State Long-Term Care Partnership Insurer Reporting Requirements

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State Long-Term Care Partnership
Insurer Reporting Requirements

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Long Term Care Partnership Reporting Requirements

This document presents reporting requirements for carriers selling long-term care insurance policies certified by a state Insurance Commissioner as qualifying for participation in a State Partnership for Long Term Care. The Long Term Care Partnership was enacted under the Deficit Reduction Act of 2005 (DRA), Public Law 109-171. Section 6021 (a)(1)(A) of the DRA expanded state Long Term Care Partnership Programs to include all states that elect to participate in the program.

The Deficit Reduction Act requires insurers participating in a state Long Term Care Partnership Programs to provide regular reports to the Secretary of the Department of Health and Human Services (HHS). Section 6021 of the Deficit Reduction Act contains the following requirement:

"The issuer of the [Partnership] policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships."

On XXXXXX the Secretary promulgated regulation 45 CFR Part 144 Subchapter B enacting the following reporting requirements.

Basic File Structure

The reporting requirements consist of four distinct file types. For all four file types, insurers are required to report on only those insureds, policyholders, and claimants who have active Partnership Qualified (PQ) policies or certificates. These requirements do not apply to insurance policies or certificates that are not Partnership Qualified (PQ). The following are some general instructions and some file specific instructions:

Field Type Key: N = numeric; AN = alphanumeric; A = alpha

Field Formatting Instructions:

Alpha and Alphanumeric Fields:
Includes A - Z (lower or upper case), 0 – 9, spaces, and special characters
Left justified, right blank/space filled
Unrecorded or missing values in character fields are blanks/spaces

Numeric Fields:
All numeric fields should be right-justified and left zero-filled.

Special Notes:

Financial fields should not contain any dollar signs, commas or decimals but may be signed when negative. Round dollars to the nearest whole dollar as follows, .50 and above round upward; otherwise downward.

Instructions for Specific Files

File 1: Registry File for Individual and Voluntary or Partially Voluntary Group Coverage.

Overview
This file will include data on each Partnership Qualified (PQ) policy or certificate sold under the Long Term Care Partnership Program for which the insurer has information on the individual insured (i.e. name, address, etc.). The file includes both PQ policies sold on either an individual or group basis, as long as individual-level data are available to the insurer.

Criteria for Inclusion
File 1 should include any insured individual who held an active PQ policy or certificate at some point during the reporting period, even if the policy or certificate was subsequently cancelled, lost PQ status, or otherwise terminated during the reporting period. Therefore, File 1 should also include individuals who were issued coverage for a PQ policy or certificate during the reporting period but who elected to not continue coverage. If the individual elected not to continue coverage before the end of the free-look period (known as "Not Taken Out" or NTO), the insurer should indicate NTO status on the Policy Status field (Field #47) on File 1. Persons in NTO status would then not be included on subsequent File 1 submissions.

File 1 should include all policies or certificates with active coverage during the reporting period regardless of whether they were included in previous File 1 submissions. The insurer should report the most current information about the insured (e.g. address) and about the terms of their coverage. These data will be compared with information provided in previous file submissions to determine if there have been any changes in coverage in the intervening period. However, once a policy or certificate has lapsed, lost PQ status, or been otherwise terminated, it should no longer be reported in the active file. Once again, only those policies or certificates which were active at some point during the designated reporting period need to be included in the File 1 submission.

File 2: Claimant File for Individual and Voluntary or Partially Voluntary Group Coverage.

Overview
This file provides information on claimants originally reported in File 1 who are presently using long-term care benefits under PQ policies, and on their utilization of insurance benefits.

Criteria for Inclusion
File 2 will include information on all PQ policies or certificates for which the insurer paid at least one claim during the reporting period. Thus, persons who may be eligible for insurance benefits but who had no claims paid during the reporting period will not be included. Please note that claimants reported in File 2 will also be reported in File 1, since they will have active PQ policies or certificates in force.

File 3: Registry File for Employer-Paid Coverage Only and Core and Buy-Up Plans.

Overview
This file will include information at the group level for PQ policies sold on a group basis *and where the insurer does not have access to information on the insured individuals.* This file is only to be used in cases where insurers do not have certificateholder-level information on PQ policies sold on a group basis.

