

Long-term Care Partnership Data Reporting System  
Comprehensive Questions and Answers for  
Registry File 1 and Claimant File 2

**Notices from the LTC Partnership Team**

1. The most current version of the reporting requirements is Version 1.2. It was posted to the project website and e-mailed to carrier and TPA contacts on June 11, 2009. This update reflects minor changes to the reporting requirements that have emerged from the Question and Answer process (e.g., Field 46, Registry File - Termination of FPO Option has newly added field values created as part of the Q & A process). This same version number was re-posted to the website on June 29, 2009 to correct the value to indicate an Insured's SSN was unavailable – it now reflects the use of 10 9's (i.e., 9999999999) rather than 9 9's.
2. A 90 minute Webinar training session for Claimant File 2 is planned for Friday, September 18, 2009, at 1 p.m. EDT. The submission date for Claimant Files is November 1<sup>st</sup>. More details will be forthcoming.
3. The project website contains a document that provides the status of PQ Carriers, including whether or not they have successfully initiated/completed the registration process with Thomson Reuters to submit data under the reporting requirements. It is named "LTC DR PQ Carrier Status" and is updated biweekly. It can be found on the website's Reporting Requirements page at <http://www.dehpg.net/LTCPartnership/map.aspx>. Any insurer that has PQ certified policies but who has not yet begun selling on those forms or does not have any active PQ policies does not have to submit data to the Data Reporting System until such time as they have active PQ policies. However, an insurer in this situation should notify the project team that they are not reporting data because they do not yet have any active PQ policies. Please submit your notification to the project mailbox [ltpartnership@thomsonreuters.com](mailto:ltpartnership@thomsonreuters.com).

**Registration Clarification:** The only vendors that need to register are those that will actually transmit data to Thomson Reuters. So, if an insurer has hired a third party administrator and will never actually transmit partnership data, then they do not need to register. Rather, the third party administrator that will transmit data on behalf of an insurer must register. The function of this registration is to initiate the processes required to establish connectivity for electronic data submission between any organization that will transmit partnership data and Thomson Reuters.

4. The project team is pleased to announce a comprehensive reorganization of the Q & A process, as reflected by this first document created under the new paradigm. At this time, it has become apparent that all carriers and TPAs submitting data are able to adhere to the specifications designed for Registry File 1 and Claimant File 2. Accordingly, this newly designed Q & A process focuses on those two files only. Additional features of this new process are:
  - A single, historical Q & A document is posted on the website. It will replace Q & A Sets # 1 through 3, and, includes all questions received to date as well as new questions asked of the team since July 1, 2009. This approach minimizes the set of materials both the project team and end users will need to manage moving forward.
  - The subsections remain the same as appeared in prior versions (e.g., Notices, followed by Policies/Claims to Include, and so on). If needed, new subsections will be developed.

- Within each subsection, questions will be organized by File # (i.e., all questions that pertain to both files will be grouped together, followed by all File 1 questions; finally, all File 2 questions). Further, the questions will be presented in Field # order whenever possible. This should enable the team and end users to more rapidly determine whether a question has already been posed and answered.
- With each updated posting of the Q & A, new questions will be readily identifiable, as they will be presented in **red font**, allowing the team to maintain both the overarching File and Field # organization. For example, there have been more than a dozen new questions since July 1 and you will notice them throughout. When the September/October set of questions is posted, these dozen questions will be changed to black font, and, any new questions since August 31 will be in **red font**.
- In the rare event that subsequent Q & A discussions require that an earlier Q & A be refined, such Q & A will appear in **green font** to alert end users that the response has been refined.
- This reorganization of the Q & A sets will allow a new carrier who has not yet been following each Q & A posting to easily review prior and new questions.
- Due to the expansion of upcoming project tasks (e.g., training, file submission and analytic table software development and testing for Claimant File 2, second Registry File 1 submissions requiring new software development and testing), the team will no longer answer any question that has already been addressed in prior Q & A.

**Policies/Claims to Include in File Submissions**

**FILE 1**

**Question:** The reporting requirements for the database are set-up to begin 8/1/09 for reporting of 1/1/09 – 6/30/09. What if a carrier has Partnership plans in force prior to that time period? Our Partnership was effective 8/1/08. Should these be included with our first data file?

**Answer:** Carriers should include policies that were in force prior to any reporting period as long as they are still in force for at least one day during the reporting period. Specifically, since the above Partnership was effective 8/1/08, this carrier should include policies that were in force prior to 1/1/09 as long as they are still in force for at least one day between 1/1/09 and 6/30/09.

**Question:** We need to know how to report on the following scenario: If a policy was Partnership Qualified at issue and was later terminated, with all of this activity occurring prior to the 1st reporting period, do we need to report this activity on the 1st file due August 1, 2009?

**Answer:** No.

**FILE 2**

**Question:** When we receive a phone call that an Insured has just begun care, we open a claim to request pertinent information. At this time, we complete our claim with generic information. As we receive 'actual' information, we will replace the 'generic' information on our claim. Does the State wish us to report on newly opened claims with no payments? If yes, how will the State view the 'generic' information we report.

**Answer:** No. The Reporting Specifications' **Criteria for Inclusion** section for File 2 states that individuals will only be included if a claim has been paid on his or her behalf during the reporting period.

**Question:** Does the State wish us to report on pended claims as well as paid claims?

**Answer:** No. The purpose of File 2 is to track the relationship between actual benefits paid during a reporting period and remaining policy benefits. While pending claims may well reflect service utilization, since no payment is made there would be no impact on either any of the files' "Benefits Paid During Reporting Period" fields or the "Remaining ... Benefits" fields.

**Question:** Regarding File 2 – Claimant file, does the insurer report benefits paid prior to the start of the first reporting period?

**Answer:** Yes, but only if those benefits were incurred after the policy became Partnership qualified. For example, if an individual exchanges a policy they had previously, and from which they received benefits, to one that is now PQ, the only benefits eligible for asset disregard, and thus the only benefits which should be reported, are those which were incurred after the latter of either the PQ effective date of the exchanged policy or the effective date of the state’s Partnership program.

**Question:** File 2 - If an insured has a claim during the reporting period but then dies within the same reporting period, do we still report the claim paid on File 2? I know we would report them on the next File 1 with a Field 47 Policy Status of deceased and Field 48 Partnership Status of NQ but I need to know how to report on File 2?

**Answer:** Yes. File 2 reports the amount paid on any claim activity during the reporting period and also any claim activity prior to the reporting period which was not already included in a prior report (e.g., because it had not yet been processed for payment). It is also correct that on the next File 1 registry submission that you would report Field 47 Policy Status as deceased.

**Question:** File 2 - If a policy loses PQ status during a reporting period and ends up in claim do we still report on File 2? For example - File 1 reporting period 1/1/09 – 6/30/09 and the Policy is PQ from 7/1/06 – 1/15/09. There is a coverage change to NQ on 1/15/09. We would report on File 1 as NQ because they had status at a point during the reporting period. However, if you throw a claim in there...  
Claim paid on 3/15/09 - **service date 1/8/09 - included**  
File 2 reporting period 1/1/09 – 3/31/009---Do we report the claims paid?  
Claim paid on 4/15/09 – **service date 1/23/09 - excluded**  
I would assume that we would not report this second claim as paid but I want to confirm.

**Answer:** If a claim was paid for a service provided on a date during which the policy was PQ, then that claim should be reported even if the insured’s status changes to NQ at a later date during the reporting period. The critical operational date to consider in reporting is the date on which the claim was incurred (not the claim payment date); if the policy is PQ at that point in time, the claim is to be reported.

Field 11 – Benefit Start Date of the Current Claim Period – says to indicate the date FOR WHICH benefit payments begin (not the date ON WHICH benefit payments begin). The phrase “date for which benefit payments begin” refers to the first date of service which is deemed eligible for benefit payment. We will clarify the field definition for Fields 12 through 16 to more clearly indicate that the reporting should be for the amount of benefit paid for days of service (or disability) for which benefits are paid.

## **Clarification of Overall File Format Specifications**

### **GENERAL QUESTIONS –APPLY TO ALL FILE TYPES**

**Question:** What kind of file should the data be in for uploading?

**Answer:** Version 1.1 of the State Long-Term Care Partnership Insurer Reporting Requirements contains detailed file specifications for each of the four file types, including field characteristics, field lengths and valid values. When you refer to these specifications, you will see that the files should contain fixed-length records and are required to be in ASCII format. All insurers are required to comply with these specifications. These requirements can be found at <http://www.dehpg.net/LTCPartnership/map.aspx> or <http://aspe.hhs.gov/daltcp/reprots/2008/partreq.pdf>

**Question:** What are the sort order requirements for File 1 and File 2?

**Answer:** There are no sort order requirements for these files.

**Question:** We are an administrator for multiple carrier clients that participate in Partnership. It is our assumption that we will be able to submit one file for each of our clients rather than collating all data together in to the same file. Is this a correct assumption?

**Answer:** Yes, that is a correct assumption. Alternatively, a data supplier that administrates the Partnership program for more than one carrier client could choose to collate all data together in a single file at their discretion. Each carrier's data could be split-out using Field 1 – Company Code. All data fields for each carrier must be complete (i.e., the TPA cannot capture some fields and allow the carrier to send an additional file with other fields).

**Question:** As an administrator for multiple carrier clients, we have clients that administer older blocks of business at their home office that will also need to be reported. Can you confirm that the repository will be able to accept multiple files for the same carrier because it is coming from different suppliers? In other words, may we assume that the different Supplier IDs in the file name will prevent overwriting of files?

