PLAN OF ACTION REQUIREMENTS

for

The Connecticut PARTNERSHIP FOR LONG-TERM CARE™

REVISED SEPTEMBER 2022

The purpose of this document is to assist insurers in writing the Plan of Action.

The Plan of Action should be submitted to the Office of Policy and Management (OPM) at the time a policy is filed with OPM for review and approval as a Connecticut Partnership for Long-Term Care policy. Before a policy can be filed with the Insurance Department for approval as a Partnership policy, OPM must approve the policy forms and the Plan of Action.

For additional information, please call the Connecticut Partnership for Long-Term Care at (860) 418-6318.

PLAN OF ACTION REQUIREMENTS

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Section 38a-475-5(e) of the Insurance Department regulation outlining requirements for approval of long-term care insurance policies under the Connecticut Partnership for Long-Term Care states that: "Each insurer shall, prior to Partnership-approval by the Insurance Department, submit to the Office of Policy and Management a plan for complying with the information maintenance and documentation requirements set forth in this section."

The purpose of this document is to assist insurers in writing this "Plan of Action". It will do so by describing the major pieces of information required by the regulations and suggesting how to present them. In order to facilitate a speedy review process, ***please include all requested information and answer all the questions.***

I. PROCESS FOR SUBMISSION AND REVIEW:

The Plan of Action should be submitted to the Office of Policy and Management (OPM) at the time a policy is filed with OPM for review and approval as a Connecticut Partnership for Long-Term Care policy. Before a policy can be filed with the Insurance Department for Partnership-approval, OPM must approve the policy forms and the Plan of Action.

Insurers shall submit one copy of the Plan of Action to:

Connecticut Partnership for Long-Term Care
Office of Policy and Management
450 Capitol Avenue, MS# 52LTC
Hartford, CT 06106-1308
OPM.CTPartnership@ct.gov
(860) 418-6318

When submitting the Plan of Action please include the **Policy Form Number** used for your policy filing. In addition, please include the name, email address and telephone number of a contact person for questions regarding the Plan of Action.

OPM will assist insurers in meeting the Plan of Action requirements.

II. PLAN OF ACTION SECTIONS:

A) Location of and Access to Records:

The Plan of Action must state where the records required in the regulations for the Connecticut Partnership for Long-Term Care will be kept. The records must be available in one location, which is easily accessible to staff of the Department of Social Services (DSS) and the Insurance Department, both of which are based in Hartford, CT. If the records are not kept in Connecticut, as required by **Section 38a-475-5(e)(2)** of the Insurance Department Regulation, the insurer must include a statement in the Plan of Action that the company **"agrees to pay the reasonable expenses incurred by personnel of the State of Connecticut to perform a legitimate record audit of the records for the Connecticut Partnership for Long-Term Care located outside of Connecticut, including travel, lodging and other related necessary expenses."**

Please attach an auditing cost agreement signed by an officer of the company and put on your company's stationery (see Appendix A).

The Plan of Action must also include the name, job title, mailing address, telephone and fax numbers and email address of the person primarily responsible for the maintenance and reporting of the required information and who shall act as a liaison with OPM regarding matters of auditing and reporting of information.

As part of this section, the insurer must include the following statement:

> **"(Name of Company) agrees to give the Connecticut Department of Social Services access, for auditing purposes, to all information described in Section 38a-475-5(b) - "Maintaining Auditing Information" of the Insurance Department regulation. This will be provided on an aggregate basis for all policyholders and on an individual basis for all policyholders who have ever received benefits under a precertified policy."**

In addition, if any records for auditing purposes are to be made available at any other organization or entity other than the insurer, such as an Access Agency, the above statement must be included for each organization that will make records available. Insert the name of the organization where the insurance company's name appears and have the statement appear on the organization's letterhead.

B) Documentation of the Insured Event:

In order for insurance benefits to qualify for asset protection, the policyholder must meet certain tests of functional, cognitive or cognitive/behavioral limitations which are described in the regulation under **Section 38a-475-5(b)(1).** The Plan of Action should state:

1. Which method or methods from among the four ways of documenting the State's definition of the insured event outlined in **Section 38a-475-5(b)(1)** of the regulation the insurer intends to use and in what situations.

2. Who will conduct the assessments.

3. What forms will be used. Copies should be attached. The forms should document in which of the State's Activities of Daily Living **(Dressing, Bathing, Eating, Toileting, Continence and Transferring - see Section 38a-475-2(e) of the regulation)** the person required assistance, and the results of any cognitive and behavioral tests administered. The Plan of Action should specify which cognitive test will be administered.

4. What insured event the insurer will be utilizing. A detailed description should be included as to how all benefit triggers will be measured for the Insured Event. *This should include descriptions of how terms such as "**substantial assistance,"** etc., will be measured.* If the policy's insured event differs from the State's insured event **(see Section 38a-475-2(j) of the regulation)** the Plan of Action must state how the insurer intends to assure there will be proper accounting of those services, which count towards asset protection.

