U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

STATE LONG-TERM CARE PARTNERSHIP INSURER REPORTING REQUIREMENTS:

VERSION 1.3

October 2, 2009

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-100-03-0022 between HHS's ASPE/DALTCP and MEDSTAT Group, Inc. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Hunter McKay, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: Hunter.McKay@hhs.gov.

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Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-100-03-0022

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REVISIONS TO REPORTING REQUIREMENTS

Version 1.3

1. File 2 -- revised text for Overview and Criteria for Inclusion sections to better clarify when it is necessary to report claimant data.

2. The following fields had either clarifying language added to the Field Definition or Field Value section, or, new values added to represent more complex scenarios:
   a. Inflation Protection or Benefit Increase Amount or Index Value (File 1, Field 36) -- use of 99.99 refined.
   b. Policy Status at End of Reporting Period (File 1, Field 47).
   c. Partnership Status (File 1, Field 48).
   d. Benefit Start Date of the Current Claim Period (File 2, Field 11).
   e. Home Health Care Benefits Paid During Reporting Period (File 2, Field 13).
   f. Assisted Living/Other Facility Benefits Paid During Reporting Period (File 2, Field 14).
   g. Total Cash Benefits Paid During Reporting Period (File 2, Field 15).
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   j. Remaining Lifetime Benefits for all Pools Combined -- Dollars (File 2, Field 18).
   k. Remaining Lifetime Home Health Care Benefits -- Dollars (File 2, Field 20).
   l. Remaining Lifetime ALF/Other Facility Benefits -- Dollars (File 2, Field 21).
   m. Remaining Single Lifetime Maximum or Nursing Home Benefits -- Days (File 2, Field 22).
   n. Remaining Lifetime Home Health Care Benefits -- Days (File 2, Field 23).
   o. Remaining Lifetime ALF/Other Facility Benefits -- Days (File 2, Field 24).

3. The following fields were renamed and had clarifying language added to the Field Definition and Field Value sections, and, new values added:
   a. File 2, Fields 12, 19.

4. Eliminated Files 3 and 4 until, and if, they are needed.

Version 1.2

1. Created Revisions to Reporting Requirements section.

2. Basic File Structure -- added second paragraph.

3. Files 1 and 3 -- Criteria for Inclusion -- added second sentence.

4. Integrated the four file specifications tables located after the Glossary in Version 1.1 into their respective sections in the main body of the document.

5. Added additional details and clarified several instructions in the General Information/Field Specifications section (e.g., financial field instructions, including passing negative signs, rounding instructions, etc.), which now appear before all four detailed File Specifications tables.

6. The following fields had either clarifying language added to the Field Definition or Field Value section, or, new values added to represent more complex scenarios:
    a. Lifetime Maximum Structure (File 1, Field 24; File 3, Field 16; File 4, Field 23).
    b. Lifetime Policy Maximums (File 1, Fields 26-31; File 3, Fields 18-23).
    c. Daily Benefit Amounts (File 1, Fields 32-34; File 3, Fields 24-26; File 4, Fields 31-33).
    d. Termination of FPO Option (File 1, Field 46; File 4, Field 45).
    e. Partnership Status (File 1, Field 48; File 4, Field 47).
    f. Qualifying Condition (File 2, Field 10; File 4, Field 48).
    g. Benefits Paid During Reporting Period (File 2, Fields 12-15; File 4, Fields 50-53).

7. The following fields were renamed and had clarifying language added to the Field Definition and Field Value sections:
    a. File 1, Fields 39-40.
    b. File 3, Fields 31-32.
    c. File 4, Fields 38-39.

8. Files 2 and 4 -- Criteria for Inclusion -- added second paragraph.

LONG-TERM CARE PARTNERSHIP REPORTING REQUIREMENTS

The Deficit Reduction Act of 2005 (DRA), Public Law 109-171, allowed states to offer special Medicaid asset disregards to persons purchasing and using specially certified (Partnership) long term care insurance policies. Section 6021 (a)(1)(A) of the DRA also requires insurance carriers to report data to the Secretary related to the sale and use of Partnership Long Term Care Insurance policies in states with a Medicaid state plan amendment approved after May14, 1993. This document presents reporting requirements for insurance carriers selling such policies in such states.

The Deficit Reduction Act requires insurers participating in state Long Term Care Partnership Programs with a Medicaid state plan amendment approved after May14, 1993 to provide regular reports to the Secretary of the Department of Health and Human Services (HHS). Section 6021 of the Deficit Reduction Act contains the following requirement:

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

On December 18, 2008 the Secretary promulgated regulation 45 CFR Part 144 Subchapter B enacting the following reporting requirements.