**Answer:** This assumption is correct because the electronic file names contain your data supplier number as part of their naming convention scheme. This will prevent overwriting of files when a single carrier is served by multiple data suppliers. Once again, all data fields must be complete (i.e., the TPA cannot capture some fields and allow the carrier to send an additional file with other fields) even though the data file might not include every single insured with PQ coverage from that carrier.

**Question:** What response would be best to use with regard to a blank field, such as no middle initial? Do we place an NA, leave it blank or is there another response we should use?

**Answer:** Please space-fill an unrecorded or missing value in alpha or alphanumeric fields, unless there are other instructions specific to a field as indicated in the Field Values cell.

**Question:** Since the UDS files must be in an ASCII format, how should we pass a negative sign on a financial field in the UDS files?

**Answer:** Please pass the negative sign using the most significant (or left-most) position.

**Question:** Regarding the requirement that the Partnership Program data be submitted in fixed-width format, I noticed that both of the main tools I use, Query Analyzer and Access 2003 (SQL Server 2000 on the back end) introduce spaces between the fields into my test exported .txt files. Indeed, Access offers only two choices for the .txt/.asc Type of File export: delimited or "fixed-width with spaces between the fields". The Access export wizard at least allows me to adjust the start position and length of each field to remove the spaces (under the Advanced button, and I can save the settings if it's working on a native Access file in an .mde database, but not when it is working on a SQL Server table in an .adp project). My understanding of a fixed-width file (and Wikipedia agrees!) is that there are no spaces in a fixed-width file. For our purposes here on the Partnership Program reporting, the requirement is fixed-width WITHOUT spaces between the fields, correct?

**Answer:** You are correct when you state that the LTC Partnership file requirements DO NOT have spaces between fields. However, in some instances, one would be required to space-fill Partnership fields to maintain the fixed width when alpha or alphanumeric fields are not available (e.g., the Middle Initial insured's name component field; a portion of the trailer record Carrier Contact and Comments field, which is 333 bytes long). In the General Information/Field Specifications section that precede each file, it is stated that Alpha and Alphanumeric fields that are "Unrecorded or missing values in character fields should be space-filled."

**Question:** If an insured's name, address, etc. is too long for the field length defined, what should we do?

**Answer:** In the event that any valid data value for a name or address component exceeds the field length specified in the Reporting Requirements, these values will be truncated. Field lengths may not be changed at this point in time. We ask that you consistently follow the Alpha and Alphanumeric Field formatting instructions that appear in the Reporting Requirements regarding field justification. For example, if an insured's first name is actually longer than 30 characters, you would assign the 30 left-most characters of that insured's name. If this procedure is followed routinely, an insured's name and/or address component should be the same over time.

## **Clarification of Field Coding Specifications**

*Note: Fields 1 through 9 are identical for Files 1 & 2. Questions regarding these fields will be presented first.*

### **FILES 1 & 2**

#### **FIELD 2, REPORT DATE**

**Question:** We have a question regarding Field 2, Report Date. Is this supposed to be:  
A) The date of the actual extract from our applications. If so, is it OK if that date varies somewhat throughout the file as the data is being extracted from multiple applications and those extracts could conceivably happen on different days (e.g. before and after midnight on the same night).  
B) The date of the transmission to Thomson Reuters. If so, would there be an issue if it is off by a day? For example, if we create the file, allow time for a review, and then don't transmit it until the next day, does that create a problem? or  
C) The ending date of the report period?

**Answer:** Field 2, Report Date – your option B represents the intent of this field – submission date to HHS via Thomson Reuters. It will not be the case that a file would be rejected if the value in this field does not match the actual transmission date. FYI – your option C – ending date of the report period – this value belongs in Field 3, Reporting Period, as the second date in this two-date field (i.e., begin date of reporting period and end date of reporting period). For this August submission, it would be 0101200906302009.

#### **FIELD 3, REPORTING PERIOD**

**Question:** Files 1 & 2, Field 3: Since the first submission of File 2 (due November 1, 2009) should include all claims paid since 1/1/09, should Field 3 - Reporting Period be: 0101200909302009 (January 1, 2009, through September 30, 2009)?

**Answer:** Page 16 of Reporting Requirements Version 1.2 says "The insurer will report benefits paid prior to the start of the reporting period as long as those benefits were incurred after the policy became Partnership qualified." This means that any Partnership claims paid prior to 1/1/09 should be reported in your first File 2 submission. Our preference would be that the start date for the reporting period still be Jan, Apr, July or Oct 1 as specified. We know that the first one will include some "catch up" claims and subsequent ones may include claims incurred in a subsequent period but not yet reported because they haven't yet been paid (per Q & A in the prior Policies/Claims to Include in File Submissions – File 2 section). So we can't assume if a carrier says they paid \$5,000 in HC claims during the period that they were all incurred only during that 3 month period - some might be from the end of the month prior to the start of the new report date.

**Question:** Files 1 & 2, Field 3: Reporting Period - We assume it will be 0701200909302009 (relating to July 1 - Sept. 30) for this very first submission, even though we may be reporting eligible claims paid for PQ policies that were incurred before this particular quarter. Is that a correct assumption?

**Answer:** Yes.

**FIELD 4 – INSURED’S/CLAIMANT’S SOCIAL SECURITY NUMBER**

**Question:** I see that Field 4, Insured’s/Claimant’s Social Security Number is defined as Field Length = 10 and the value 999999999 is the default-if-missing value. But Social Security Numbers have only 9 digits to my understanding, and the default-if-missing value also only has 9 digits. The rule on Numeric Fields indicates they should be “left zero-filled”. Am I to conclude that the first (left-most) digit should be a zero to fill the field, even in the event of a missing value (0999999999)? Or should the field length be corrected to 9?

**Answer:** Thank you very much for identifying this inconsistency during your implementation of the reporting requirements for this field. The correct missing value should have been 10 9s (i.e., 9999999999). This error has been corrected in Files 1 & 2 for Version 1.2 of the Reporting Requirements, which was re-posted to the website on June 29, 2009.

**Question:** File 1 & 2, Field 4, Insured’s/Claimant’s Social Security Number: We do not have the tenth position, alpha character, of our Insured’s Social Security Number. Is it acceptable to leave this position blank?

**Answer:** That is not acceptable. Please follow the Numeric Field formatting instructions that appear in the Reporting Requirements. Specifically, since the SSN is a numeric field, and, the instructions indicate that numeric fields should be right-justified and left zero-filled, a properly formatted SSN would be as follows – 0148338796 for John Q Public, whose SSN is 148-33-8796. In the rare event that SSN is unavailable, it should be values with 10 9s (i.e., 9999999999).

**FIELD 6, FIRST NAME; FIELD 7, MIDDLE INITIAL; FIELD 8, LAST NAME**

**Question:** We have a question about File 1, Field 6-First Name, Field 7-Middle Initial, Field 8-Last Name. Our name field does not separate the name into First, Middle Initial, Last. We simply have a complete name (example John R Doe). Would it be acceptable to leave the Field Number 6 and Field Number 7 blank and populate Field 8 with the entire insured's name?

**Answer:** This proposed approach is not acceptable. All vendors that will be submitting data as part of the federal reporting requirements are required to comply with the formal data submission specifications. Many software applications contain character string parsing routines that will enable you to comply with the formal specifications for the three name fields.

**Question:** In our system when a person is deceased, we only have one name field and we change the name to "Estate of John Q Public" unless the name is too long then we use "Estate of and use an initial for the First Name adding as much of the last name as possible" in the First Name field. Our plan is then to leave Field 7, Middle Initial and Field 8, Last Name blank.

**Answer:** This is unacceptable. All vendors that will be submitting data as part of the federal reporting requirements are required to comply with the formal data submission specifications. Many software applications contain character string parsing routines that will enable you to comply with the formal specifications for the three name fields. Although no one has asked yet, this same response would also apply to the name component Fields 6, 7, 8 in File 2.

**Question:** File 1 & 2 Field 7, Middle Initial: We do not always have middle initials or our insured does not have a middle name. Is there a standard default we should use for this situation? Should we leave this field blank?

**Answer:** Please do not leave this field blank. Rather, follow the Alpha and Alphanumeric Field formatting instructions that appear in the Reporting Requirements. Specifically, unrecorded or missing values should be space-filled.

**FILE 1**

**FIELD 18, CURRENT ANNUAL PREMIUM**

**Question:** I would like to clarify whether Field 18, Current Annual Premium is to include the cents amount in annual premium, i.e. \$2,345.67 would be reported as 234567 without commas, decimals or dollar signs. I want to confirm that you do not want us to report whole dollars only.

**Answer:** The General Information/Field Specifications sections that appear before each file-specific reporting specifications section provide instructions re: how to report values in financial fields. We do request whole dollars and provide rounding instructions. Using your example, you would report 002346 to represent the annual premium value \$2,345.67.

**FIELD 19, PARTNERSHIP QUALIFIED (PQ) COVERAGE EFFECTIVE DATE**

**Question:** File 1, Field 19: We have a question for you to help us finish up our file corrections. It is in reference to Field 19 – Partnership Qualified (PQ) Coverage Effective Date. In the following scenario, what date do you expect for field 19? The idea is that the person modified their coverage multiple times that impacted their partnership status. I guess it depends what you are using this field for and it's meaning on your side. Note: these are all changes on the same policy.

Coverage	Effective Date	End Date	Partnership Status
1	1/1/2008	4/15/2008	PQ
2	4/15/2008	6/30/2008	NQ
3	6/30/2008	9/1/2008	NQ
4	9/1/2008	Still active	PQ

**Answer:** Field 19 indicates the date on which the insured's coverage first became effective as a PQ policy. In this example it would be 1/1/2008 even though the insured has had changes from and back to PQ status since then. By analysis of prior vs. current period reports, we will be able to identify "lapses" and "restorations" of PQ status such as those provided in this example.