C) Description of Services:

The Plan of Action must specify how the insurer will collect and make available the following information for each policyholder as outlined in **Section 38a-475-5(b)(2**) of the regulation:

1. For the provider of each service the name, address, telephone number and license number, if applicable.

2. The date of each service, and the number of units of service rendered on each date.

3. The type of service rendered. In general, the units of service for nursing facilities, assisted living facilities and chronic disease hospitals will be days. The units of service for Home Health Services and for Community Based Services should be indicated by service codes. Insurers must use the service codes included in the Long-Term Care Uniform Data Set Reporting Requirements and Documentation {UDS}. (See Section F)

4. For each type of service, the insurer must report the amount, which the provider charged by reporting quarter for the service, and the amount, which the insurer paid by reporting quarter, whether on an indemnity, expense incurred, or other basis. Insurers paying indemnity benefits, which are not tied to the provision of services, should report the benefit amounts paid for each day. Copies of invoices for all services must be available for inspection.

The Plan of Action should include all forms, which will be used for the purposes described above in C. 1-4. The Plan of Action should also include a list of services covered under the policy.

D) Access Agency and Assessment Information:

The Plan of Action must specify how the insurer will collect and make available the following information for each policyholder receiving Home Health and/or Community Based Services outlined in **Section 38a-475-5(b)(3)** of the regulation: (See Appendix E for link to a list of currently approved Access Agencies.)

1. Name, address, and telephone number of the Access Agency responsible for the policyholder's plan of care.

2. Copies of all plans of care and of all changes to plans of care. All plans and changes to plans must be dated.

3. Signed and dated copies of all assessments and reassessments.

The Plan of Action should include all forms, which will be used for the purposes described above in D. 1-3, including the actual assessment and reassessment forms.

Please note the name and contact person for each Access Agency that will be utilized for the policy.

E) Payment and Asset Protection Determination Mechanism:

Insurers should provide a clear description of how the policy will determine when benefits are to be paid to an insured person who has met the State's insured event, and how the amount of benefits will be calculated. This description should answer at least the following questions:

1. What is the relationship between providers' charges for services and the amounts paid in benefits? Does the policy pay:

   A) A percentage of charges? If so, what is the percentage?

   B) A percentage of charges up to a cap? If so, please give both the percentage and the cap.

   C) A fixed daily amount?

2. Are amounts paid calculated on a daily, weekly, monthly or other basis? If there are any caps, are they imposed on daily payment amounts, weekly payment amounts, monthly payment amounts, or on some other basis?

The description should also include any aspects of the determination of benefit amounts, which are not specifically covered by these questions.

Coordination With Other Benefits

In addition, insurers must have a mechanism whereby they can determine when other long-term care or health policies are making payments for benefits the insurer's policy also covers. This mechanism is essential if an insurer is to know how much of a particular payment should be credited toward asset protection.

In order to meet this requirement, we suggest that insurers incorporate into their policies a coordination with other benefits provision and use the following language.

> **"COORDINATION WITH OTHER BENEFITS: The benefits of this Policy [Certificate] are designed to supplement NOT duplicate other benefits.**
>
> **If You have any health insurance plan or non-Partnership long-term care plan and You are entitled to benefits under those plans that would also be covered services under this Policy [Certificate], You are required to obtain coverage for those benefits first, prior to using benefits under this Policy [Certificate]. Examples of health insurance plans include, but are not limited to, basic hospital, health maintenance organization (HMO), medical/surgical, major medical plan, Medicare, Medicare managed care plan, and Medicare supplemental programs.**
>
> **If You are eligible to receive benefits under this Policy [Certificate] and any other Partnership-approved long-term care plans, then the plan with the earliest Effective Date shall be deemed to be the primary coverage and the other Partnership-approved plans shall be deemed secondary coverage, in order by Effective Date, from earliest to latest.**
>
> **Any benefit amounts that You are entitled to receive under this Policy [Certificate] will be reduced by any benefits payable by those other plans. This provision will NOT reduce the [Lifetime Maximum Benefit] payable under this Policy [Certificate]."**

(Please note: the Insurance Department will allow a coordination with other benefits provision for Partnership-approved policies as long as the policy remains Partnership-approved, a notice is included providing disclosure to the policyholder, and a report on the effect of a coordination with other benefits provision is sent to OPM - for more details, contact the Insurance Department.)

For those companies choosing not to include a coordination with other benefits provision, an alternative mechanism, which produces the same result as if a coordination with other benefits provision were included, would have to be described in detail in the Plan of Action.

