

which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws of this state as implemented and interpreted by this rule [760 IAC 1-18]. It is requested that the chief executive officer of each such insurer to which this rule [760 IAC 1-18] is addressed acknowledge its receipt and indicate its intention to comply therewith. (*Department of Insurance; Reg 19, Sec C; filed May 9, 1972, 4:15 pm: Rules and Regs. 1973, p. 423; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

## **Rule 19. Group Accident and Sickness Insurance—Succeeding Carrier Requirements**

### **760 IAC 1-19-1 Authority to promulgate rule; purpose of rule**

Authority: IC 27-1-3-7

Affected: IC 27-8-5

Sec. 1. AUTHORITY AND PURPOSES. This regulation [760 IAC 1-19] is issued pursuant to the authority set out at I.C. 1971, 27-1-3-7.

Many Indiana citizens have purchased coverage under group disability policies which contain pre-existing conditions limitations. If the policy holder replaces an existing group disability policy issued by a succeeding carrier, pre-existing conditions limitations in the new policy may cause unfair hardship on the insureds. The purpose of this regulation [760 IAC 1-19] is to eliminate this hardship. (*Department of Insurance; Reg 20,I; filed Jun 25, 1975, 10:45 am: Rules and Regs. 1976, p. 172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

### **760 IAC 1-19-2 Pre-existing condition limitations**

Authority: IC 27-1-3-7

Affected: IC 27-8-5

Sec. 2. LIMITATIONS. In the case of persons insured under a prior carrier's group disability policy at the date of change in coverage to a succeeding carrier's group disability policy containing a pre-existing conditions limitation, during the period of time the limitation applies under the new policy, the level of benefits shall be the lesser of

- (a) the benefits of the new plan determined without application of the pre-existing conditions limitation; or
- (b) the benefits of the prior plan.

(*Department of Insurance; Reg 20,II; filed Jun 25, 1975, 10:45 am: Rules and Regs. 1976, p. 172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

### **760 IAC 1-19-3 Effective date of rule**

Authority: IC 27-1-3-7

Affected: IC 27-1-3-7; IC 27-8-5

Sec. 3. APPLICATION. All group disability policies issued on or after the effective date of this regulation [760 IAC 1-19] must contain policy provisions consistent with Sec. II [760 IAC 1-19-2] of this regulation. (*Department of Insurance; Reg 20,III; filed Jun 25, 1975, 10:45 am: Rules and Regs. 1976, p. 172; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

## **Rule 20. Individual Deferred Annuity Policies and Riders (Expired)**

(*Expired under IC 4-22-2.5, effective January 1, 2008.*)

## **Rule 21. Medical Malpractice Insurance**

**760 IAC 1-21-1 Authority to promulgate rule; purpose of rule (Repealed)**

Sec. 1. *(Repealed by Department of Insurance; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA)*

**760 IAC 1-21-2 Definitions**

Authority: IC 34-18-5-4

Affected: IC 12-15-18-3; IC 12-24-1-3; IC 12-25; IC 16-28; IC 25-14-1-1.5; IC 25-14-1-3; IC 25-22.5; IC 25-29-1-13; IC 34-18