### **FIELD 20, POLICY EXCHANGE TO PQ**

**Question:** Field 20, Policy Exchange to PQ: Are policies that were Partnership qualified but did not become qualified until the carrier launched its Partnership product (we launch in that state after the Partnership program effective date) considered an exchange? Is simply adding the Partnership disclosure notice considered giving rise to an exchange?

**Answer:** Field 20, Policy Exchange to PQ: each state has a different process for exchanges; some allow an exchange by rider or endorsement and some require a new policy to be issued. As long as you comply with the procedures required for PQ exchanges in your state, the effective date of the exchange can take place after (but not before) the state partnership program launch if an insurer has not yet launched its PQ program or has not yet made the exchange. Whether or not simply adding a partnership disclosure notice can be considered an exchange is dependent upon the rules and regulations for exchanges in that state.

**Question:** The response to the Field 20, Policy Exchange to PQ question immediately above regarding the addition of the Partnership disclosure notice is considered an exchange states, "Whether or not simply adding a partnership disclosure notice can be considered an exchange is dependent upon the rules and regulations for exchanges in that state..." This conflicts with the definition of "Policy Exchange to PQ" in the Version 1.2 reporting requirements which states, "The exchange may be in the form of an amendment or rider or disclosure statement indicating that coverage is now Partnership qualified."

**Answer:** The statement "...may be in the form of an amendment or rider..." is intended to describe those situations in which this is allowed. The data reporting specifications do not supersede state rules in this regard.

**Question:** Field 20, Policy Exchange to PQ: Are policies that were non-qualified with the exception of adding a required endorsement to be qualified to be considered an exchange?

**Answer:** Field 20, Policy Exchange to PQ: an exchange includes both the situation where coverage changes - either with regard to policy form or additional benefits (e.g., inflation protection) are required - as well as situations where no changes are required except for the fact that the insured's coverage effective date pre-dates the state's partnership effective date. In that case, an exchange is necessary by whatever means both the state and the carrier agree is suitable for that purpose.

**Question:** What do we enter in Field 20, Policy Exchange to PQ if a state does not provide guidance on whether the addition of a disclosure notice is an exchange? Do we then default to the Version 1.1 requirements which say that it is an exchange?

**Answer:** If a state does not provide any guidance on how exchanges are to be made, each company should follow its own protocols and procedures for doing so as deemed appropriate by the company. The Version 1.1 requirements are not intended to provide a "safe harbor" for how exchanges can be made. They are merely descriptive of how many states are allowing exchanges to take place.

**Question:** Field 20, Policy Exchange to PQ - Please clarify what, if anything is to be reported in Field 20 in the following scenario. Policy is exchanged from non-Partnership to Partnership and "1" is reported in field 20 in the data file submitted 8/01/09. That same policy then loses Partnership status during the subsequent reporting period. What do we indicate in field 20 in the next reporting period?

**Answer:** You do not need to reflect anything about that specific policy in field 20 in the next reporting period. As it is now a non-PQ policy, it is neither an exchange to PQ nor a new PQ sale. You would however indicate in Field 47, Policy Status at End of Reporting Period that that policy was still in force (I) and then in Field 48, Partnership Status that it is NQ = no longer Partnership qualified.

**Question:** Field 20, Policy Exchange to PQ - We have Partnership certification approvals in states that we are not currently marketing Partnership. Does anything need to be reported for these states?

**Answer:** Field 20, Policy Exchange to PQ - If you have no Partnership sales or exchanges, you would not have anything to report. Certified carriers who do not report may be notified reminding them that, if they have any PQ sales or exchanges, they are required to report as specified, and at that time it would be appropriate for you to identify that you do not have any sales or have not begun marketing PQ. We will establish an appropriate process for doing this and communicate that as soon as it is established. It may, like the File 2 protocols, request that certified carriers send an e-mail in advance notifying us of their reason for not submitting File 1 on the submission due date.

**Question:** Field 20, Policy Exchange to PQ - Florida's defines an exchange as follows: "An exchange occurs when an insurer offers an existing LTC policyholder the option to replace an existing policy with a different LTC policy and the policyholder accepts the offer to terminate the existing contract and accepts the new contract". The requirements do not address an exchange being in the form of an amendment, rider or disclosure statement. We contact existing policyholders that have a CPI-U Offer inflation and provide them the option to add an Auto Elect endorsement which qualifies their policy as Partnership. If they accept, they are sent the endorsement and a partnership notice, not a new policy. Do we report policies that add the endorsement as an exchange in FL and other states with a similar exchange definition?

**Answer:** Once again, if a state does not provide any guidance on how exchanges are to be made, each company should follow its own protocols and procedures for doing so as deemed appropriate by the company. The Version 1.1 requirements are not intended to provide a "safe harbor" for how exchanges can be made. They are merely descriptive of how many states are allowing exchanges to take place.

#### **FIELD 24, LIFETIME MAXIMUM STRUCTURE**

**Question:** Field 24, Lifetime Maximum Structure. "Indicates whether the Lifetime Maximum is expressed as a single benefit pool across all covered services (Integrated Lifetime Maximum) or whether there are separate Lifetime Maximums for two or more covered benefits". In addition to services applicable to our policies Lifetime Benefit Maximum (LBM) we have two types of service with maximums:

1. Care Giver Training (CGT) = 3 times the current DBM, per condition change or caregiver change and subject to the policies LBM
2. Supportive Services Benefit (SSB) = 50 times current DBM and subject to the policies LBM

How should we report this situation in terms of the Lifetime Maximum Structure? As a Single, 'S', LBM because all services are subject to the one policy LBM or as a Multiple, 'M', LBM because each type of service has a maximum payable benefit?

**Answer:** In field 24, it indicates that a policy with a single lifetime maximum for all covered services may have inner limits on some benefits. This is intended to refer to benefits such as the Supportive Services or Caregiver Training benefit you cite. You should report Lifetime Maximum Structure as "S" since all services are subject to one overall Lifetime Benefit Maximum, even though you have separate "inner" limits on some specific benefits. The code "M" is only used if you have separate Lifetime Maximums for one or more of the following: NH vs. ALF vs. HC.

#### **FIELD 26, SINGLE LIFETIME MAXIMUM OR LIFETIME POLICY MAXIMUM FOR NURSING HOME COVERAGE (DOLLARS)**

**Question:** Field 26, Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Coverage (Dollars). Do we report the original Lifetime Maximum from the effective date of the policy or from the effective date of the Partnership Qualification?

**Answer:** You would report the original Lifetime Maximum from the effective date of the policy. The current lifetime maximum can be derived from other data provided in the reporting so it is not necessary for data submitters to report anything other than the Original Lifetime Maximum.

**Question:** Field 26, Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Coverage (Dollars). Do we report the Lifetime Maximum at policy purchase or the current Lifetime Maximum amount? The current Lifetime Maximum amount would have paid claims subtracted from it and inflation increases added to it.

**Answer:** We are clarifying the field definition to clarify that we want you to report the "original" Lifetime Maximum amount rather than the current amount. So you would report the Lifetime Maximum at policy purchase for fields 26 and for fields 27 and 28 if relevant.

**Question:** With regard to field number 26, Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Coverage (Dollars), do you want us to report this amount as of the beginning value on Policy total dollar value or do you want us to report the Policy total dollar value as of the date of the report to reflect the Policy value if claims have been paid?

**Answer:** File 1, Field 26, Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Coverage should report the original Lifetime Policy Maximum value(s) purchased. The claimant report has fields that query about lifetime policy maximum as of the end of the reporting period which would reflect both inflation increases and benefit decreases.

**Question:** We have another clarification question on File 1 Field 26, Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Coverage. In version 1.2 of the requirements the word "original" was added to the field definition. It now reads as follows: "Indicates the whole dollar amount of the original Policy Lifetime Maximum for a Single Lifetime Maximum Structure (Field 24=S) or for Nursing Home Benefits when lifetime maximums differ for covered services (one or more). Nearest whole dollar amount." We currently have the program written to pull the current policy lifetime maximum as this was programmed before the word original was added to the field definition. With the addition of the word original, our questions are as follows: 1. If a policy became effective in 1991, does the definition mean we need to pull and report the Policy Lifetime Maximum that was effective in 1991 when the policy became effective? 2. If the answer is yes to question 1, if there was a lapse in coverage (was effective in 1991, termed in 1994, became active again in 1996), do we then use the Policy Lifetime Maximum that was effective in 1996, which is the most recent effective policy? 3. Should we be using the Policy Lifetime Maximum that was effective on May 1, 2009, which is when the policy became a Partnership Qualified policy?

**Answer:** Field 26 does pertain to the original Policy Lifetime Maximum at the time the policy became effective even if the policy became PQ through an exchange even if the PLM might be different due to inflation increases and/or benefit decreases. However, as discussed in a different set of Q&A, in File 2, you would only report benefits paid after the policy has become PQ qualified, if it was an exchange from a policy bought prior to the Partnership program, as those are the only benefits that qualify toward asset disregard. In your Item #2, if a policy lapses in 1994, it would seem that the only way it could become active again in 1996 is by a new application and new policy purchase at the attained age (this being the most likely scenario since the typical "reinstatement" provision is only 1 year long). In that case, you would report the PLM associated with the newly purchased 1996 coverage as the 1991 policy has termed. If, however, you extend reinstatement to the policy termed in 1994 and allow the insured, with payment of back premiums to restore their coverage as if it never lapsed, then you would report the original LPM from the 1991 policy. Again, keep in mind that only benefits paid after the policy becomes PQ count toward asset disregard.