BASIC FILE STRUCTURE

The reporting requirements consist of four distinct file types. The following is an overview of each file and a corresponding set of criteria for determining what data belongs in each file. For all four file types, insurers are required to report on only those insureds, policyholders, and claimants who have active Partnership Qualified (PQ) policies or certificates. These requirements do not apply to insurance policies or certificates that are not Partnership Qualified (PQ).

A data supplier that administers Partnership programs for more than one carrier client can choose to collate all data together in a single file, using Field 1, Company Code to distinguish among clients; or they can submit one file for each of their clients rather than collating all data together in one file. 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 data for the other fields).

FILE 1: REGISTRY FILE FOR INDIVIDUAL AND VOLUNTARY OR PARTIALLY VOLUNTARY GROUP COVERAGE

Overview

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

Criteria for Inclusion

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

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

Also, if an individual covered under a group plan reported on File 3 ports or converts his or her coverage upon leaving the group, and by virtue of that change, the insurer obtains access to information about the individual insured, then that insured individual should then be reported on File 1 and, when relevant (e.g., when the insured is on claim), in File 2.

Reporting Frequency

Insurers are required to submit data for File One as outlined below:

File	Period Covered	Submission Deadlines
One	January 1 - June 30 July 1 - December 31	August 1 February 1

General Information/Field Specifications for File 1

File Specifications: all files are fixed width, ASCII. There is no sort-order requirement.

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

Field Formatting Instructions:

Alpha and Alphanumeric Fields:
Includes A - Z (lower or upper case), 0 - 9, spaces, and special characteristics.
Left justified, right space-filled.
Unrecorded or missing values in character fields should be space-filled.

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

Special Notes:
Financial fields should not contain any dollar signs, commas or decimals but may be signed when negative. Please pass the negative sign using the most significant (or left-most) position.
Round dollars to the nearest whole dollar as follows, .50 and above round upward; otherwise downward.
Percentage Fields should have decimals; do not include % symbol.

Reporting Specifications for File 1 -- Registry File

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
1	Company Code	AN	5	Unique company identifier using NAIC company code. If the block of business was purchased from another carrier, the company code of the acquiring company should be provided. The HHS data repository will develop a unique code for self-funded and FLTCIP plans that do not have NAIC codes.	5 Digit NAIC Code or a uniquely assigned company code for self-funded plans and Federal Employees Long Term Care Insurance program (FLTCIP)
2	Report Date	N	8	Date on which the report was submitted to HHS.	Format: MMDDYYYY
3	Reporting Period	N	16	Begin date and end date of reporting period. In general, the reporting period for File 1 will be a six-month period, either January 1 through June 30, or July 1 through December 31.	Format: MMDDYYYYMMDDYYYY
4	Insured's Social Security Number	N	10	Social security number of the person insured under the Partnership Qualified (PQ) policy.	10 digit numeric code (no dashes) 9999999999 if not available
5	Policy Number	AN	30	The unique certificate or policy number assigned by the carrier to the insured	A/N
6	First Name	A	30	First name of insured	First Name
7	Middle Initial	A	1	Middle initial in name of insured	Middle Initial Space-fill if unavailable
8	Last Name	A	40	Last name of insured	Last name; include generational suffixes here i.e., JR SR
9	Date of Birth	N	8	Birth date of insured	Format: MMDDYYYY
10	Gender	A	1	Gender of insured	M = Male F = Female U = Unknown
11	Current Address Line 1	AN	50	Insured's current street address	Street name and number
12	Current Address Line 2	AN	50	Insured's current street address line 2	Additional Address Line
13	Current City of Residence	A	40	Insured's current city of residence	Insured's city of residence during reporting period
14	Current State	A	2	Insured's current state of residence	USPS state code Use FN if current residence is outside the US.