Criteria for Inclusion
File 3 will include information, at the group level, for all active group policies in which at least one policy is known to be a PQ policy and for which the insurer does not have access to information about the specific individuals covered under the group policy. This file was designed specifically for insurers who sell and service group policies to employers offering core and/or core/buy-up coverage and who are unable to identify individual insured level data until such time as that individual goes into claim. This report is only provided if the Core coverage offered by the employer, when offered without a Buy-up Option, is Partnership Qualified, or if the Core and Buy-up Coverage combined represents Partnership Qualified coverage. If an insurer has individual level data on persons covered under group policies, whether or not the employer (group policyholder) contributes to the cost of the PQ policy, then the insurer should include those individuals on File 1, and not submit File 4. Also, if an individual covered under a group plan reported on File 3 ports or converts his or her coverage upon leaving the group, and by virtue of that change, the insurer obtains access to information about the individual insured , then that insured individual should then be reported on File 1 and, when relevant (e.g., when the insured is on claim), in File 2.

File 4: Claimant File for Employer-Paid Core and Buy-Up Plans without Individual Insured Data.

Overview
This file provides information on claimants who initially secured PQ policies through the groups included in File 3. Even if insurers eventually obtain individual-level data on persons included in File 3 (i.e. once they go into claim) these persons will also be reported in File 4, not in File 2.

Criteria for Inclusion

File 4 includes information on persons who obtained active certificates for PQ policies in group plans covered under File 3 and then later became eligible for long term care benefits as claimants. As in File 2, individuals will only be included on File 4 if a claim has been paid on his or her behalf during the reporting period. While there may be an argument for consolidating Files 2 and 4, a separate file structure was decided upon as a mechanism for maintaining a clear link between claimants who originally obtained PQ coverage on a group basis in File 3, and those who obtained PQ coverage under the inclusion criteria for File 1. Thus, File 2 will represent claimants originally reported in File 1, and File 4 will represent claimants originally reported in File 3.

Reporting Frequency

Insurers are required to submit data for different reporting periods, depending upon file type as outlined below:

File	Period Covered	Submission Deadlines
One	January – June 30 July 1 - December 31	August 1 February 1
Two	January 1 – March 30 April 1 - June 30 July 1 - September 30 October 1 – December 31	May 1 August 1 November 1 February 1
Three	January 1 – December 31	February 1
Four	January 1 – March 30 April 1 - June 30 July 1 - September 30 October 1 – December 31	May 1 August 1 November 1 February 1

GLOSSARY & DEFINITIONS

Assisted Living Facility (ALF) Benefit Amount
The maximum amount which the policy or certificate will pay for care received in an assisted living facility. If the benefit is paid as weekly or monthly, the daily amount should be derived by whatever convention is most appropriate for the carrier to use. The data should be the current amount on the policy in order to account both for any voluntary increases in coverage the insured has elected or any automatic coverage increases as a result of inflation protection

Assisted Living Facility – Non Nursing Home Benefit Amounts Paid This Period
The total dollar amount of benefits paid during the reporting period for care provided in an Assisted Living Facility or similar Alternate Care Facility other than a nursing home.

Automatic Inflation Protection Type
The type of Inflation Protection used in the policy. This includes automatic inflation protection on a compound, level-funded basis; or a simple increase and level-funded basis; a graded inflation protection feature where both the premium and the benefit amounts increase at a known and pre-set amount each year; step-rated inflation protection; level-funded increases based on the Consumer Price Index; level-funded increases based on the specific long-term care price index; level-funded inflation protection based on some other published index value; level-funded inflation protection based on an increase amount determined by the carrier which could change from year to year based on the changes in actual costs of care. All these types of inflation protection are provided annually and continue on claim (unless other pre-defined limits are reached first as specified below).

Benefit Start Date of Current Claim
The date on which benefit payments began during the reporting period.

Buy up Options Available
Indicates that, in addition to an employer paid core plan, insureds can elect to purchase on their own additional coverage amounts and types, typically subject to some form of underwriting.

Cash Benefit Amounts Paid this Period
The total dollar amount of benefits paid on a cash basis during the reporting period.

Certificate Issue State
The state in which a certificate under a group policy is delivered. This would be either the situs state for the group policy or, in the case of a state that claims extraterritorial jurisdiction over the group policy situs state, it would be the state of residence for the individual certificateholder.