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

- (1) "Ancillary provider" means all health care providers as defined in IC 34-18-2-14, except the following:
  - (A) Physicians.
  - (B) Nursing homes.
  - (C) Hospitals.
  - (D) Psychiatric hospitals.
- (2) "Claims made coverage" means coverage for claims made during a coverage period.
- (3) "Comprehensive nursing care" means nursing that includes, but is not limited to, any of the following:
  - (A) Intravenous feedings.
  - (B) Enteral feeding.
  - (C) Nasopharyngeal and tracheostomy aspiration.
  - (D) Application of dressings to wounds that:
    - (i) require the use of sterile techniques, packing, or irrigation; or
    - (ii) are infected or otherwise complicated.
  - (E) Treatment of Stages 2, 3, and 4 pressure ulcers or other widespread skin disorders.
  - (F) Heat treatments that:
    - (i) have been specifically ordered by a physician as part of active treatment; and
    - (ii) require observation by nurses to adequately evaluate the process.
  - (G) Initial phases of a regimen involving administration of medical gases.
- (4) "Dentist" means any person with a license to practice dentistry under IC 25-14-1-3 not meeting the definition for dentist - oral surgery set forth in subdivision (5).
- (5) "Dentist - oral surgery" means any person with a license to practice dentistry under IC 25-14-1-3 treating patients with general anesthesia as defined by IC 25-14-1-1.5 in an office setting.
- (6) "Department" means the Indiana department of insurance.
- (7) "Employed physician" means a physician for whom an employer:
  - (A) withholds and pays Social Security and Medicare taxes; and
  - (B) pays unemployment tax;on wages paid to the physician. The term does not include a physician that is treated as an independent contractor for purposes of the Internal Revenue Service.
- (8) "For-profit facility" means a nursing home not meeting the definition for not-for-profit facility as defined in subdivision (13).
- (9) "Independent ancillary provider" means an ancillary provider that holds a state-issued license to provide health care and functions in an advanced role at a specialized level through the application of advanced knowledge and skills in the provision of health care. The term includes, but is not limited to, the following:
  - (A) A dentist.
  - (B) A psychologist.
  - (C) A podiatrist.
  - (D) An optometrist.
  - (E) A nurse practitioner.
  - (F) A nurse midwife.

- (G) A certified registered nurse anesthetist.
  - (H) A physician assistant.
  - (I) A clinical nurse specialist.
  - (J) An anesthesiologist assistant.
- (10) "Insurer" means any entity that issues a policy of insurance used as proof of financial responsibility under IC 34-18 including, but not limited to, an insurance company doing business on an admitted or nonadmitted basis or a risk retention group.
- (11) "IRMIA" means the Indiana residual malpractice insurance authority created by IC 34-18-17.
- (12) "Medical director" means a licensed physician whose duties primarily relate to oversight of the following:
- (A) Program policies and procedures.
  - (B) Program development.
  - (C) Improvement of quality of care.
  - (D) Compliance.
  - (E) Supervision.
- (13) "Not-for-profit facility" means a nursing home that is owned by a nonprofit corporation, governmental entity, or other organization that is exempt from federal income tax under Section 115 or 501, or both, of the Internal Revenue Code of 1986, as amended, or the corresponding provisions of any future United States Internal Revenue law.
- (14) "Nurse midwife" means a certified nurse midwife as defined at 848 IAC 3-1-1.
- (15) "Nursing home" means a facility named on the license issued by the state department of health under IC 16-28.
- (16) "Occurrence coverage" means coverage for acts that occur during a coverage period.
- (17) "PCF" means the Indiana patient's compensation fund.
- (18) "PCF certificate of insurance" means the form prescribed by the department to show proof of financial responsibility as required by IC 34-18-3-2(1) to become a qualified provider.
- (19) "Physician" means an individual with an unlimited license to practice medicine under IC 25-22.5.
- (20) "Podiatrist – no surgery" means any podiatrist, as defined by IC 25-29-1-13, not meeting the definition for podiatrist – surgery set forth in subdivision (21).
- (21) "Podiatrist – surgery" means a podiatrist, as defined by IC 25-29-1-13, performing any procedure requiring an anesthetic, including a local anesthetic as defined by 845 IAC 1-1-1 or intravenous or gaseous sedation, including postoperative treatment. Exceptions to these procedures include the following:
- (A) Diagnostic and therapeutic injections.
  - (B) Surgical procedures involving the nails.
  - (C) Excision of skin lesions.
  - (D) Incision and drainage of abscesses.
  - (E) The treatment of ulcers.
- The term includes podiatric physicians assisting in surgery.
- (22) "Psychiatric hospital" means an inpatient facility that is a private institution licensed under IC 12-25 and public institutions under the administrative control of the director of a division as designated by IC 12-24-1-3 and includes a private mental health institution, as defined by 440 IAC 1.5-1-8, and a private psychiatric institution, as defined by IC 12-15-18-3.
- (23) "Qualified actuary" means an individual that is a member in good standing with the Casualty Actuarial Society of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinion by the Casualty Practice Council of the American Academy of Actuaries.
- (24) "Reporting endorsement" means coverage that extends the time a claim may be made beyond the final claims made policy period. A reporting endorsement is commonly referred to as tail coverage.
- (25) "Residential nursing care" means nursing that includes, but is not limited to, any of the following:
- (A) Identifying human responses to actual or potential health conditions.
  - (B) Deriving a nursing diagnosis.
  - (C) Executing a minor regimen based on a nursing diagnosis or executing minor regimens as prescribed by any of the following:
    - (i) A physician.