**Question:** We have a question about File 1, Field 26-Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Coverage (Dollars), Field 27- Lifetime Policy Maximum for Home Health Care (Dollars), Field 28- Lifetime Policy Maximum for ALF/Other Facility Care (Dollars). We do not have a separate Maximum Amount for each of these facilities only one combined Comprehensive Maximum Benefit. For reporting, should we put the same Maximum Benefit in each field 26, 27, & 28 or should we put the Maximum Benefit in only one field and fill the other two with 9 zeros (00000000)?

**Answer:** Field 26 is intended to capture either a single lifetime maximum, like your combined Comprehensive Maximum Benefit, or a Nursing Home Coverage amount when lifetime maximums differ for one or more covered services. Accordingly, it would be appropriate for you to report your Comprehensive Maximum Benefit value in Field 26. Fields 27 & 28, however, should be filled with eights (i.e., 88888888), the specifications value that indicates the policy/certificate only has one or two pools of dollars.

**FIELDS 27, LIFETIME POLICY MAXIMUM FOR HOME HEALTH CARE (DOLLARS); FIELD 28, LIFETIME POLICY MAXIMUM FOR ALF/OTHER FACILITY CARE (DOLLARS); FIELD 29, SINGLE LIFETIME MAXIMUM OR LIFETIME POLICY MAXIMUM FOR NURSING HOME BENEFITS (DAYS); FIELD 30, LIFETIME POLICY MAXIMUM FOR HOME HEALTH CARE BENEFITS (DAYS); FIELD 31, LIFETIME POLICY MAXIMUM FOR ALF/OTHER FACILITY CARE BENEFITS (DAYS)**

**Question:** Upon review of the State LTC Partnership insurer reporting requirements document version 1.2, I noticed on File 1 fields 27-31 there is a change from the text "current policy LTM" to the "original policy LTM". Based on this change, I have the following questions: Is "Original" defined as the original policy LTM as policy inception? If not, please provide the definition of Original? If "Original" is defined as at the policy inception, please note based on the current version, carriers will never report any benefit changes on NP policies. The same values will be reported on each subsequent file submissions. Is this the intent?

**Answer:** The intent is to report the original value (from policy inception) for the Lifetime Maximum. The remaining lifetime maximum under the policy can be captured from data reported in other fields pertaining to benefits paid (File 2 – Claimant File) and the inflation protection fields in File 1.

**Question:** Field 27, Lifetime Policy Maximum for Home Health Care (Dollars). If policy has multiple pools and pays in dollars, this field indicates the current dollar amount of the Lifetime Policy Maximum for Home Health Care Benefits when lifetime maximums differ for covered services (one or more). Should we consider our policy as having multiple pools based on the first question about Field 24, Lifetime Maximum Structure above? If yes, we still have only one LBM per policy which reduces when claims are paid and increases with the inflation rider. Should we report the numeric value of the current LBM or '88888888 = Policy only has one pool of dollars'?

**Answer:** As referenced in the first question about Field 24, Lifetime Maximum Structure, a policy with inner limits on some ancillary benefits is still classified as having a Single Lifetime Policy Maximum if there is only one pool of dollars for nursing home, ALF and home care benefits. So you would not consider your policy as having multiple pools. Since you have a single lifetime maximum policy, you would report '88888888 = Policy only has one pool of dollars' for Fields 27 and 28, but would report the policy's original (not current) LBM in Field 26.

**Question:** Field 28, Lifetime Policy Maximum for ALF/Other Facility Care (Dollars). Same question as Field 27 above.

**Answer:** Same answer as for Field 27, above.

**Question:** Our policy is a single lifetime maximum, which is expressed in dollars, and we would like clarification on how to value Fields 29, 30, and 31 (corresponding Single Lifetime Maximum or Lifetime Policy Maximums expressed in Days, not Dollars). We believe they should be valued with "99999." Is this correct?

**Answer:** Yes.

**Question:** Field 29, Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Benefits (Days). The Field Definition is: "Indicates the day's limits of the Policy Lifetime Maximum for a Single Lifetime Maximum (Field 24=S) or for Nursing Home Benefits when lifetime maximums differ for covered services (one or more)." The Field Values indicates: "Numeric value without commas or decimals, 77777 = Unlimited and 99999 = Pool maximum expressed in dollars." Should we indicate the LBM dollar amount here or the number of days payable? If you want days, do we report the number of day's payable on the policy from the effective date of the policy or the effective date of the partnership exchange (example: 1 year = 365 days)? Or should we report the Daily Benefit Maximum dollar amount payable?

**Answer:** If your policy has a Single Lifetime Maximum which ultimately pays out and counts dollars of benefit used, then you would complete Fields 29-31 as "99999" which indicates that the pool maximum is expressed in dollars, not days. You would only provide a numeric value in Fields 29 if you offer a policy that literally counts each day of care and has a lifetime maximum limit specified only in days (not days times DBA to equate to a Lifetime Maximum dollar value, e.g., 365 x \$100/day = \$36,500 Lifetime Maximum.)

In the case of a policy which is PQ by virtue of exchange, you should indicate the original Lifetime Maximum value (in either days or dollars) of the policy unless the insured made a change in their Lifetime Maximum upon making the PQ exchange (e.g., if someone had a lifetime policy and exchanged it for one that was PQ but offered a Lifetime Maximum of \$109,500, you would report the new PQ Lifetime Maximum applicable to the coverage that insured now has which would be \$109,500.

The Daily Benefit Maximum dollar amounts payable under a PQ policy are reported in fields 32-34.

**Question:** Field 30, Lifetime Policy Maximum for Home Health Care Benefits (Days). The Field Definition indicates: If the policy has multiple pools, with day limits on individual pools, this field indicates the current lifetime maximum number of Home Health Care days. The Field Values Indicates: Numeric value without commas or decimals, 77777 = Unlimited, 99999 = Pool maximum expressed in dollars and 88888 = Policy only has one pool of days.

- Our policies pay one service (NHB, ALC, HHC) per day and subtract this day from the benefit period  
(Example: Policy purchased for a benefit period of 1 year = 365 days – one days service = 364 days remaining).
- Our policies have one pool of money  
(Example: DBM times benefit period purchased, in this case 365).

How should we report this field?

- Numeric value without commas or decimals (is this the remaining LBM)?
- 99999 = Pool maximum expressed in dollars (we also have a benefit period amount)?
- 88888 = Policy only has one pool of days (we also have a lifetime benefit amount)?

**Answer:** The example you provide is confusing and doesn't make it clear whether your policy pays solely on the basis of days or dollars. You say the "policy only has one pool of days" but in the second bullet you indicate that your policies have one pool of money. Field 30 (Lifetime Policy Maximum for Home Health Care Benefits (Days) is coded as 88888 if the policy only has a single pool for all covered services (nursing home, ALF and home care). It is coded as 99999 if the policy uses dollars, not days, to determine when the Lifetime Maximum has been satisfied, and is coded with the actual value if there is a defined DAY limit to the amount of home care an insured can receive under the policy (e.g., a policy with 750 days of nursing home care and 365 days of home care). Most policies today have a single lifetime maximum and pay on the basis of dollars, not days, so we anticipate Fields 29-31 will mostly be coded as "99999." However, the fields exist for those policies that pay based solely on days of care and for those that have separate Lifetime Maximums for NH vs. ALF vs. HC, whether counted in dollars or days.

**Question:** Field 31, Lifetime Policy Maximum for ALF/Other Facility Care Benefits (Days). Same question as Field 30 above.

**Answer:** See answer for Field 30 above.

**FIELD 32, NURSING HOME BENEFIT AMOUNT; FIELD 33, HOME HEALTH CARE BENEFIT AMOUNT; FIELD 34, ASSISTED LIVING FACILITY (ALF) BENEFIT AMOUNT**

**Question:** Benefit Amount fields (32-34) in File 1 – What denominators should I use if my systems stores weekly or monthly benefit amounts?

**Answer:** To ensure consistency across all benefit amount units, please divide by 7 if your system contains weekly benefit amounts and by 30.4 if your system contains monthly benefit amounts. In File 1, this pertains to Fields 32, 33, 34. This same algorithm should be used for all Benefit Amount fields, regardless of the file in which they reside.

**Question:** In regard to Fields 32 -34 we have a single pool of funds for Nursing Home, Home Health Care and Assisted Living Facility so do we report the same amount in each of the three fields or do we only report the funds in field 32. Fields 27 & 28 offer the choice of 888888888 = Policy/certification only has one or two pools of dollars where field 33 & 34 do not offer this as a response.

**Answer:** If there is a single pool of lifetime maximum benefits for all benefits, you would report the structure as such in field 24 = S and indicate in field 25 if the design is paying dollars or days. Additionally, you would report the amount of the Single Lifetime Maximum in field 26 and then in fields 27 and 28, you would report 888888888 since that is identified in the field value column to mean "policy only has only one pool."

Regarding fields 32-34, these pertain to the Daily Benefit Amount(s) not lifetime maximums so even if you have the same DBA for all covered services, you would still report what that DBA is based on the choice made by the insured. There is no field value to indicate that all DBAs (or some DBAs) are the same. The only option you have is if your policy does not have a NH, ALF or HC benefit in which case it would not have a daily/monthly benefit amount associated with it. As explained in the field definition, even if the policy pays benefits based on a weekly or monthly allowance, the data is still provided in days (with one month/30.4 days)

**Question:** I also have a question on Field 34, Assisted Living Facility (ALF) Benefit Amount. We include Assisted Living Facility (ALF) Benefit Amount in with our field number 32, Home Health Care Benefit Amount and do not have separate pools of funds for each benefit, so do we use "8888" to answer field number 34 since it is included in field number 32 amounts?