Chronically Ill
Means that You have been certified by a Licensed Health Care Practitioner as:

being unable to perform, without Substantial Assistance from another person, at least two (2) Activities of Daily Living for a period that is expected to last at least ninety (90) consecutive days due to a loss of functional capacity; or requiring Substantial Supervision to protect Yourself from threats to health and safety due to a Severe Cognitive Impairment.

Claim Status
Indicates whether or not an insured with a Partnership policy is in claim status during the reporting period.

Core Plan
An employer-paid long term care insurance benefit provided typically on a guaranteed issue basis to all eligible actively at work employees as defined by the insurer and/or the employer in the group Policy. Wherever the term Core appears before another term (e.g., Core Nursing Home Daily Benefit Amount) it refers to the term as defined here specifically within the Core Plan)

Company Code
The 5-digit code assigned by the National Association of Insurance Commissioners to each insurance company. For self-funded plans or the Federal Employees' Long Term Care Insurance Program (FLTCIP), a unique 5-digit code will be assigned for use in these Reporting Requirements.

Coverage Basis
Indicates whether the coverage is issued as a group or an individual policy. The coverage basis is determined by how the State Department of Insurance classifies the policy or certificate, not based on the basis by which the policy is marketed. For example, a worksite-based product which uses an individual policy form but is marketed to an employer group is an individual coverage basis.

Current Annual Premium
The amount of annual premium being paid for the coverage, including both the insured's portion and any portion paid by the employer, if applicable. This would reflect the current premium amount such that any voluntary changes in coverage that might have increased or decreased the premium from its original issue amount would be reflected in this figure.

Current Claim
Refers to an insured who is in active claim status which means that they meet the definition of Chronically Ill and are receiving benefit payments in accordance with the coverage provisions and requirements of the policy or certificate.

Employer Name
The name of the Employer identified as the group Policyholder

Employer Type
The category of the employer as expressed using standard industry codes.

Future Purchase Option
The type of periodic benefit increase which allows the individual to purchase additional increments of coverage for additional premium amounts based on their attained age at the time they elect the increase. These coverage increases are available at set time periods (annually or otherwise) and are available to the insured who wishes to elect them without requiring evidence of insurability.

Future Purchase Option Structure
Indicates whether the FPO is made on an annual basis, or on a frequency less often than that (e.g., every two or three years).

Future Purchase Option – Offers End or Termination of FPO Option (if this is supposed to match the field name)
Indicates when the FPO offers end. For some policies they may continue for the life of the policy even while the insured is on claim; for others they may end when the individual is on claim or within a specified time period of having received benefits. The FPO offers may end at a defined age or when the insured has declined a certain number of increase offers.

Home Health Care Benefit Amount
The maximum amount which the policy or certificate will pay for care received at home (or for home and other community care benefits). If the benefit is paid as weekly or monthly, the daily amount should be derived by whatever convention is most appropriate for the carrier to use. The data should be the current amount on the policy in order to account both for any voluntary increases in coverage the insured has elected or any automatic coverage increases as a result of inflation protection.

Home Health Care Benefit Amounts Paid This Period
The total amount of benefits paid during the reporting period for care at home or in a non-institutional covered care setting (e.g., adult day care) as defined as "home or community-based care" within the policy or certificate.

Inflation Protection Increase Amount
The specific percentage increase applied to benefits each year designed to keep pace with inflation, if it is a set amount as previously defined. If the increase is based on an index, the specific increase amount expressed in terms of a percent of the prior year's increase, that is applicable to the current reporting period.

Inflation Protection Duration Type - Attained Age
The type of inflation protection that ends when the insured reaches a specified age (e.g., age 80, or others).

Inflation Protection Duration Type - Specific Number of Years.
The type of inflation protection that ends when the insured has received annual benefit increases for a pre-defined number of years (e.g., 10 or 20 years).

Inflation Protection Duration Value - Specific Number of Years
The type of inflation protection that ends when the insured has received annual benefit increases for a pre-defined number of years. Value refers to the actual number of years which are specified in the coverage.

Inflation Protection Duration Type – Life of the Policy/Certificate
The type of inflation protection that continues through the life of the coverage, and continues even while the insured is in claim status (receiving benefits).