- (ii) A physician assistant.
- (iii) A chiropractor.
- (iv) A dentist.
- (v) An optometrist.
- (vi) A podiatrist.
- (vii) A nurse practitioner.
- (viii) A clinical nurse specialist.

*(Department of Insurance; Reg 22, Sec II; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 514; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; filed May 29, 2012, 3:22 p.m.: 20120627-IR-760120046FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA; filed May 18, 2018, 2:25 p.m.: 20180613-IR-760180069FRA)*

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

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

Affected: IC 27-1; IC 27-4-5-2; IC 34-18-2-14; IC 34-18-3; IC 34-18-4; IC 34-18-15-4; IC 34-18-17

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

- (1) An insurance company holding a certificate of authority from the department under IC 27-1-6 or IC 27-1-17.
- (2) A risk retention group domiciled in Indiana or a foreign risk retention group registered with the department.
- (3) An insurer that does not hold a certificate of authority from the department through one (1) of the following:
  - (A) A surplus lines transaction under IC 27-1-15.8.
  - (B) An industrial insured transaction under IC 27-4-5-2(a)(8).
- (4) A captive insurer registered with the department under IC 27-1-2-2.3.

(b) The commissioner has the right to review the financial condition of any insurer used as proof of financial responsibility as follows:

- (1) An insurer shall have adequate assets to cover the reserves associated with all potential liabilities that are neither fronted by, nor reinsured with, an insurer. The commissioner may require an insurer to increase the funding if it is determined that the insurer's financial condition poses a financial risk to the PCF.
- (2) The commissioner may disapprove the use of an insurer as proof of financial responsibility if the commissioner determines, after notice and an opportunity to be heard, the insurer's financial condition poses a financial risk to the PCF. A disapproval must be in writing and served upon the insurer. If the insurer uses an agent to file proof of financial responsibility, service on that agent shall be considered service on the insurer.

(c) Upon request of the commissioner, an insurer shall provide a copy of the policy form and premium rates used as proof of financial responsibility.

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

- (1) submitted to the medical malpractice division of the department; and
- (2) approved by the commissioner, in writing, specifically for use as proof of financial responsibility under IC 34-18-3 and IC 34-18-4.

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

(f) A health care provider who fails to purchase a reporting endorsement policy will not be allowed PCF coverage for any claim made after the termination date of the final claims made coverage used as proof of financial responsibility for the PCF, unless the underlying insurer considers the claim to be covered under its policy language because it was previously reported.

(g) In the event a policy of insurance is rescinded, the health care provider's status as a qualified health care provider is similarly rescinded. The department will refund any surcharge that was received for the period that was subject to the rescission.

The insurer shall notify the department within ten (10) days of any policy that is rescinded.

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

- (1) The health care provider remains a qualified health care provider.
- (2) The PCF is not responsible for any amounts due by the health care provider except as provided in IC 34-18-15-4.
- (3) The PCF does not assume the insurer's obligation to pay costs to defend a claim.