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
15	Current ZIP Code	N	9	Postal zip code of insured's current residence	5-digit numeric code 9-digit numeric code optional (no hyphen for zip+4) If unavailable, assign 999999999
16	Policy Issue State	A	2	State in which the individual or group policy was originally issued.	USPS state code.
17	Certificate Issue State	A	2	For group business, this is the original residence state. The state where the certificate holder lived at the time of original purchase.	USPS state code Use NA if not applicable due to individual policy purchase.
18	Current Annual Premium	N	6	The current annualized premium for the policy/certificate. Nearest whole dollar amount.	Numeric code without commas, decimals or dollar signs. The premium amount may be zero for policies in waiver of premium, in a paid up status or in non-forfeiture status.
19	Partnership Qualified (PQ) Coverage Effective Date	N	8	Indicates date on which the insured's coverage first became effective as a PQ policy under his or her individual policy or group certificate.	Format: MMDDYYYY
20	Policy Exchange to PQ	N	1	Indicates whether the policy is a PQ policy as a result of an exchange from a non-PQ policy, rather than as an original purchase.	1 = Yes 0 = No
21	Policy Benefit Type	A	2	Indicates the major type of benefits allowed under the policy.	CP = Comprehensive NH = Nursing Home Only FC = Facility Care Only (includes NH and ALF) HC = Home Health Care Only OT = Other
22	Original Coverage Basis	A	1	Indicates whether the policy is a group or an individual policy. For multi-life groups, the value selected should be based on how the policy was filed with the Department of Insurance.	G = Group Policy I = Individual Policy
23	Ported Coverage from Group Policy	N	1	Indicates whether the policy was originally purchased on a group basis and previously reported in File 3.	1 = Yes 0 = No

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
24	Lifetime Maximum Structure	A	1	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.	S = Single lifetime maximum for all covered services (although there may be inner limits on some benefits provided either within or over and above the lifetime maximum) M = Multiple lifetime maximums for one or more of the following services: NH vs. ALF vs. HC.
25	Lifetime Maximum Structure Detail	A	2	Indicates whether the policy counts Dollars or Days of benefits used as the Lifetime Maximum.	DL = Dollars (pool(s) of dollars design) DY = Days and not pool of dollars design
26	Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Coverage (Dollars)	N	9	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.	Numeric value without commas, decimals or dollar signs. 777777777 = Lifetime/Unlimited 999999999 = Pool maximum expressed in days
27	Lifetime Policy Maximum for Home Health Care (Dollars)	N	9	If policy has multiple pools and pays in dollars, this field indicates the original dollar amount of the Lifetime Policy Maximum for Home Health Care Benefits when lifetime maximums differ for covered services (one or more). Nearest whole dollar amount.	Numeric value without commas, decimals or dollar signs. 777777777 = Lifetime/Unlimited 999999999 = Pool maximum expressed in days 888888888 = Policy/certificate only has one pool of dollars
28	Lifetime Policy Maximum for ALF/Other Facility Care (Dollars)	N	9	If policy has multiple pools and pays in dollars, this field indicates the original dollar amount of the Lifetime Policy Maximum for ALF/Other Facility Benefits when lifetime maximums differ for covered services (one or more). Nearest whole dollar amount.	Numeric value without commas, decimals or dollar signs. 777777777 = Lifetime/Unlimited 999999999 = Pool maximum expressed in days 888888888 = Policy/certificate only has one or two pools of dollars
29	Single Lifetime Maximum or Lifetime Policy Maximum for Nursing Home Benefits (Days)	N	5	Indicates the days limits of the original 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).	Numeric value without commas or decimals. 77777 = Unlimited 99999 = Pool maximum expressed in dollars

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
30	Lifetime Policy Maximum for Home Health Care Benefits (Days)	N	5	If the policy has multiple pools, with day limits on individual pools, this field indicates the original lifetime maximum number of Home Health Care days.	Numeric value without commas or decimals. 77777 = Unlimited 99999 = Pool maximum expressed in dollars 88888 = Policy/certificate only has one pool of days
31	Lifetime Policy Maximum for ALF/Other Facility Care Benefits (Days)	N	5	If the policy has multiple pools, with day limits on individual pools, this field indicates the original lifetime maximum number of ALF/Other Facility days covered.	Numeric value without commas or decimals. 77777 = Unlimited 99999 = Pool maximum expressed in dollars 88888 = Policy/certificate only has one or two pools of days
32	Nursing Home Benefit Amount	N	4	The current daily benefit amount for nursing home coverage. If the benefit is paid as weekly or monthly, the daily amount should be derived by dividing by 7 or 30.4 respectively, rounding to whole dollars. If the insured has inflation protection, this field should reflect the current daily benefit amount, as inflated.	Numeric value without commas, decimals or dollar signs. 7777 = Unlimited daily benefit amount 8888 = No Nursing Home Benefit
33	Home Health Care Benefit Amount	N	4	The current daily benefit amount for Home Health Care provision on the policy. If the benefit is paid as weekly or monthly, the daily amount should be derived by dividing by 7 or 30.4 respectively, rounding to whole dollars. If the insured has inflation protection, this field should reflect the current daily benefit amount, as inflated.	Numeric value without commas, decimals or dollar signs. 7777 = Unlimited daily benefit amount 8888 = No Home Health Care Benefit
34	Assisted Living Facility (ALF) Benefit Amount	N	4	The current daily benefit amount for Assisted Living Facility/Other Facility Care. If the benefit is paid as weekly or monthly, the daily amount should be derived by dividing by 7 or 30.4 respectively, rounding to whole dollars. If the insured has inflation protection, this field should reflect the current daily benefit amount, as inflated.	Numeric value without commas, decimals or dollar signs. 7777 = Unlimited daily benefit amount 8888 = No ALF Benefit