**Answer:** Field 34 and the related fields pertain to the daily benefit amount, not the policy's lifetime maximums. Field 32 pertains to the Nursing Home Care Daily Benefit Amount and not the Home Health Care Daily Benefit Amount so I'm not sure if you have the same DBA for NH and ALF or for ALF and HC, or if you possibly have a single DBA for all covered services. Either way, you would report the DBA for NH, ALF and HC in fields 32, 34 and 33 respectively. The only time you use 8888 is, as noted in the field values column, "if there is no ALF benefit." Since you have an ALF benefit and pay it at the same DBA as one or more other benefits, you need to report the actual amount payable (in this case the same as the other benefit). The only place where you "combine" reporting is with respect to lifetime maximum pools of benefit (fields 26-28 for policies paid based on dollars and not days of care). In that case, if there is a single pool of lifetime maximum benefits for NH and ALF, you would report that amount in field 26 and then in field 28, you would report 888888888 since that is identified in the field value column to mean "policy only has one or two pools" - i.e., NH and ALF are combined and counted against one pool or all benefits (NH, ALF and HC) are all counted against one pool - the prevailing policy approach for most carriers.

**FIELD 35, AUTOMATIC INFLATION PROTECTION OR BENEFIT INCREASE TYPE**

**Question:** This question is in reference to field 35 on File 1, Automatic Inflation Protection or Benefit Increase Type. We are not sure where our Riders should fall under. Below is a list of our riders available on the product.

Each policy anniversary, the following benefits will increase by % of the amount in effect on the previous Policy Anniversary:

- 3% Lifetime Compound Benefit Increase Rider (ABI)?
- 4% Lifetime Compound Benefit Increase Rider (ABI)?
- 5% Lifetime Compound Benefit Increase Rider (ABI)?

Each policy anniversary, the Insured's Daily/Monthly Benefit will be increased by 5% of the amount in effect on the previous Policy Anniversary. The Maximum Lifetime Benefit will be increased by 5% of the Remaining Lifetime Benefit (the Maximum Lifetime Benefit on the previous Policy Anniversary less claims paid to the current Policy Anniversary). Annual increases will occur each year until the current Daily/Monthly Benefit first exceeds two times the original Daily/Monthly Benefit. The annual increases will occur even if benefits are being paid.

- 2x Compound Benefit Increase Rider (GIP?)
- 2x Compound with Additional Purchase Option (GIP or FPO?)

Each policy anniversary, the benefits will increase by 5% of the original amount in effect on the Issue Date. The Remaining Lifetime Benefit will increase by the same proportion as the increase in daily benefits. The annual increases will occur even if benefits are being paid.

- Simple Benefit Increase Rider (ABI)?

**Answer:** All of the riders you mention, except for the last one and possibly the second to last one (which is a hybrid approach as described here), are likely considered Automatic Benefit Increases (ABI) in that the insured does not have to elect or decline each offer – hence they are automatic. GIP refers specifically to a graded inflation option where by both benefits and premiums increase by a set percentage. There is not enough information in your description of the “2x Compound Benefit Increase Rider” to know if it is ABI or GIP. If premiums do not increase as benefits increase 2% compounded annually, then it is ABI. If premium increase 2%/year as well, then it is GIP.

For the first 3 riders you mention, and for the last one you mention (Simple Benefit Increase Rider), you would indicate “ABI” in field 35,(assuming these have level-funded premiums). For the second two options, you would also indicate “ABI” in field 35. However, in field 41, you would indicate 0 = no because increases do not continue for the life of the policy; they end when the DMA/MMB reaches 2 times the original. While you indicate that increases occur even while benefits are paid, I suspect that these end when the increases reach 2x the original amounts, without regard to claim status. Therefore, field 41 = 0 in either event.

With regard to the Simple Benefit Increase Rider, field 35 would be populated as ASI (not ABI) assuming the increase is automatic, premiums are level-funded but the increase is based on the original amounts, not prior year amounts.

Finally, with regard to the "2x Compound with Additional Purchase Option" rider, it is unclear to us how this works. We would need to know more in order to give you direction on how to code it. This is an unfamiliar variation which sounds like it combines more than one inflation protection approach. We assume this means that the insured has an ABI (field 35 = ABI) and Field 41 = 1 because increases end when DBA doubles. If indeed the insured can additionally periodically increase benefits on a "guaranteed purchase option" basis over and above the ABI 2x compound inflation protection they have, then you would also indicate in field 44 either YA or YV depending upon how frequently the additional purchase option is offered. If it is a purchase option with underwriting, then it is classified as a voluntary coverage increase and is not reflected in the reporting requirements.

**Question:** Field 35, Automatic Inflation Protection or Benefit Increase Type, OTH appears to specify that OTH cannot be used if the policy has no inflation protection or benefit increase. What, for example, is to be placed in the field for an insured that is 76+ that is not required to have inflation protection to have a Partnership qualified policy?

**Answer:** You would use value NIP - No inflation protection or benefit increase.

**Question:** File 1, Field 35 - How should we be classifying the following Inflation Protection Type? This is what our Group Long Term Care Plan states under the Inflation Protection Benefit:

"The unused amount of your Maximum Lifetime Benefit will also be automatically increased each year on September 1 by 5% of the unused amount remaining on the preceding day."

The amount is simply stated in the policy and is not based on any index, etc,  
Thanks for your help.

**Answer:** This seems to clearly fit the category of a 5% compound annual inflation protection with (we assume) a level-funded premium so it would be ABI. If the premium increases each year or periodically as benefit increase, then a different code would be appropriate but since the section you cite above does not so indicate, we are assuming that premiums for the automatic annual 5% compound inflation increase is funded on a level issue-age basis.

**FIELD 36, INFLATION PROTECTION OR BENEFIT INCREASE AMOUNT OR INDEX VALUE**

**Question:** File 1, Field 36, Inflation Protection or Benefit Increase Amount or Index Value: The field length required by the state is 5 (2.2). We use the monthly CPI-U which is five characters but the format is (3.1). How should we indicate the CPI-U?

**Answer:** The 2.2 format was selected to allow for two places before and after the explicit decimal point. Since your system only stores a single decimal place, you would code 5% inflation protection as 05.00. Similarly, if inflation protection was 9.8%, it would be coded as 09.80. In your case since you never have the second decimal place, for any single-digit inflation protection amount you would need to pad the first and fifth positions with zeroes. For larger values, the fifth place would always be zero-filled. Does this answer your question?

**FIELD 41, INFLATION PROTECTION DURATION TYPE: LIFE OF POLICY/CERTIFICATE**

**Question:** For numeric fields on File 1 & 2, Field 41, please provide guidance/response on the following. Should we zero-fill a numeric field to pass unrecorded values? For example, field 41 (1 character position field) on Registry File #1- if a policy does not have an active automatic inflation protection rider, can we value the field with 0 (zero)?

**Answer:** The page titled "General Information/Field Specifications for Files 1 through 4" that appears immediately before the individual file specification sections requests that for Alpha/Alphanumeric fields, unrecorded or missing values in character fields are blanks/spaces, so please space-fill any alpha or alphanumeric field that has an unrecorded value. Using your example, File 1, Field 41 would contain a space since there is no inflation protection rider. A 0 (zero) would be coded for policies that have inflation protection, but the duration type is not for the life of the policy/certificate.

**FIELD 42, INFLATION PROTECTION DURATION TYPE: WHEN BENEFIT HAS DOUBLED AND FIELD 43, INFLATION PROTECTION DURATION TYPE: OTHER TRIGGER TYPE**

**Question:** In regard to Field 42, Inflation Protection Duration Type: When Benefit Has Doubled and Field 43, Inflation Protection Duration Type: Other Trigger Type on File 1, would the carrier report a '1' (Yes, inflation Protection ends by some other trigger) in Field 43 if the PQ LTC contract ends the Inflation Protection benefits when the benefit has tripled (3X) or quadrupled (4X) the original benefit? Or, is there an intent to further refine Field 42 to accommodate "other multiples" (besides 2X) of the original benefit for cases like this?

**Answer:** Since an Inflation Protection benefit that ends when it doubles is the currently prevailing approach for those that do not continue for the life of the policy, there is no intent at this point in time to add additional field values. In the scenario you describe, Field 42 would be coded = 0 and field 43 = 1.

**FIELD 45, FREQUENCY OF FUTURE PURCHASE OPTION**

**Question:** We have a few additional questions that came up when we started our testing. Field 45, Frequency of Future Purchase Option. The field length is 2 however the field value is only 1 character. Should we add a leading zero?

**Answer:** Yes, both these fields are numeric so they should adhere to the Numeric Fields Formatting Instructions that appear in Version 1.2 of the Reporting Requirements document. You have correctly specified how Field 45 should be coded, that is, right-justified and left zero-filled as you have indicated. So, if FPO was offered every three years, 03 should be assigned; for every ten years, 10 would be assigned.

**FIELD 46, TERMINATION OF FPO OPTION**

**Question:** In regard to Field 46, Termination of FPO Option on File 1, how should the field value be coded for the following contract benefits scenario? Policy is PQ. Policy has both of the following coverage attached from original issue of contract:

- (1) 5% Compound Lifetime Inflation Protection coverage; and
- (2) FPO providing a bi-annual opportunity to insured (beginning with Policy Anniversary #2 and continuing up until anniversary coinciding with or next following Attained Age 80) to increase value of contract benefits by 10% of original benefit purchased. (Please note that the FPO increases are in addition to the Compound 5% Inflation increases occurring on the base). Under this scenario, the insured is ineligible for FPO election if he is on claim (or in process of satisfying Elimination Period). The insured is also ineligible for further FPO offers (prior to Attained Age 80) if three consecutive bi-annual offers have been declined.