*(Department of Insurance; 760 IAC 1-21-2.5; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA; filed May 18, 2018, 2:25 p.m.: 20180613-IR-760180069FRA)*

#### **760 IAC 1-21-3 Establishment of financial responsibility by health care provider by means other than insurance**

Authority: IC 34-18-5-4

Affected: IC 34-18-4-1

Sec. 3. (a) A health care provider desiring to establish financial responsibility under IC 34-18-4-1 by a means other than insurance may do so by submitting, to the commissioner, the following:

- (1) An agreement in writing, in a form and manner prescribed by the commissioner, to pay any final judgment or agreed settlement arising from claims of malpractice in accordance with the limits on liability set forth in IC 34-18-4-1(1).
- (2) Filing and maintaining with the commissioner cash or surety bonds from a company acceptable to the commissioner, in accordance with the limits on liability set forth in IC 34-18-4-1(1) for each year in which financial responsibility is established by a means other than insurance.

(b) A health care provider that establishes proof of financial responsibility under this section may obtain only occurrence coverage. Claims made coverage is not available.

(c) This section does not apply to a hospital or psychiatric hospital establishing financial responsibility under IC 34-18-4-1(3). *(Department of Insurance; Reg 22, Sec III; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 514; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

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

Authority: IC 34-18-5-4

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

Sec. 4. If a health care provider that has established financial responsibility, in the manner set forth in section 3 of this rule:

- (1) ceases practice;
- (2) establishes financial responsibility by means of insurance; or
- (3) decides that he or she no longer wishes to establish financial responsibility under IC 34-18;

any cash or surety bond filed with the commissioner shall remain on deposit until liability ceases to exist. *(Department of Insurance; Reg 22, Sec IV; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 515; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2874; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

#### **760 IAC 1-21-5 Financial responsibility of hospital or psychiatric hospital**

Authority: IC 34-18-5-4

Affected: IC 12-25; IC 16-21-2; IC 34-18-4-1; IC 34-18-5-3

Sec. 5. A hospital or psychiatric hospital may establish financial responsibility for itself and its officers, agents, and employees by submitting, to the commissioner, all of the following at least sixty (60) days before the requested effective date of

coverage with the PCF:

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

(2) An agreement in writing that the hospital or psychiatric hospital will establish and maintain a claims management and risk management program. The program shall include, at a minimum, the following:

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

- (i) Whether malpractice liability exists.
- (ii) Its cause.

(B) Procedures for the following:

- (i) The efficient processing, adjustment, and reasonable settlement of claims.
- (ii) The defense by legal counsel of claims that cannot be adjusted or settled.
- (iii) Examining the cause of losses and taking action to reduce their frequency and severity, including a safety program and employee and professional training program.

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

(3) A verified financial statement that demonstrates the financial resources of the hospital or psychiatric hospital are sufficient to satisfy all malpractice claims incurred by it up to the limits on liability set forth in IC 34-18-4-1(3). Notwithstanding, if the hospital or psychiatric hospital:

- (A) is an agency of any governmental unit; and
- (B) desires to use the taxing power of that governmental unit to establish its financial security;

it may establish financial responsibility by filing with the commissioner a copy of an ordinance or resolution of the taxing governing body of the governmental unit, authorizing the hospital or psychiatric hospital to do so, and acknowledging the responsibility of the governmental unit for any judgment or settlement arising from claims of malpractice.

(4) An agreement in writing that if the hospital or psychiatric hospital:

- (A) discontinues operation; or
- (B) decides to purchase insurance to establish financial responsibility under IC 34-18 et seq.;

the hospital or psychiatric hospital will continue to be liable in the amounts set forth in subdivision (1) until liability ceases to exist.

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

- (A) The hospital's or psychiatric hospital's most recent application for licensure to operate a hospital under IC 16-21-2, or IC 12-25 for psychiatric hospitals, on file with the state department of health or family and social services administration, as applicable.
- (B) Any other information reasonably requested by IRMIA to accurately determine the surcharge amount.