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
35	Automatic Inflation Protection or Benefit Increase Type	A	3	Indicates the type of inflation protection or benefit increase provided in the policy.	ABI = Automatic annual compound inflation protection, funded on level issue-age basis ASI = Automatic annual simple inflation protection, funded on level issue-age basis GIP = Graded inflation protection; both benefits and premiums increase by specified amount each year SIP = Step-rated design where nature of inflation protection changes over time or at certain attained ages CPI = General consumer price index LCI = Long Term Care specific consumer price index OTI = Other price index value CDI = Carrier determined index FPO = Future Purchase Option OTH = Other (but not to include Future Purchase Option/Guaranteed Purchase Option/Benefit Increase Offer) NIP = No inflation protection or benefit increase
36	Inflation Protection or Benefit Increase Amount or Index Value	N	5 (2.2)	This field provides the annual percentage of inflation protection or benefit increase provided in the policy (e.g., 2%, 3%, 5%). If the annual increase is tied to an index, as indicated in field #35, apply the current index value.	If the annual increase is tied to an index, as indicated in field #35, apply the current index value. Percentage value with two decimal points (e.g., 02.50) 88.88 = If field 35 equals NIP 99.99 = If annual increase amount is determined by a method other than use of a percentage value or index
37	Inflation Protection Duration: Attained Age of Insured	N	1	Indicates if automatic inflation protection stops at an attained age of the insured.	1=Yes, inflation protection stops at an attained age 0=No, inflation protection does not stop at an attained age If field 35 = NIP or there is no limit on inflation protection, this field may be zero-filled.

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
38	Attained Age at Which Inflation Protection Ends	N	3	Indicates attained age of insured when automatic inflation protection ends.	Numeric value in years If field 35 = NIP or there is no limit on inflation protection, this field may be zero-filled.
39	Inflation Protection Duration: By Policy/Certificate Duration	N	1	Indicates if automatic inflation protection stops after a specified policy/certificate duration.	1=Yes, inflation protection stops after a specified policy/certificate duration 0=No, inflation protection does not stop after a specified policy/certificate duration If field 35 = NIP or there is no limit on inflation protection, this field may be zero-filled.
40	Policy/Certificate Duration at Which Inflation Protection Ends	N	2	Indicates the duration of the policy/certificate when automatic inflation protection ends.	Numeric value in years If field 35 = NIP or there is no limit on inflation protection, this field may be zero-filled.
41	Inflation Protection Duration Type: Life of Policy/Certificate	N	1	Indicates if automatic inflation projection continues for the entire duration of the policy/certificate.	1=Yes, inflation protection continues for entire duration of the policy/certificate 0=No, inflation protection does not continue for the entire duration of the policy/certificate
42	Inflation Protection Duration Type: When Benefit has Doubled	N	1	Indicates if automatic inflation protection ends when the benefit has doubled.	1=Yes, inflation protection ends when benefit has doubled 0=No, inflation protection does not end when benefit has doubled If field 35 = NIP or there is no limit on inflation protection, this field may be zero-filled.
43	Inflation Protection Duration Type: Other Trigger Type	N	1	Indicates if automatic inflation protection ends by some trigger other than the triggers described in fields 37, 39, or 42.	1=Yes, inflation protection ends by some other trigger 0=No, inflation protection does not end by a trigger If field 35 = NIP or there is no limit on inflation protection, this field may be zero-filled.
44	Future Purchase Option	A	2	Indicates if the insured has elected or automatically has a Future Purchase Option (FPO) as a provision of their policy or certificate and the type of FPO structure.	YA = Annual FPO YV = FPO, but not Annual NO = No FPO

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
45	Frequency of Future Purchase Option	N	2	Indicates the frequency (in years) with which the FPO offer is made to the insured.	1 = Annual FPO Other numeric value for non-annual FPO offers (e.g. 2 for every 2 years) 0 = No FPO
46	Termination of FPO Option	A	2	Indicates circumstances, if any, under which Future Purchase Option ends	<u>Existing field values</u> 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 = Insured goes into claim and/or is in the elimination period. OT = Other means of ending the offers NO = No FPO <u>Newly added field values</u> 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.