Inflation Protection Duration Type – Stops when Benefit Has Doubled
The type of inflation protection that continues until the daily benefit amount for nursing home care has doubled from its original value at time of purchase.

Inflation Protection Increase Amount
The annual percentage amount by which coverage increases each year as a result of inflation protection.

Lifetime Benefits Paid This Period – All Pools
The total amount of benefits paid out under the policy during this reporting period

Lifetime Maximum – Dollars – Pool 1 – Nursing home Care
If the coverage uses a pool of dollars design and has separate pools for the major covered services, this is where the dollar amount which represents the lifetime maximum paid for nursing home care (or facility care all levels combined) would be specified.

Lifetime Maximum – Dollars – Pool 2 – Home Health Care

If the coverage uses a pool of dollars design and has separate pools for the major covered services, this is where the dollar amount which represents the lifetime maximum paid for home health care would be specified.

Lifetime Policy Maximum – Dollars – Pool 3– ALF/Other Facility Pool
If the coverage uses a pool of dollars design and has separate pools for the major covered services, this is where the dollar amount which represents the lifetime maximum paid for assisted living facility care would be specified. If the policy combines nursing home and assisted living facility care into a single "facility care lifetime maximum" this entry would be indicated as "not applicable."

Lifetime Maximum – Days – Pool 1 – Nursing Home Care
If the coverage uses days of benefit received to calculate the policy maximum and has separate pools for the major covered services, this is where the number of days which represents the lifetime maximum paid for nursing home care (or facility care all levels combined) would be specified.

Lifetime Maximum – Days – Pool 2 – Home Health Care
If the coverage uses days of benefit received to calculate the policy maximum and has separate pools for the major covered services, this is where the number of days which represents the lifetime maximum paid for home health care would be specified.

Lifetime Maximum – Days – Pool 2 – Assisted Living Facility
If the coverage uses days of benefit received to calculate the policy maximum and has separate pools for the major covered services, this is where the number of days which represents the lifetime maximum paid for assisted living facility care would be specified.

Lifetime Maximum Structure (LMS)
Whether there is a single Lifetime Maximum for all services and benefits covered by the policy, or whether there are separate Lifetime Maximums for the major policy benefits such as nursing home care vs. home care. Limits that are specific to smaller benefits like respite care, caregiver training or medical devices and the like are not considered. LMS refers primarily to whether there is a single "pool" for either facility and home care benefits or whether there are separate "pools" for the major benefit categories of nursing home, assisted living, and home and community care. While the prevailing benefit structure today is a single Lifetime Maximum for all covered services, there are some policies being sold today which have separate Lifetime Maximums for these major covered services.

Lifetime Maximum Structure – Detail
The basis on which total benefits paid under the policy are determined in terms of either days or dollars. This refers to whether the Policy or Certificate counts days on which benefits have been received or whether it counts dollars of benefits paid out in determining when the coverage's lifetime maximum has been met. While the prevailing policy design today is a "pool of dollars" benefit approach, some policies being sold today still count days on which benefits are paid in determining the policy's lifetime maximum.

Number of Insureds with Buy-Up Coverage
The number of covered lives who have elected to purchase the voluntary buy-up coverage offered by the group plan, in addition to the Core Plan coverage already provided to them.

Number of Insureds in Core Plan
Indicates the number of covered lives enrolled in the core plan coverage offered by the employer.

Nursing Home Benefit Amount

The maximum amount which the policy or certificate will pay for care received in a nursing home. If the benefit is paid as weekly or monthly, the daily amount should be derived by whatever convention is most appropriate for the carrier to use. The data should be the current amount on the policy in order to account both for any voluntary increases in coverage the insured has elected or any automatic coverage increases as a result of inflation protection.

Nursing Home Benefit Amounts Paid This Period
The total amount of benefits paid during the reporting period for care in a nursing home or in a similar covered care institutional setting as defined as "nursing home" or "facility-based" care within the policy or certificate.

Original Coverage Effective Date
The date that coverage first became effective under the policy or certificate help by the insured.

Other Benefits Paid this Period
The total amount of any other benefits paid during this period (e.g., caregiver training, medical devices, other ancillary benefits and services, etc.).