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

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

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

(8) The department may require a hospital or psychiatric hospital to:

- (A) submit to an independent audit; or
- (B) provide a certification by an independent person acceptable to the commissioner;

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

*(Department of Insurance; Reg 22, Sec V; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 515; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2875; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2375; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

**760 IAC 1-21-6 Financial reserves**

Authority: IC 16-9.5-2-7

Affected: IC 5-14-3; IC 16-9.5-1-1; IC 16-10-1-6; IC 34-18-9-3

Sec. 6. A health care provider that establishes financial responsibility by a means other than insurance must maintain reserves adequate to cover the possible loss and expected litigation costs in conjunction with any claim submitted against that health care provider. Such reserves must be established within sixty (60) days after a claim is reported. Upon the request of the department, the health care provider shall provide an actuarial opinion that states the health care provider has adequate reserves for its potential liabilities under generally accepted standards of actuarial practice. Any information received by the department regarding claim reserves is confidential under IC 5-14-3 and IC 34-18-9-3. The department shall request not more than one (1) report in a twelve (12) month period unless the department receives information that indicates a financial issue. *(Department of Insurance; Reg 22, Sec VI; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

**760 IAC 1-21-7 Cash deposits**

Authority: IC 34-18-5-4

Affected: IC 34-18-4-1

Sec. 7. Cash deposited by a health care provider under IC 34-18-4-1(2) and this rule may be deposited in an interest-bearing account in any bank located in Indiana. Such a deposit must be in a joint account under the control of the commissioner and the health care provider. The health care provider may withdraw accrued interest from the account. *(Department of Insurance; Reg 22, Sec VII; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 516; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA; filed May 18, 2018, 2:25 p.m.: 20180613-IR-760180069FRA)*

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

Authority: IC 34-18-5-4

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

Sec. 8. The annual surcharge for an ancillary provider or independent ancillary provider shall be as follows:

- (1) An ancillary provider who is not an independent ancillary provider that purchases insurance as proof of financial responsibility shall pay one hundred percent (100%) of the premium charged by the insurer.
- (2) An ancillary provider who is not an independent ancillary provider that establishes financial responsibility by means other than insurance under section 3 of this rule shall pay an amount equal to one hundred percent (100%) of the premium that would be charged to the ancillary provider by IRMIA. The payment must be made each year under IC 34-18-5-3 within thirty (30) days after qualification.
- (3) An independent ancillary provider's surcharge shall be calculated at the following percentage of the published surcharge for a specialty class 1 physician:
  - (A) Twenty percent (20%) for each dentist.
  - (B) One hundred thirty percent (130%) for each dentist - oral surgery.
  - (C) Twelve and one-half percent (12.5%) for each psychologist.
  - (D) Ninety-two and one-half percent (92.5%) for each podiatrist - no surgery.
  - (E) One hundred forty-five percent (145%) for each podiatrist - surgery.

- (F) Twelve and one-half percent (12.5%) for each optometrist.
  - (G) Thirty-five percent (35%) for each nurse practitioner.
  - (H) One hundred fifty percent (150%) for each nurse midwife.
  - (I) Forty-five percent (45%) for each certified registered nurse anesthetist.
  - (J) Thirty-five percent (35%) for each physician assistant.
  - (K) Thirty-five percent (35%) for each clinical nurse specialist.
  - (L) Forty-five percent (45%) for each anesthesiologist assistant.
- (4) An independent ancillary provider who provides health care on a part-time basis shall pay a reduced surcharge as follows:
- (A) An independent ancillary provider who provides health care twelve (12) hours per week or less on an annual basis shall receive a credit equal to seventy-five percent (75%) of the surcharge amount.
  - (B) An independent ancillary provider who provides health care more than twelve (12) hours but fewer than twenty-five (25) hours per week on an annual basis shall receive a credit equal to fifty percent (50%) of the surcharge amount.
  - (C) An independent ancillary provider who provides health care at least twenty-five (25) hours but fewer than thirty-one (31) hours per week on an annual basis shall receive a credit equal to twenty-five percent (25%) of the surcharge amount.