For Individual and Voluntary or Partially Voluntary Group Coverage					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
47	Policy Status at End of Reporting Period	A	1	Indicate the status of the PQ policy at the end date of the current reporting period. Note that values E, V, R, and D would only be reported if that status was obtained at some point during the current reporting period. A policy/certificate may still be I=In force while at the same time having lost PQ status during the reporting period such that Field 48 = NQ.	I = Inforce N = Active in non-forfeiture E = Exhausted benefits V = Voluntary Lapse R = Rescission D = Death T = Not Taken Out (NTO)
48	Partnership Status	A	2	Indicates if the policy remains Partnership Qualified at the end of the reporting period. NQ is assigned if Field 47 equals E, V, R or D. NQ should only be reported once, since persons without PQ policies would be dropped from File 1 in subsequent reporting periods. If a policy loses PQ status during the reporting period (Field 48 = NQ) but the policy is still in force, please indicate field 47 = I.	Space-fill this field when Field 47 = "T" - Not Taken Out (NTO) PQ=Partnership Qualified NQ=No longer Partnership Qualified

For Individual and Voluntary or Partially Voluntary Group Coverage Trailer Record Format					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
1	Reporting Period Begin Date	N	8	Begin date of reporting period. In general, the reporting period begin date for File 1 will be the begin dates of the six month period (e.g. January 1 and July 1)	Format: MMDDYYYY
2	Reporting Period End Date	N	8	End date of reporting period. In general, the reporting period end date for File 1 will be the end dates of the six month period (e.g. June 30 and December 31)	Format: MMDDYYYY
3	Record Count	N	8	Total row count for the current file	Numeric value (count). Total rows in file including the Trailer Record
4	Submitting Carrier Name	AN	50	Carrier name that is submitting the current file	Carrier Name
5	Carrier Contact and Comments	AN	333	Carrier Contact name and telephone contact information to be used for resolving any file issues followed by any other comments desired concerning the current file and empty space to pad the Trailer Record out to the same byte length as the Detail Records	Alphanumeric (freeform). Contact information and any other desired comments concerning the current file followed by blank space

FILE 2: CLAIMANT FILE FOR INDIVIDUAL AND VOLUNTARY OR PARTIALLY VOLUNTARY GROUP COVERAGE

Overview

This file provides information on claimants reported in File 1 who are presently using long-term care benefits under PQ policies.

Criteria for Inclusion

File 2 will include information on all insured with PQ policies or certificates for which the insurer paid at least one claim during the reporting period. Thus, persons who may be eligible for insurance benefits but who had no claims paid during the reporting period will not be included. Please note that claimants reported in File 2 will also be reported in File 1, since they will have active PQ policies or certificates in force. It is possible that an insured began their PQ coverage after the File 1 report date but had a claim shortly after coverage taking effect, thus making them eligible to be reported in File 2 even though they have yet to be included in File 1. In such rare cases, the individual would be included in the subsequent File 1 reporting.

Also, an insured's benefit start date may fall within one of the File 2 reporting periods but the insurer is not yet aware of the claim or has not yet paid at least one claim during the reporting period. In that case, the insurer would report the claimant at the next File 2 reporting submission date and indicate the benefit start date, even if it falls prior to the period covered in the File 2 submission.

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. For example, if an individual exchanges a policy they previously had 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.

Special note for policies that lose PQ status during the reporting period: If a policy loses PQ status during the reporting period for File 2, and a claim was paid for a service provided on a date during which the policy was still 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.

Reporting Frequency

Insurers are required to submit data for File Two as outlined below:

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

General Information/Field Specifications for File 2

File Specifications: all files are fixed width, ASCII. There is no sort-order requirement.

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

Field Formatting Instructions:

Alpha and Alphanumeric Fields:
Includes A - Z (lower or upper case), 0 - 9, spaces, and special characteristics.
Left justified, right space-filled.
Unrecorded or missing values in character fields should be space-filled.

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

Special Notes:
Financial fields should not contain any dollar signs, commas or decimals but may be signed when negative. Please pass the negative sign using the most significant (or left-most) position.
Round dollars to the nearest whole dollar as follows, .50 and above round upward; otherwise downward.
Percentage Fields should have decimals; do not include % symbol.

