductions to the benefits promised in the policy.

Living Will – A document which enables a person to declare her or his wishes in advance concerning the use of life-sustaining procedures in the event of a terminal illness or injury when the person has become incompetent.

Loading Up (or “Stacking”) – Selling two or more health insurance policies when one is adequate. It is usually the result of unscrupulous sales practices.

Long Term Care Facility – A facility that is licensed to provide both nursing facilities and residential care facilities.

Long Term Care Facility Policy – A qualified long term care insurance policy that provides coverage only for care in a long term care facility.

Long Term Care Insurance – A policy designed to help alleviate some of the costs associated with long term care. Often, benefits are paid in the form of a fixed dollar amount (per day or per visit) for covered expenses. In Indiana, long term care insurance must provide benefits for at least a twelve-month period.

Limited Policy – Type of insurance policy which only pays benefits for a specific type of illness or specific health care services named in the policy.

Loss – The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

Medicaid – A federal and state funded health care financing program available to persons who meet income and other eligibility criteria. Medicaid covers skilled or intermediate care in a nursing home and some home and community care services.

Medically Necessary – Medical necessity must be established under some policies (via diagnostic and/or other information presented on the claim under consideration) before the carrier or insurer will make payment.

Medicare – A federally funded health insurance program that is available to persons age 65 and over or younger persons who meet eligibility criteria due to handicapping conditions.

Medigap (or Medicare Supplement Insurance policy) – A policy that at a minimum covers co-payments and deductibles for Medicare.

NAIC – National Association of Insurance Commissioners – An association of State insurance commissioners active in resolving insurance regulatory problems. The association also prepares model legislation and regulations. The association has no regulatory authority.

Nonforfeiture Benefit – If an insurance policy includes this option, the insurance company will return part of the paid premiums if the policyholder cancels coverage or allows coverage to lapse. Benefits returned are usually as a guarantee of some portion of benefit (reduced benefit).

Nursing Home – Also known as a convalescent hospital; A place where persons reside who need some level of medical assistance and/or assistance with activities of daily living. The term, nursing home, is used to cover a wide range of institutions, including Skilled Nursing Facilities, Intermediate Care Facilities and Custodial Care Facilities. Not all nursing homes are Medicare approved/certified facilities.

Nursing Home Policy – A type of limited long term care insurance policy which generally pays indemnity benefits for medically necessary stays in nursing facilities.

Older Americans Act (OAA) – Enacted in 1965, this Act focuses on promoting the well-being of older persons so they can remain independent within their communities. Through the AAA's, the OAA serves persons of any income level who are at least 60 years of age, but targets services to persons with the "greatest social or economic need." Services provided include home delivered meals, some in-home assistance, transportation and adult day care. AAA's coordinate services, enhance access, and serve as a focal point from which to receive information on other services.

Out-of-Pocket Expenses – Costs borne directly by the patient without benefit of insurance; direct costs.

Outpatient – A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in organized programs, such as outpatient clinics.

Paid Up Policy – If the policyholder pays a higher premium for a limited number of years, say for ten or twenty years or until a certain age, at that point the policy will be "paid up".

Personal Care – Assistance provided to people who need help with bathing, cooking dressing, eating, grooming or personal hygiene. Medicare does not routinely pay for these services.

Plan of Care – A written individualized plan of home and community based services developed by a case management agency which specifies the type and frequency of all services required to maintain the individual in the community, their service providers, and the cost of services.

Post – Claim Underwriting – When a company discovers a previously undisclosed health condition that would have led to the rejection of an application, the company may deny benefits, cancel the policy, or both.

Pre-existing Condition – A condition for which you received or were recommended medical advice or treatment from a provider of health care services before signing an insurance application. Policies will usually not cover pre-existing conditions for a specified amount of time after the policy is effective. Indiana law states that a waiting period on a pre-existing condition cannot exceed six (6) months.

Premium – The dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder, in exchange for a designated amount of insurance coverage to be kept in force.

Primary Insurer/Primary Payer – When a person has more than one health insurance plan, the primary insurer is the first one that covers the initial payments after the deductible. It usually pays the largest share. The secondary insurer pays next.

Private Duty Nurse – A registered nurse who is licensed to provide medical care at the direction of a physician.

Provider – Someone who provides medical services or supplies, such as a physician, hospital, x-ray company, home-health agency, or pharmacy.

Quarterly Asset Protection Report – A written summary prepared by an insurer for a qualified insured and issued on a quarterly basis, which identifies the following: (1) the specific qualified policy or certificate; (2) the total benefits paid for the services to date; and (3) the amount of benefits qualifying for asset protection.

Reasonable and Necessary Care – The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Residential Care Facility or Assisted Living Facility – A facility providing primarily custodial care and not providing any nursing services. The Department of Health under regulations for residential facilities licenses these facilities in Indiana.

Respite Care – Short term care given to a sick person in the home, nursing home or hospital; intended to give relief to the principal caretakers.

Rider – A legal document which modifies the protection of an insurance policy, either extending or decreasing its benefits, or which adds or excludes certain conditions from the policy's coverage.

Robert Wood Johnson Foundation – A national philanthropy, which specializes in funding innovative health care and health care financing, programs, such as the Indiana Long Term Care Insurance Program.

SHIP – State Health Insurance Assistance Program – A statewide consumer counseling program, formed by the Department of Insurance, that provides information and counseling by trained local volunteers and through a toll-free phone line. The trained personnel will help seniors with questions on Medicare, Medigap, long term care insurance, other health insurance and the Indiana Long Term Care Insurance Program.

Seminars for Partners – An annual 3-hour continuing education course created by the Indiana Long Term Care Insurance Program and taught by several CE providers.

Secondary Payer – A payer of health benefits whose payments cannot be made until another primary party has processed the claim and issued a claim determination.

Service Summary Report – A written summary report, prepared by an insurer for a qualified insured, which identifies the following: (1) the specific qualified policy or certificate; (2) the total benefits paid for services to date; and (3) the amount of benefits qualifying for asset protection.

Skilled Care – Intensive medical care provided around the clock by trained licensed personnel.

Skilled Nursing Care – Care, which can only be provided by or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility (SNF) – A nursing facility, which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services, and other important related health services.

Social Security Administration (SSA) – The branch of the Department of Health and Human Services that is responsible for administration of the Medicare program.

Spend Down – A process of becoming eligible for Medicaid by exhausting the savings and assets of an individual.

“Spousal Impoverishment” Provision – A provision of federal law that protects couples’ financial resources when one is in a nursing home and one is living at home. The “community spouse” living at home can keep some income and assets and the nursing home spouse can qualify for Medicaid.

Substantial Assistance – Means hand-on or stand-by help required to do activities of daily living (ADLs).

Substantial Supervision – The presence of a person directing and watching over another who has a cognitive impairment.

Supplemental Security Income (SSI) – A federally funded program that provides income to low income aged, blind and disabled persons. Eligibility is based on income and assets.

Tax-Qualified Long Term Care Insurance Policy – A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

Term Life Insurance - Covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build cash value.

Third Party Notice – A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment. This can be a relative, friend, or professional such as a lawyer or accountant.

Total Asset Protection – When applying for Medicaid eligibility, the amount of the disregard is equal to the total sum of assets owned by the qualified insured once the Partnership policy benefits have been exhausted.

Underwriting – The process of examining, accepting, or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each.

Waiting Period – See definition of elimination period.

Waiver of Premium – An insurance policy provision which exempts the policyholder from further payment of premiums after the policyholder has been disabled for a specified period of time (usually 90 days, in long term care policies).