If the FPO termination will be due to a "third consecutive offer decline" in the case above, what should be coded? There is no code-decode option I could locate for a "three consecutive offers declined" FPO termination. Are you planning to add "3-consecutive-offers-declined" codes-decodes For Field 46? Or, is this a case where we use the "OT - Other means of Ending the offers" code, because none of the other decodes matches up to the termination condition?

**Answer:** Since Field 46 refers only to the termination of the FPO portion of your inflation protection coverage features as outlined above, you would follow the values provided there with regard to the basis on which the FPO offers end. Please refer to the newly added field values as well as the original field values to identify the ones appropriate for an FPO option that ends as yours does. Given that your FPO offers end either at age 80, upon claim, while during the EP or after 3 declines, you would indicate Field 46 = OT since your model combines more than one of the existing and additional code categories.

**Question:** We have a question about Field 46 - Termination of FPO Option. The requirements as listed appear to expect a single field value to be reported. But what should an insurer report if the FPO can terminate for more than one of field values listed (e.g. Insured goes into claim (CL); or Offers end at specified age (AG))?

**Answer:** You are correct that there can be more than one reason for termination of the FPO option and the field values will be modified to accommodate that. Revised field values will include the following:

Existing field values:

LT = Offers continue for the life of the policy  
D1 = 1 decline triggers termination of offers  
D2 = 2 declines trigger termination of offers  
C2 = Offers end with 2 consecutive declines  
AG = Offers end at specified age  
CL = Offers end when insured goes into claim  
OT = other means of ending the offers  
NO = no FPO

Newly added field values:

L1 = Offers end with one decline or on claim  
L2 = Offers end with two declines or on claim  
LC = Offers end with 2 consecutive declines or on claim  
EM = Offers continue as long as the individual remains with the employer group no matter how many declines and despite being on claim, but converts to one of the other termination criteria once they leave the employer  
EC = Offers continue as long as the individual remains with the employer group no matter how many declines, but end if the individual goes on claim at any time.

**Question:** Field 46, Termination of FPO Option. The revised (June 10) set of values made available still do not fit all insurer's models. We believe that you are expecting us to report for each insured that bought FPO/GPO a value in this field that indicates how this inflation option MAY cease in the future - not why it actually ceased for this particular insured during the 6 months period being reported. For certain policy series and states, this insurer offers an FPO inflation type whose offers could terminate for more than two reasons:

Value = AG (i.e., offers end at specified age)  
or CL (i.e., offers end when insured goes on claim)  
or OT (e.g., offers end if policy goes into non-forfeiture status)

For our initial submission, we are going to report "OT" as the field value, and hope this is acceptable.

**Answer:** You are correct that you are to report the conditions on which FPO may terminate based on the policy language, not the specific reason applicable to each insured if and when their FPO offer terminates. See the existing and newly created field values for Field 46 which include the "more than one reason" why FPO offers may cease. If your policy offers yet another combination of reasons which are not included in the list, then you may indicate OT = other.

**FIELD 47, POLICY STATUS AT END OF REPORTING PERIOD**

**Question:** Our project team needs clarification on Field 47, Policy Status at End of Reporting Period for File 1. In the latest reporting specifications, version 1.2, they changed Field 47 and removed the answer "O = Other" from the responses; however, they did not reference this change in the Revisions to Reporting Requirements page. We would like to know if this change was meant to happen and if the remaining options (without option "O = Other") are the correct answers available.

**Answer:** Yes, this change was intentional. It was felt that value O – Other would never be coded as all other remaining values cover the full universe of valid responses.

**FIELD 47, POLICY STATUS AT END OF REPORTING PERIOD; FIELD 48, PARTNERSHIP STATUS**

**Question:** File 1, Fields 47 & 48: In our review, we noticed a policy that during the reporting period was a Long Term Care Partnership Qualified Policy; however, near the end of the reporting period, the policyholder removed the inflation protection rider. Please note this person is under the age of 76. For coding this policy, our system considers the policy "In force" as we still have a Long Term Care Insurance policy in force. We currently have Field 47 coded as I for this policy. For Field 48, would this policy be considered NQ (as it is a LTC policy without the inflation protection rider)? I guess we wanted to make sure it is ok to have a Field 47 of "I" and a Field 48 of "NQ". If this coding is not acceptable, could you please provide what would be the acceptable values in Field 47 & 48 for the above situation?

**Answer:** That is perfectly acceptable coding. We want to acknowledge that we are not determining the rules for when a benefit change triggers a policy from going from PQ to NQ; that is based on insurer protocol and state Partnership requirements.

**FIELD 48, PARTNERSHIP STATUS**

**Question:** How do we treat policy replacements?

**Answer:** If an insured has a PQ policy and makes an internal replacement that retains their PQ status, nothing need be indicated. That insured continues on the database but the policy design information reported would change in accordance with the terms of their new policy. If the internal replacement causes the policy to lose PQ status (e.g., the insured moves to a policy form that is not PQ or moves to one that is PQ but does not elect IP of the nature and type required for their issue age), then they would be reported as no longer PQ qualified (i.e., value NQ for the field Partnership Status in files 1). If the insured makes an external replacement, then they are indicated by the original carrier as a voluntary lapse (i.e., value "V" for the Policy Status at End of Reporting Period in files 1) and by the new carrier as a new insured. The data repository will attempt to "match" individual insureds such that we are not double counting the number of individuals with PQ coverage in the event that someone maintains PQ coverage but moves from one carrier's policy to another.

**Question:** Partnership Status Field 48 in file 1: Please distinguish between whether the “blank” response means insurers should make this field location null or value it with blank.

**Answer:** For policies Not Taken Out, please space-fill this field position.

**Question:** If an insured moves to a new state, should the Partnership Status field value be coded as “NQ” – No longer Partnership Qualified?

**Answer:** No. A move would not be treated as an event that would result in the loss of PQ status; rather this event would be reported under the insured’s Current address information field set in File 1 (i.e., Fields 11 through 15). Accordingly, the Partnership Status field in File 1 would still be coded using value “PQ” – Partnership Qualified.

## ***FILE 2***

### **FIELD 10, QUALIFYING CONDITION**

**Question:** Can you please answer the following question about Claimant File 2, Field 10- Qualifying Condition. If a member had an active claim for the previous three month reporting period, and the qualifying condition of ‘C’ was reported to the State for that period, and then the qualifying condition changed to ‘B’ for the second reporting period, what will the State do when they receive the qualifying condition of ‘B’ in the second reporting period and compare it to the first reporting period where the qualifying condition was ‘C’?

**Answer:** Under the scenario as described in your question, use of value B – ADL and Cognitive Impairment for the second reporting period is an accurate interpretation of what a vendor should code. We will add language to the specifications indicating that the value should reflect an individual’s Qualifying Condition at the END of the reporting period for those rare instances when it might possibly change DURING a reporting period. While States may conduct ad hoc analyses of Qualifying Conditions between current and prior claimant reporting periods, there will be no attempt to analyze Qualifying Conditions at the time of service (i.e., claims) versus the time services are reported (i.e., claims information aggregated and reported for one of the four Claimant File quarterly reporting periods).

**FIELD 11, BENEFIT START DATE OF THE CURRENT CLAIM PERIOD**

**Question:** Regarding File 2, Field 11 - "Benefit Start Date of the Current Claim Period," defined as, "Indicates date for which benefit payments begin for the current claim period. This date should occur after any elimination period has been satisfied."

For the reporting period of 7/1/09 thru 9/30/09, if we make a payment on 7/20/09 (the check date) for services provided from 6/15/09 through 7/15/09, which date do we use for the benefit start date in field 11?

**Answer:** All claims paid for services received before or during the reporting period for which a policy is in PQ status should be reported (as long as they were not previously reported). So for the example above, the report for 7/1/09 through 9/30/09 would report the amount of claims paid associated with the services provided 6/15 through 7/15/09. In field 11, the start date for the claim is 6/15/09 because that was the first day of services for which benefits were paid.

Please note that in subsequent File 2 reports, if the insured in this example remains on claim continuously, then their Field 11 "Benefit Start Date of the Current Claim Period" would still be 6/15/09. Only if they go off claim and then have a second episode of claim would Field 11 carry a new claim start date on any subsequent reports.

**Question:** File 2, Field 11 - I was wondering if you could answer a question for me about the Benefit Start Date of the Current Claim Period. We are conflicted as to the date being required here. Is it the date of our 1st check in the reporting period, or is it the first date in the reporting period that is covered by a benefit payment?

For example #1: Claimant file reporting period is 7/1/09 thru 9/30/09. On 7/15/09 we send the insured a check for X dollars that covers a period of service from 7/5/09 thru 7/10/09. Is the date reported in field 11, 7/5/09 (1st date in reporting period covered by the payment) or 7/15/09 (date payment is made)?

Example #2: Same Claimant file reporting period. On 7/15/09 we send a check that covers benefits incurred for the period, 6/26/09 thru 7/10/09. Is the date reported in field 11, 7/1/09 (1st date in reporting period covered by the payment) or 7/15/09 (date payment is made), or 6/26/09 (1st date in benefit period that leads to the file reporting period)?

**Answer:** As you indicate, File 2, Field 11 is the first date in the reporting period that is covered by a benefit payment. Field definition 11 – Benefit Start Date of the Current Claim Period – says to indicate the date **for which** benefit payments begin (not the date ON WHICH benefit payments begin. The phrase "date for which benefit payments begin" refers to the first date of service which is deemed eligible for benefit payment.