Reporting Specifications for File 2 -- Claimant File

For Individual and Voluntary or Partially Voluntary Group Coverage Detail Record Format					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
1	Company Code	AN	5	Unique company identifier using NAIC company code. If the block of business was purchased from another carrier, the company code of the acquiring company should be provided. The HHS data repository will develop a unique code for self-funded and FLTCIP plans that do not have NAIC codes.	5 Digit NAIC Code or a uniquely assigned company code for self-funded plans and Federal Employees Long Term Care Insurance Program (FLTCIP)
2	Report Date	N	8	Date on which the report was submitted to HHS.	Format: MMDDYYYY
3	Reporting Period	N	16	Begin date and end date of reporting period. In general, the reporting period for File 2 will be a calendar year quarter (e.g. January 1 to March 31)	Format: MMDDYYYYMMDDYYYY
4	Claimant Social Security Number	N	10	Social security number of insured claimant.	10 digit numeric code (no dashes) 9999999999 if not available
5	Policy Number	AN	30	The unique certificate or policy number assigned by the carrier to the insured.	Any alphanumeric combination as determined by the carrier.
6	First Name	A	30	First name of insured	First Name
7	Middle Initial	A	1	Middle initial in name of insured	Middle Initial Space-fill if unavailable
8	Last Name	A	40	Last name of insured	Last name; include generational suffixes here i.e., JR SR
9	Date of Birth	N	8	Birth date of insured	Format: MMDDYYYY
10	Qualifying Condition	A	1	Indicates whether claimant became eligible for benefits based on ADL deficits, Cognitive Impairment, Both ADL and Cognitive Impairments, or some other benefit trigger.	A = ADL Dependency C = Cognitive Impairment B = ADL and Cognitive Impairment O = Other Benefit Eligibility Trigger(s) Note: 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.

For Individual and Voluntary or Partially Voluntary Group Coverage Detail Record Format					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
11	Benefit Start Date of the Current Claim Period	N	8	Indicates date for which benefit payments began for the current claim being reported. This date should occur after any elimination period has been satisfied, if one is required. The Benefit Start Date is the first day of service or loss for which benefits will be paid. Please note an insured would retain the same Benefit Start Date in subsequent File 2 submissions if they remain on claim continuously. However, if they go off claim then have a second episode of claim, Field 11 would carry a new Benefit Start Date on subsequent File 2 reports.	Format: MMDDYYYY
12	Nursing Home Benefits or Facility Care Benefits Paid During Reporting Period	N	9	Indicates the total amount of benefits paid for nursing home services (or for facility care when benefits for nursing home and ALF are combined in one benefit) during the current reporting period. Fields 12-14 are 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 used for any benefits that are paid purely on the basis of cash. A cash benefit (also called a Disability Payment Benefit) is one that is paid when the insured satisfies the policy's benefit trigger of being Chronically Ill and where payment is made without regard to whether or not the insured uses services.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no benefits of this type paid during reporting period. 666666666 = not applicable for Home Care Only Policies, File 1, Field 21 = HC

For Individual and Voluntary or Partially Voluntary Group Coverage Detail Record Format					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
13	Home Health Care Benefits Paid During Reporting Period	N	9	Indicates the total amount of benefits paid during the reporting period for home health care and related home health care services. Fields 12-14 are 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 used for any benefits that are paid purely on the basis of cash. A cash benefit (also called a Disability Payment Benefit) is one that is paid when the insured satisfies the policy's benefit trigger of being Chronically Ill and where payment is made without regard to whether or not the insured uses services.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no benefits of this type paid during reporting period. 666666666 = not applicable for Nursing Home/Facility Care Only Policies, File 1, Field 21 = NH or FC
14	Assisted Living/Other Facility Benefits Paid During Reporting Period	N	9	Indicates the total amount of benefits paid during the reporting period for assisted living or other non-nursing home facility care. Fields 12-14 are 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 used for any benefits that are paid purely on the basis of cash. A cash benefit (also called a Disability Payment Benefit) is one that is paid when the insured satisfies the policy's benefit trigger of being Chronically Ill and where payment is made without regard to whether or not the insured uses services.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no benefits of this type paid during reporting period. 666666666 = not applicable for Home Care Only Policies, File 1, Field 21 = HC