*(Department of Insurance; Reg 22, Sec VIII; filed Jan 27, 1977, 2:35 p.m.: Rules and Regs. 1978, p. 516; filed Mar 18, 1986, 10:41 a.m.: 9 IR 2057, eff Apr 18, 1986; filed May 28, 1987, 4:00 p.m.: 10 IR 2298; filed Aug 13, 1991, 4:00 p.m.: 15 IR 7; filed Apr 29, 1999, 2:22 p.m.: 22 IR 2875; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2376; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA; filed May 18, 2018, 2:25 p.m.: 20180613-IR-760180069FRA)*

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

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

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

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

- (1) The actual number and type of beds licensed by the state department of health.
- (2) A per bed charge for for-profit facilities as follows:
  - (A) Eighty-one dollars and sixty-one cents (\$81.61) for each comprehensive nursing care bed.
  - (B) Thirty-seven dollars and sixty-seven cents (\$37.67) for each residential nursing care bed.
- (3) A per bed charge for not-for-profit facilities as follows:
  - (A) Seventy-four dollars and nineteen cents (\$74.19) for each comprehensive nursing care bed.
  - (B) Thirty-four dollars and twenty-five cents (\$34.25) for each residential nursing care bed.
- (4) A charge for each employed physician covered by the nursing home.

*(Department of Insurance; 760 IAC 1-21-8.5; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; filed May 29, 2012, 3:22 p.m.: 20120627-IR-760120046FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA; filed May 18, 2018, 2:25 p.m.: 20180613-IR-760180069FRA)*

**760 IAC 1-21-9 Effective date of rule (Repealed)**

Sec. 9. *(Repealed by Department of Insurance; filed May 28, 1987, 4:00 pm: 10 IR 2298)*

**760 IAC 1-21-10 Scope of coverage**

Authority: IC 34-18-5-4

Affected: IC 16-21-2; IC 34-18-2-14; IC 34-18-2-24.5; IC 34-18-5-2; IC 34-18-5-3; IC 34-18-5-4

Sec. 10. (a) A hospital's or psychiatric hospital's coverage with the PCF is limited to facilities identified in the hospital's or



psychiatric hospital's application for licensure to operate as facilities operated under the hospital or psychiatric hospital license. Each hospital or psychiatric hospital shall identify on the surcharge calculation worksheet prescribed by the department all of the:

- (1) facilities operated under the license; and
- (2) classes of employees intended to be included in the coverage.

(b) Any health care provider, including a physician or independent ancillary provider, that uses an assumed business name must state the assumed business name on the PCF certificate of insurance filed with the department for the assumed business name to be included in the health care provider's status as a qualified provider as defined by IC 34-18-2-24.5. A health care provider may amend a filing to add a d/b/a. In the event of such an amendment, the health care provider shall remit the greater of the following:

- (1) Additional surcharge if the d/b/a brings any additional risk to the coverage already filed.
- (2) A minimum surcharge payment of one hundred dollars (\$100).

If a proposed complaint has been filed, the d/b/a may only be added if it does not bring any additional risk that was not already considered in its surcharge payment.

(c) To become a qualified health care provider each physician and independent ancillary provider shall do the following:

- (1) File individual proof of financial responsibility.
- (2) Pay a surcharge as required by 760 IAC 1-60 or IC 34-18-5, or both.
- (d) No ancillary provider may include a physician or independent ancillary provider in its qualification.

(e) Qualification for individual health care providers may not include employees. Including a d/b/a on a PCF certificate of insurance does not allow an individual to include employees. However, nothing in this subsection shall prevent a corporation, sole proprietorship, partnership, or any other entity organized or registered under state law from including employees in the entity's qualification.

(f) A hospital, psychiatric hospital, or nursing home may include an employed physician or employed independent ancillary provider in its qualification under the following conditions:

- (1) The hospital, psychiatric hospital, or nursing home shall pay an appropriate surcharge for each. For a physician the appropriate surcharge is the current rate for the specialty class defined at 760 IAC 1-60.
- (2) For an independent ancillary provider, the appropriate surcharge is encompassed in the calculations contained in the PCF's hospital or nursing home calculation sheet.
- (3) The physician's or independent ancillary provider's qualification status is limited to duties performed within the scope of his or her employment as an employee of the hospital, psychiatric hospital, or nursing home.

(g) A hospital, psychiatric hospital, or nursing home may include a nonemployed medical director in its qualification under the following conditions:

- (1) The medical director provides no direct patient care as part of the medical director duties.
- (2) The medical director's qualification status is limited to duties performed within the scope of his or her medical directorship.