In the examples you provide, the Field 11 value in example #1 would be 7/5/09 and in example #2 the Field 11 value would be 6/26/09. Please also see the note above for Question #4 regarding reporting on Field 11 in subsequent reporting periods.

**Question:** There is a claim on a PQ policy.  
The first benefit was paid on 1/25/2009 for care incurred from 1/7/09 thru 1/20/09.  
We later made payments made on 4/15/09 for care incurred from 4/1/09 thru 4/11/09.

Which Date is to be considered the Benefit Start Date of the Current Claim Period?  
4/1/09, 1/7/09, or the actual dates on which the benefits were paid out (after the elimination period) (1/25/09 or 4/15/09)?

**Answer:** 1/7/09.

**Question:** File 2, Field 11 - Where more than one claims payment may have been made during the reporting period, we assume you are only looking for the first date to be reported in Field 11.

Is that a correct assumption?

**Answer:** Yes. In fact, this same date would be used for the next reporting period if the insured was still within the same "on-claim" episode. Even if the insured has multiple episodes of claim all occurring within a single reporting period, field 11 should still report the claim start date (first date for which a benefit was paid) which in your example is 1/7/09. If the insured recovered from the claim starting 1/7/09 and then had a second claim occurrence starting during the second claim reporting period, you would report that second claim occurrence date in field 11 on the second claim reporting file.

#### **FIELD 12, SINGLE LIFETIME MAXIMUM OR NURSING HOME BENEFITS PAID DURING REPORTING PERIOD**

**Question:** This question is in regards to the Claimant File 2, Field 12-Single Lifetime Maximum or Nursing Home Benefits Paid During Reporting Period. How is Single Lifetime Maximum defined? If a policy has a single pool for all benefits do we add it all under field 12?

#### **Original**

**Answer:** Field 12 is intended to capture either the benefits paid during a reporting period when there is single pool for all benefits, as you indicated, or the Nursing Home benefits paid during a reporting period when lifetime maximums differ for one or more covered services. Accordingly, it would be appropriate for you to add all benefits paid under your single pool during a reporting period using Field 12.

#### **Refined**

**Answer:** The intent is to report dollar amounts paid under each of the major benefits you have – Nursing Home, ALF, Home Care – in fields 12 through 14 respectively, even though they all draw down a single Lifetime Maximum. For some insurers, the benefit amounts paid per unit of service will differ across these benefits while for others it may be the same benefit amount. While the asset disregard is only dependent on the total amount of benefits paid, information by type of benefit paid is requested as deemed appropriate by the Technical Advisory Committee responsible for guiding development of the data reporting system. Other benefits paid like respite care, caregiver training and the like can be grouped and reported in Field 16.

**Question:** Question for Claimant Reports (File 2). Where should we report Respite Care and Bed Reservation benefits? Would it be File 2, Field 12, Single Lifetime Maximum or Nursing Home Benefits Paid During Reporting Period or Field 16, Other Benefit Amounts Paid During Reporting Period?

**Answer:** Claims paid for these benefits should be reported under Field 16, Other Benefit Amounts Paid During the Reporting Period. However, some carriers include Bed Reservation as a covered service within the nursing home or ALF benefit. In that case, you would report benefits paid for Bed Reservation under the respective benefit of which it is a part. The same would apply to Respite Care; if it is a separate benefit, report it as "Other Benefit Amounts Paid" but if it is paid as part of a Nursing Home, ALF or home care benefit, then report it as such.

**Question:** File 2, Field 12 - Our policies basically have one pool of money from which Nursing Home, Assisted Living and Home Health Care benefits are paid. Field 12 on File 2 is for Single Lifetime Maximum or Nursing Home Benefits Paid During the Reporting Period and Fields 13 and 14 are for Home Health and Assisted Living Benefits respectively. Since we pay all three of these benefits from a single pool will all benefits paid for these services get reported in Field 12 or is the intent for these fields to be a breakdown of which services were paid under each benefit during the period?

**Answer:** The intent is to report dollar amounts paid under each of the major benefits you have – Nursing Home, ALF, Home Care – in fields 12 through 14 respectively, even though they all draw down a single Lifetime Maximum. For some insurers, the benefit amounts paid per unit of service will differ across these benefits while for others it may be the same benefit amount. While the asset disregard is only dependent on the total amount of benefits paid, information by type of benefit paid is requested as deemed appropriate by the Technical Advisory Committee responsible for guiding development of the data reporting system. Other benefits paid like respite care, caregiver training and the like can be grouped and reported in Field 16.

**Question:** File 2, Field 12: It is our understanding that because we have a Single Lifetime Maximum, we would report the total of any claims paid during the reporting period for Nursing Home, Home Health Care, or Assisted Living/Other Facility Benefits in File 2, Field 12: Single Lifetime Maximum or Nursing Home Benefits Paid During Reporting Period and File 2, Fields 13 and 14 would be zero-filled. Is this correct?

**Answer:** This is incorrect. As stated previously, the intent is to report dollar amounts paid under each of the major benefits you have – Nursing Home, ALF, Home Care – in File 2, Fields 12 through 14 respectively, even though they all draw down a single Lifetime Maximum. For some insurers, the benefit amounts paid per unit of service will differ across these benefits while for others it may be the same benefit amount. While the asset disregard is only dependent on the total amount of benefits paid, information by type of benefit paid is requested as deemed appropriate by the Technical Advisory Committee responsible for guiding development of the data reporting system. Other benefits paid like respite care, caregiver training and the like can be grouped and reported in File 2, Field 16.

**FIELD 15, TOTAL CASH BENEFITS PAID DURING REPORTING PERIOD**

**Question:** This question is in regards to the Claimant File 2, Field 15-Total Cash Benefits Paid During Reporting Period. We have an optional Monthly Indemnity rider available. The insured can choose an additional cash indemnity benefit paid in any month that a reimbursement benefit is paid. The benefit does not come out of Lifetime benefit Max pool, but has a separately defined limit of its own. Where should we record these benefit payment amounts?

**Answer:** In this case, the carrier would utilize fields 12 through 15, assuming 12-14 are also each applicable. Assuming that your Monthly Indemnity Benefit Rider pays a cash disability payment (without regard to whether or not services are received), then benefits paid under it would be reported in Field 15 as that is where benefits paid on a cash/disability basis are reported. It is not relevant to reporting whether or not benefits paid reduce the Lifetime Benefit Maximum. There is a separate field in which the carrier reports on the remaining Lifetime Maximum so that would be a calculation internal to the carrier.

**Question:** What I'm interested in specifically is what CMS considers "cash benefits" (File 2 – Claimant File Field Number 15). We want to know whether this means a daily cash allowance while on claim, or, could this be an amount that perhaps the claimant receives from us (in the form of a check) to reimburse for services that the claimant paid directly to the provider upon receipt of the service or could this just be the total paid to all providers for the reporting period?

**Answer:** The fields 12-14 are to be used for a policy that pays on either an indemnity or a reimbursement basis for the level of care referred to in that field. Field 15 is to be used for any benefits that are paid purely on the basis of cash. A cash benefit (also called a Disability Benefit Payment) is one that is paid when the insured satisfies the policy's benefit trigger of being Chronically Ill and where the payment is made without regard to whether or not the insured uses services. This benefit type is sometimes called a "Disability Payment Plan" and is similar to the way UNUM and some other carriers structure their non-facility benefit payment. It is not intended to reflect a reimbursement for services rendered –whether the payment goes directly to the insured or to the provider.

We consider that there are three types of policy payments: (A) Reimbursement policy pays expenses up to DBA (or other limits) where the insured is both Chronically Ill and incurs covered expenses (B) Indemnity Policy pays expenses up to a pre-set amount regardless of the cost of services, but covered services still are required to be provided and the insured must be chronically ill; (C) Cash/Disability policy pays a set benefit amount in cash when the insured is chronically ill but without regard to whether or which services are incurred. It is the last of these models which we consider a "cash benefit." Some policies pay benefits on more than one basis – e.g., they may pay for facility care on a reimbursement basis (in which case they would report total benefits paid in fields 12 and 14) but pay for non-facility care based on disability alone (in which case they would report total benefits paid in field 15 as well and indicate that field 13 for home health care benefit paid is not applicable as described in the field values column).

**FIELD 16, OTHER BENEFIT AMOUNTS PAID DURING REPORTING PERIOD**

**Question:** File 2, Field 16 - Most of our policies have the main pool of money from which Nursing Home, Home Health Care and Assisted Living Benefits are paid but also have ancillary pools from which Care Advisory Services (a separate Calendar Year pool) and Stay at Home Benefits (a separate Lifetime pool) are paid. These benefits are available as long as there is money left in the main pool and are no longer available when the main pool is exhausted. It looks like payments made under these benefits will be reported in File 2, Field 16. My question is for File 2, Field 18: do we report just the main pool of money remaining balance or do we add in the Care Advisory Services and Stay at Home Benefit to the main pool?

**Answer:** If it is correct to assume from your description that the separate lifetime pools for Care Advisory Services and Stay at Home Benefits are in effect “inner limits” and that benefits paid against those services also draw down the overall policy Lifetime Maximum, the amount reported in File 2, Field 18 would simply be the amount remaining in the overall policy Lifetime Maximum. Whether or not the Stay at Home Benefit is exhausted is not relevant since it is the Lifetime Maximum which determines the total policy payout.