For Individual and Voluntary or Partially Voluntary Group Coverage Detail Record Format					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
15	Total Cash Benefits Paid During Reporting Period	N	9	Indicates the total amount of benefits paid during the reporting period for cash benefits. Fields 12-14 are 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 used for any benefits that are paid purely on the basis of cash. A cash benefit (also called a Disability Payment Benefit) is one that is paid when the insured satisfies the policy's benefit trigger of being Chronically Ill and where payment is made without regard to whether or not the insured uses services.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no benefits of this type paid during reporting period. 666666666 = not applicable for policies with no cash benefit.
16	Other Benefit Amounts Paid During Reporting Period	N	9	Indicates the total amount of benefits paid during the reporting period for all benefits paid other than nursing home, home and community care, assisted living/other facility care, or cash benefits.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no benefits of this type paid during reporting period. 666666666 = not applicable for policies with no cash benefit.
17	Total Lifetime Benefits Paid to Date	N	9	Indicates the total amount of benefits paid under the policy or certificate to date as of the end of the reporting period.	Numeric value (in dollars) rounded to the nearest dollar amount.
18	Remaining Lifetime Benefits for all Pools Combined (Dollars)	N	9	Indicates the total amount of benefits remaining under the lifetime maximum (for all pools combined) as of the end of the reporting period where the Lifetime Maximum Structure for the policy/certificate as reported in File 1, Field 24 = S indicating a single lifetime maximum for all covered services.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no remaining lifetime benefits at end of this reporting period. 666666666 = not applicable (policy has multiple Lifetime Maximums) 777777777 = Unlimited Lifetime Benefits 999999999 = Lifetime benefit expressed in days

For Individual and Voluntary or Partially Voluntary Group Coverage Detail Record Format					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
19	Remaining Lifetime Nursing Home Benefits or Facility Care Benefits (Dollars)	N	9	Indicates the total amount of nursing home benefits (or for facility care if both nursing home and ALF are included in one pool) remaining for the policy or certificate as of the end of the reporting period, if the lifetime maximum for nursing home benefits or facility care is expressed in dollars. This field is used where the Lifetime Maximum Structure for the policy/certificate as reported in File 1, Field 24= M indicating multiple lifetime maximum pools.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no remaining benefits of this type at the end of this reporting period. 666666666 = not applicable (policy has Single Lifetime Maximum) 777777777 = Unlimited Lifetime Benefits 999999999 = Lifetime benefit expressed in days
20	Remaining Lifetime Home Health Care Benefits (Dollars)	N	9	Indicates the total amount of home health care benefits remaining for the policy or certificate as of the end of the reporting period, if the lifetime maximum for home health care benefits is expressed in dollars. This field is used where the Lifetime Maximum Structure for the policy/certificate as reported in File 1, Field 24= M indicating multiple lifetime maximum pools.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no remaining benefits of this type at the end of this reporting period. 666666666 = not applicable (policy has Single Lifetime Maximum) 777777777 = Unlimited Lifetime Benefits 999999999 = Lifetime maximum expressed in days 888888888 = No second pool of dollars
21	Remaining Lifetime ALF/Other Facility Benefits (Dollars)	N	9	Indicates the total amount of ALF/Other Facility benefits remaining in the policy or certificate as of the end of the reporting period, if the lifetime maximum for home health care benefits is expressed in dollars. This field is used where the Lifetime Maximum Structure for the policy/certificate as reported in File 1, Field 24= M indicating multiple lifetime maximum pools.	Numeric value (in dollars) rounded to the nearest dollar amount. Zero-fill if no remaining benefits of this type at the end of this reporting period. 666666666 = not applicable (policy has Single Lifetime Maximum) 777777777 = Unlimited Lifetime Benefits 999999999 = Lifetime maximum expressed in days 888888888 = No third pool of dollars

For Individual and Voluntary or Partially Voluntary Group Coverage Detail Record Format					
Field Number	**Field Name**	**Field Type**	**Field Length**	**Field Definition**	**Field Values**
22	Remaining Single Lifetime Maximum or Lifetime Nursing Home Benefits (Days)	N	5	Indicates the total amount of single lifetime maximum or nursing home benefits remaining for the policy or certificate as of the end of the reporting period, if the single lifetime maximum or lifetime maximum for nursing home benefits is expressed in days. This field is used where the Lifetime Maximum Structure for the policy/certificate as reported in File 1, Field 24 = either S or M. This is a dual purpose field.	Numeric value (in days). Zero-fill if no remaining benefits of this type at the end of this reporting period. 77777 = Unlimited Lifetime Benefits 99999 = Pool maximum expressed in dollars
23	Remaining Lifetime Home Health Care Benefits (Days)	N	5	Indicates the total amount of home health care benefits remaining for the policy or certificate as of the end of the reporting period, if the lifetime maximum for home health care benefits is expressed in days.	Numeric value (in days). Zero-fill if no remaining benefits of this type at the end of this reporting period. 77777 = Unlimited Lifetime Benefits 99999 = Pool maximum expressed in dollars 88888 = No second pool of days
24	Remaining Lifetime ALF/Other Facility Care Benefits (Days)	N	5	Indicates the total amount of ALF/Other Facility benefits remaining in the policy or certificate as of the end of the reporting period, if the lifetime maximum for ALF/Other Facility benefits is expressed in days.	Numeric value (in days). Zero-fill if no remaining benefits of this type at the end of this reporting period. 77777 = Unlimited Lifetime Benefits 99999 = Pool maximum expressed in dollars 88888 = No third pool of days