Partnership Status
Certain types of changes to one's policy or certificate may result in the loss of Partnership-qualified status. These are defined by the rules and regulations adopted by each state for the operation of its Partnership program. This variable simply indicates whether the policy or certificate continues to retain its Partnership qualified status or if a change in coverage of some sort has resulted in the policy no longer being Partnership Qualified.

Policy Benefit Type
Some policies are Comprehensive in that they pay for care in all long term care settings (nursing home, ALF, home care and others). Other policies pay just for facility-based care, and others pay for only care outside a facility. This variable indicates the type of policy with respect to the range of services it covers.

Policy Exchange
Some policies are Partnership-qualified because they were purchased after the effective date of the state's Partnership program and meet all the requirements in that state for being a Partnership policy. Other policies may have been purchased prior to the effective date of that state's Partnership program, but may have been granted Partnership qualified status as the result of being exchanged for a Partnership qualified policy. The exchange may be in the form of an amendment or rider or disclosure statement indicating that the coverage is now Partnership qualified. This variable indicates whether the policy is Partnership qualified as the result of an exchange rather than as a result of an original purchase.

Policy Issue State
The state in which the individual policy is issued. This would also be the state of residence of the insured to whom the individual policy is delivered.

Policy Number
The unique policy or certificate identification number assigned to each insured's coverage.

Policy Status
Indicates whether the policy is still inforce, whether the insured is in nonforfeiture benefits or whether the policy has terminated during the reporting period for any number of possible reasons. The policy may no longer be inforce because the insured has exhausted all their benefits, because they have died, because

they have voluntarily elected to lapse coverage, because coverage has been rescinded, or because the policy was "Not Taken Out (NTO)" as defined above.

Qualifying Condition
The specific conditions for which the individual qualifies as Chronically Ill. This could include dependency in the required number of Activities of Daily Living (ADLs), Cognitive Impairment or both.

Remaining Lifetime Benefits – All Pools
Under a policy design with a single pool of dollars as the Lifetime Maximum, the total dollar amount of benefits remaining available to the insured in the Lifetime Maximum at the end of the reporting period.

Remaining Lifetime Benefits – Days – Pool 1 – Nursing Home Pool
Under a policy design with separate pools of benefits, paying on the basis of days of covered services, the total number of days of care remaining available to the insured in the Nursing Home Benefit Pool.

Remaining Lifetime Benefits – Days – Pool 2 –Home Health Care Pool
Under a policy design with separate pools of benefits, paying on the basis of days of covered services, the total number of days of care remaining available to the insured in the Home Health Care Benefit Pool.

Remaining Lifetime Benefits – Days – Pool 3 – Assisted Living Facility/Other Facility Pool
Under a policy design with separate pools of benefits, paying on the basis of days of covered services, the total number of days of care remaining available to the insured in the Assisted Living Facility Benefit Pool.

Remaining Lifetime Benefits – Dollars – Pool 1 – Nursing Home Pool
Under a policy design with separate pools of benefits, paying on the basis of dollars for covered services, the total dollar amount of care remaining available to the insured in the Nursing Home Benefit Pool.

Remaining Lifetime Benefits – Dollars – Pool 2 –Home Health Care Pool
Under a policy design with separate pools of benefits, paying on the basis of dollars for covered services, the total dollar amount of care remaining available to the insured in the Home Health Care Benefit Pool.

Remaining Lifetime Benefits – Dollars – Pool 3 – Assisted Living Facility/Other Facility Pool
Under a policy design with separate pools of benefits, paying on the basis of dollars for covered services, the total dollar amount of care remaining available to the insured in the Assisted Living Facility Benefit Pool.

Report Date
The date on which the Registry File is submitted

Reporting Period
The period for which reporting on each file is required. File 1 - The Registry File is filed semi-annually and is required to cover the period January 1 through June 30th and July 1st through December 31st. Both File 2 – The Claimant File and File 4 – The Claimant File for Employer-Paid Core/Buy-up Plans are filed quarterly and is required to cover the period January 1 through March 31st, April 1st through June 30th, July 1st through September 30th and October 1st through December 31st. File 3 – The Registry File for Employer-Paid Core Only & Care and Buy-Up Plans will be reported annually for the reporting period January 1st through December 31st.

Situs State
The state in which the group policy is sitused, as specified on the group policy form.