No additional surcharge is required for a nonemployed medical director who meets the conditions set forth in subdivisions (1) and (2).

(h) A hospital or psychiatric hospital may include in its qualification a nonemployed resident or fellow under the following conditions:

- (1) The hospital or psychiatric hospital shall pay an appropriate surcharge for each resident or fellow.
- (2) The resident's or fellow's qualification status is limited to duties performed within the scope of his or her residency or fellowship with the hospital or psychiatric hospital.
- (3) In the case of a fellow, the fellowship is full time and the fellow engages in no additional medical practice except for part-time moonlighting work.

(i) An institution of higher education may include in its qualification dentists and optometrists who are faculty members in its school of dentistry and school of optometry, respectively, acting within the scope of their employment as faculty members.

(j) An institution of higher education may include in its qualification a fellow, resident, or student of the institution of higher education pursuing a degree as a health care provider listed in IC 34-18-2-14(1) or as a pharmacist with respect to activities that are associated with the educational requirements of the institution of higher learning. (*Department of Insurance; 760 IAC 1-21-10; filed Mar 18, 2005, 10:45 a.m.: 28 IR 2376; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; filed Apr 18, 2011, 11:34 a.m.: 20110518-IR-760100245FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

**760 IAC 1-21-11 Filings by health facilities (Repealed)**

Sec. 11. *(Repealed by Department of Insurance; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA)*

**760 IAC 1-21-12 Severability**

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

Affected: IC 16-28; IC 34-18-5-2; IC 34-18-5-3

Sec. 12. If:

(1) any section or portion of a section of this rule; or

(2) its applicability to any person or circumstance;

is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected. *(Department of Insurance; 760 IAC 1-21-12; filed Feb 2, 2007, 3:08 p.m.: 20070228-IR-760060032FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

**Rule 22. Annual Statement—Subrogation or Salvage Recovery Amounts (Repealed)**

*(Repealed by Department of Insurance; filed Mar 26, 1993, 5:00 p.m.: 16 IR 1949)*

**Rule 23. Accident and Sickness Insurance-Claim Forms**

**760 IAC 1-23-1 Authority to promulgate rule; effective date**

Authority: IC 27-1-3-7

Affected: IC 27-8-5.5-2

Sec. 1. By authority vested in the Insurance Commissioner under the terms of I.C. 27-8-5.5-2 which became law in this state effective June 1, 1977, the following regulation [760 IAC 1-23] is to become effective on September 1, 1977. This action is predicated upon the need to establish uniformity of reporting data by providers of health care or treatment for the processing of health care and health insurance benefits. *(Department of Insurance; Reg 24, Sec 1; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 528; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

**760 IAC 1-23-2 Approved forms**

Authority: IC 27-1-3-7

Affected: IC 27-8-5.5-2

Sec. 2. All accident and sickness insurers, hospitals, medical and dental service corporations, and other prepayment organizations must accept forms approved by this Department for the administration of benefit payments.

It is the opinion of the Commissioner that the interests of the insuring public would be best served by adoption of forms developed for nationwide use by national health care provider organizations, health insurers and other prepayment organizations. Accordingly, the following forms are hereby adopted and approved for use in this state:

ATTENDING DENTIST'S STATEMENT – ADS (75), (Exhibit 1), developed under the auspices of the American Dental Association by its Task Force representing dental insurance underwriters.

HEALTH INSURANCE CLAIM FORM – 6-74, (Exhibit II), developed under the auspices of an [sic.] approved by the American Medical Association by its WORK GROUP on attending physician's billing and insurance reporting forms representing health insurers.

UNIFORM HOSPITAL BILLING FORM – UB-82 HCFA-1450, (Exhibit III), developed under the auspices of the Health Care Financing Administration of the Department of Health and Human Services.

LONG-TERM DISABILITY INCOME – APS-LT/P&T DIS (75), (Exhibit IV), developed by the Standard Forms Committee of the Health Insurance Association of American Council on Consumer and Professional Relations and approved by the American