GLOSSARY AND DEFINITIONS

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

Assisted Living/Other Facility Benefits Paid During Reporting Period
The total dollar amount of benefits paid during the reporting period for care provided in an Assisted Living Facility or similar Alternate Care Facility other than a nursing home.

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

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

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

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

Chronically Ill
Means that You have been certified by a Licensed Health Care Practitioner as: being unable to perform, without Substantial Assistance from another person, at least two (2) Activities of Daily Living for a period that is expected to last at least ninety (90) consecutive days due to a loss of functional capacity; or requiring Substantial Supervision to protect Yourself from threats to health and safety due to a Severe Cognitive Impairment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inflation Protection Duration Type: Attained Age of Policy/Certificate
The type of inflation protection that ends when the insured has received annual benefit increases for a predefined number of years (e.g., 10 or 20 years).

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

Inflation Protection Duration: When Benefit Has Doubted
The type of inflation protection that continues until the daily benefit amount for nursing home care has doubled from its original value at time of purchase.

Lifetime Policy Maximum for ALF/Other Facility Care Benefits (Days)
If the coverage uses days of benefit received to calculate the policy maximum and has separate pools for the major covered services, this is where the number of days which represents the lifetime maximum paid for assisted living facility care would be specified.

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

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

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

Lifetime Policy Maximum for Home Health Care (Dollars)
If the coverage uses a pool of dollars design and has separate pools for the major covered services, this is where the dollar amount which represents the lifetime maximum paid for home health care would be specified.

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

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

benefit structure today is a single Lifetime Maximum for all covered services, there are some policies being sold today which have separate Lifetime Maximums for these major covered services.

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

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

Number of Persons Insured with Core Coverage
Indicates the number of covered lives enrolled in the core plan coverage offered by the employer.

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

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

Original Coverage Effective Date as Partnership Qualified (PQ) Policy
The date that coverage first became effective under the policy or certificate help by the insured.

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

Partnership Status
Certain types of changes to one's policy or certificate may result in the loss of Partnership-qualified status. These are defined by the rules and regulations adopted by

each state for the operation of its Partnership program. This variable simply indicates whether the policy or certificate continues to retain its Partnership qualified status or if a change in coverage of some sort has resulted in the policy no longer being Partnership Qualified.

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

Policy/Certificate Age at which Inflation Protection Ends
The type of inflation protection that ends when the insured has received annual benefit increases for a predefined number of years. Value refers to the actual number of years which are specified in the coverage.

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

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

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

Policy Status at End of Reporting Period
Indicates whether the policy is still in force, whether the insured is in non-forfeiture benefits or whether the policy has terminated during the reporting period for any number of possible reasons. The policy may no longer be in force because the insured has exhausted all their benefits, because they have died, because they have voluntarily elected to lapse coverage, because coverage has been rescinded, or because the policy was "Not Taken Out (NTO)" as defined above.

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

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

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

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

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

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

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

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

Report Date
The date on which the Registry File is submitted.

Reporting Period
The period for which reporting on each file is required. File 1 -- The Registry File is filed semi-annually and is required to cover the period January 1 through June 30th and July

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

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

Termination of FPO Option
Indicates when the FPO offers end. For some policies they may continue for the life of the policy even while the insured is on claim; for others they may end when the individual is on claim or within a specified time period of having received benefits. The FPO offers may end at a defined age or when the insured has declined a certain number of increase offers.

Total Cash Benefits Paid During Reporting Period
The total dollar amount of benefits paid on a cash basis during the reporting period.

Total Lifetime Benefits Paid to Date
Indicates the total amount of benefits paid under the certificate to date as of the end of the reporting period.

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

RETURN TO:

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[http://aspe.hhs.gov/_/office_specific/daltcp.cfm]

Assistant Secretary for Planning and Evaluation (ASPE) Home
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