**Question:** File 2, Field 16: It is also our understanding that we would report the total of any claims paid during the reporting period for other benefits such as Adult Day-care, Hospice, and Respite in File 2, Field 16 - Other Benefit Amounts Paid During Reporting Period. Is this correct?

**Answer:** That is correct as long as these other benefits are benefits on their own. Many policies include adult day care as part of the home health benefit. In that case, you would report benefits paid for adult day care in Field 13 (home health care). Similarly, if there is a “standalone” Respite Care Benefit, it would be reported in Field 16 (other benefits), but if respite care is a covered service under other benefits, it would be reported as paid under its respective other benefits (e.g., the insured had 14 days of respite care in an ALF (reported in Field 14) and 7 days of respite care at home (reported in Field 13). The same would apply to “benefits” such as Bed Reservation, for example; ; if it is a separate benefit, report it as “Other Benefit Amounts Paid” but if it is paid as part of a Nursing Home or ALF benefit, then report it as such.

**FIELD 17, TOTAL LIFETIME BENEFITS PAID TO DATE**

**Question:** File 2, Field 17 - Total Lifetime Benefits Paid to Date is intended to be the total lifetime benefits paid after the plan became partnership qualified, correct?

**Answer:** That is correct.

**FIELD 18, REMAINING LIFETIME BENEFITS FOR ALL POOLS COMBINED**

**Question:** File 2, Field 18 - Remaining Lifetime Benefit for all pools combined: What is the expected response if it is a two-pool policy where one pool is unlimited and another is not? If we indicate unlimited, then that overvalues the 2<sup>nd</sup> pool.

**Answer:** Given that the percentage of current PQ policies (and future anticipated PQ policy volume with a multiple pool design is so small (currently at less than 0.2% of all policies), we will allow this field to be filled with 888888888 to represent missing data since it is not feasible to calculate a single remaining dollar amount in lifetime benefits in the case of multiple pools.

## **File Submission and Resubmission Procedures**

### **GENERAL QUESTIONS –APPLY TO ALL FILE TYPES**

**Question:** I did not attend the February Webinar training sessions for the Registry File due August 1<sup>st</sup>. Are there any plans to conduct more Registry File training sessions?

**Answer:** At this time, no additional formal training sessions for Registry Files are planned. We encourage vendors new to the LTC Partnership Program to carefully review the training materials and reporting specifications that appear on the website's Reporting Requirements page at <http://www.dehpg.net/LTCPartnership/map.aspx>. This page contains:

- Final Regulations
- LTC Partnership Data Repository Specifications, Version 1.1
- Data Transmission Options and Requirements
- Partnership Webinar Training Slides
- Question and Answer Sets
- Web Tool for Vendor Data Submission Registration to Thomson Reuters

If your review process generates questions, please submit them to the project mailbox [lhcpartnership@thomsonreuters.com](mailto:lhcpartnership@thomsonreuters.com).

**Question:** I was unable to attend the February Webinar training sessions and would like clarification regarding the upcoming reporting deadlines for the Registry and Claimant files.

**Answer:** The first official reporting deadline is August 1, 2009 for the Registry Files (i.e., File 1). This submission covers activity from 1/1/09 through 6/30/09. Carriers and TPAs should include policies that were in force **prior to** 1/1/09 as long as they are still in force for at least one day between 1/1/09 through 6/30/09. The second official reporting deadline is November 1, 2009 for Claimant Files (i.e., File 2). This first official claimant file submission should include all claims paid since 1/1/09.

**Question:** What formal procedure should an insurer or TPA follow when there are no sales or claim activity during a reporting period?

**Answer:** It is extremely unlikely that a Registry file would be identical to the one submitted for the prior reporting period. The reporting system is designed to track not only sales activity, but changes in key field values for policy or certificate holders (e.g., policy or certificate holder moves to a new residence than the one reported for the prior submission). Accordingly, carriers and TPAs should expect to regularly submit Registry Files according to the reporting deadline schedule. In the event that no claim activity has occurred during a given quarter, an e-mail indicating no claimant activity for the particular quarter covered by a given reporting deadline should be sent to the project mailbox [lhcpartnership@thomsonreuters.com](mailto:lhcpartnership@thomsonreuters.com).

**Question:** We will have our 3rd party vendor create File 1 and our in-house team will create File 2. Can the files be sent from the different sources or do they have to be sent together?

**Answer:** This is a perfectly acceptable approach. To ensure success with this approach, both data suppliers will need to self-identify their preferred EDT option via e-mail to the project mailbox [ltpartnership@thomsonreuters.com](mailto:ltpartnership@thomsonreuters.com). This e-mail must include the data supplier name, technical contact information (i.e., technical contact's name, e-mail address and telephone number) and the selected EDT option. The Data Transmission Options and Requirements may be found under Reporting Requirements at <http://www.dehpg.net/LTCPartnership/map.aspx>

**Question:** Can data suppliers submit a test file with dummy data to test connectivity and other data submission requirements for the electronic data submission option they choose?

**Answer:** Yes. Thomson Reuters prefers to receive some sort of test file as part of the EDT set-up process. This process begins with carriers self-identifying their preferred EDT option via e-mail to the project mailbox [ltpartnership@thomsonreuters.com](mailto:ltpartnership@thomsonreuters.com). This e-mail must include the data supplier name, technical contact information (i.e., technical contact's name, e-mail address and telephone number) and the selected EDT option. The Data Transmission Options and Requirements may be found under Reporting Requirements at <http://www.dehpg.net/LTCPartnership/map.aspx>

The test file does not have to contain actual data - it can be as simple a test file that contains the sentence "This is a test file!". It cannot be empty. This enables the Healthcare EDT team to ensure that we can receive the file and process it through to MDSS. So, if applicable, it tests the connectivity, naming convention, decryption, etc.

**Question:** Thomson Reuters stated that you welcome the opportunity for participants to send in test UDS files with actual data to test with Thomson Reuters prior to registry launch. Can you please provide the **deadline** for a participant to submit a test file as an early submitter to Thomson Reuters?

**Answer:** This second type of test file involves a carrier or TPA choosing to be an early submitter. This option is intended to provide all data suppliers with the opportunity to submit beta files that will enable them to make refinements to their system/processes that are developed to support the reporting requirements for the Long-term Care Partnership program. Given the August 1 submission deadline for File 1 and the cycle required for Thomson Reuters to process beta files, schedule and conduct feedback teleconferences with data suppliers, and, the potential need for data suppliers to conduct minor refinements based upon the outcome of beta testing, Thomson Reuters will accept early submitter transmission of beta File 1s until June 1, 2009.

**Question:** If a data supplier submits a data file to the Long-Term Care Partnership Data Repository, and then discovers that there is an error in the file, should they correct the error immediately and re-submit the file, or simply correct the error in the file submission for the subsequent reporting period?

**Answer:** It depends on the magnitude of the error. If the error is relatively minor, and affects only a few of the records in the file (e.g. an incorrect address for one or more policyholders), then it is acceptable to simply make the corrections on the subsequent file submission. However, if the error is relatively large in magnitude (e.g. all values in one field are corrupted on all records) then an immediate correction of the file, and a resubmission, is warranted. If a data supplier identifies an error of large magnitude and intends to submit a correct file for the reporting period, or if a data supplier is uncertain whether a corrected file submission is needed, please contact Thomson Reuters at [lhcpartnership@thomsonreuters.com](mailto:lhcpartnership@thomsonreuters.com) .

## ***FILE 2***

**Question:** Slide 7 in the Webinar PowerPoint has a chart of the reporting deadlines. In that chart, File 1 and File 2 have an August 1, 2009 deadline; however, slide 27 states that the reporting deadline for File 2 is November 1, 2009. Can you clarify when the 1st submission of File 2 is due?

**Answer:** The first submission of File 2 will be November 1, 2009

**Question:** File 2 - If there are no claims to be reported for a certain quarter, what, if anything, do we do? Send a blank file, an e-mail or nothing at all?

**Answer:** In the event that no claim activity has occurred during a given quarter, an e-mail indicating no claimant activity for the particular quarter covered by a given reporting deadline should be sent to the project mailbox [lhcpartnership@thomsonreuters.com](mailto:lhcpartnership@thomsonreuters.com).

## **HIPAA Issues**

### **GENERAL QUESTIONS –APPLY TO ALL FILE TYPES:**

**Question:** How have you worked through the HIPAA Privacy rules regarding carriers providing you with the data and the protection of the data that we provide? What safeguards will insurers have that the data is protected and only de-identified information is made public?

**Answer:** The electronic file transfers all require user authentication and provide for either file level encryption or transmission level encryption (i.e. the tunnel/path between the sending and receiving point is encrypted). All methods comply with HIPAA privacy and security rules. Access to the data once received by Thomson Reuters is limited both physically and organizationally to staff members on a need to know basis only. As soon as files are received by Thomson Reuters readily/semi-identifiable PHI data elements are encrypted on our data stores.

The only data that will be made public and posted on the project's website are the canned report tables, which contain high-level summary statistics aggregated at either the State or Carrier level.

**Question:** I'm a business analyst working on the LTC Partnership submission. I have a question regarding options for transmitting the data. In the case of an interactive web submission, is the data encrypted after the validation process?

**Answer:** The technical answer is that the Web submission process encrypts the file during transfer then decrypts it on our server. The specific method of encryption is called triple-DES encryption. The encryption referred to in the documentation is an indicator of whether file-level encryption (i.e. PGP) is required or not. PGP is only required for FTP pushes and pulls. All other methods use an encrypted "pipe" so the data file itself doesn't necessarily need to be encrypted. However, since these data files contain extremely sensitive data, encryption of key fields (e.g., SSN, name, DOB) occurs during the validation process before the files are written to our secure server.