Medicaid Asset Protection Statement

Companies should also include a statement in their policy regarding what criteria must be met in order for insurance payments to count towards Medicaid Asset Protection. The following suggested language is one example:

"WHEN BENEFITS WILL EARN MEDICAID ASSET PROTECTION:

Benefits paid to You, or a provider of long-term care services on your behalf, under this Policy [Certificate] can count towards Medicaid Asset Protection for purposes of eligibility for Connecticut's Medicaid program or any other state's Medicaid program that has a reciprocal agreement with Connecticut's Medicaid program. In order for benefit payments to count towards Medicaid Asset Protection, the conditions in Items 1, 2, and 3 that follow must be met:

1. You have met one of the following Insured Events:

- **You have a documented need for Substantial Assistance with two or more of the following Activities of Daily Living: Dressing, Bathing, Eating, Toileting, Transferring, and Continence; or**

- **You have been assessed using the Mental Status Questionnaire (MSQ) and have seven or more incorrect answers on the MSQ test; or**

- **You exhibit specific behavioral problems requiring daily supervision, (including but not limited to, wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to You or others, and extreme or bizarre personal hygiene habits); and**

  a) You have taken either the MSQ and have four or more incorrect answers, or

  b) You have taken the Folstein Mini-Mental State Examination and achieved a score of 23 or lower.

2. The benefits are paid under this Partnership-approved Policy [Certificate]; and

3. The benefits that are paid for [list all Home and Community-based services] are provided in accordance with a written Plan of Care approved by an Access Agency (the Access Agency must be approved by the Connecticut Partnership for Long-Term Care)."

The following optional section applies when spouses can share or access one another's benefit pool.

["IMPACT ON MEDICAID ASSET PROTECTION WHEN A POLICY COVERS BOTH YOU AND YOUR SPOUSE:

The amount of assets You can protect under a Partnership-approved Policy [Certificate] is equal to the amount of benefits paid for <u>Your care</u>. Please note that Medicaid Asset Protection is only available to the individual actually receiving the benefits. This means that if You receive benefits under this Policy [Certificate] the specific dollar amount of assets You can protect is dependent upon (limited to) the amount of coverage You, as an individual, use for Your long-term care services.

If one Spouse is accessing benefits under this Policy [Certificate], the other Spouse will <u>NOT</u> receive Medicaid Asset Protection for that care. Medicaid Asset Protection is <u>NOT</u> transferable between Spouses. In addition, continued access by one Spouse to this Policy's [Certificate's] benefits could lead to the exhaustion of the Policy's [Certificate's] [Lifetime Maximum Benefit]. In such an event this Policy [Certificate] will terminate."]

This ends the optional section that applies when spouses can share or access one another's benefit pool.

"HOW TO STAY QUALIFIED FOR MEDICAID ASSET PROTECTION UNDER THE PARTNERSHIP:

1. **Each year Your [Daily Benefit Amount] must equal or exceed the minimum inflation-adjusted daily benefit specified by the Connecticut Insurance Department. The inflation-adjusted [Daily Benefit Amount] increase provided to You each year under the [Annual 5% Compounded Inflation Protection] provision will allow You to keep pace with the Department's minimum requirements.**

2. **You were a resident of Connecticut when You applied for and subsequently were issued this Partnership-approved long-term care insurance.**

3. **Benefits paid for Home and Community-based care covered under this Policy [Certificate], count toward Medicaid Asset Protection only when an Access Agency (the Access Agency must be approved by the Connecticut Partnership for Long-Term Care) developed and approved the written Plan of Care. Nursing Facility care need not be approved by an Access Agency to count towards Medicaid Asset Protection. Services may be provided in Connecticut or elsewhere.**

4. **You can accumulate Medicaid Asset Protection wherever Your Policy [Certificate] pays benefits. If You need to access Medicaid to pay for Your care and You want to utilize the Medicaid Asset Protection You have earned, You must apply to Connecticut's Medicaid program or to any other state Medicaid program that has a reciprocal agreement with Connecticut. You must be a resident of and receive care in the state where You apply to Medicaid."**

F) Description of Systems and Reporting Requirements:

The required reports must be sent by a secure Internet email attachment using a fixed file ASCII format (see the ***Long-Term Care Insurance Uniform Data Set {UDS} Reporting Requirements and Documentation*** at the following link - https://portal.ct.gov/OPM/PDPD-HHS-Long-Term-Care/Insurer/Partnership-Insurer-UDS - for details on reporting requirements). Hard copy reports of UDS data files are not permitted. The **UDS Data Transmittal Form (DTF)** and **Coordination With Other Benefits (COB)** report should accompany the quarterly data submission. Copies of the **Asset Protection and Service Summary Reports** sent to policyholders in benefit, must be forwarded quarterly to the Office of Policy and Management. The **DTF, COB, Asset Protection** and **Service Summary** reports may be forwarded by mail, fax or email attachment.

The Plan of Action should include sample copies of the reports (COB Report, Asset Protection Report and Service Summary Report) and a description of standard procedures to be used for maintaining and reporting the required information.

Please include the name, job title, mailing address, telephone and fax numbers and e-mail address of the person who will be responsible for reporting the quarterly data to the Office of Policy and Management.

The following text must appear in the Reporting Section of the Plan of Action:

"[Name of Company] agrees to adhere to all of the reporting requirements set forth in the current version of the Partnership for Long-Term Care, Long-Term Care Insurance Uniform Data Set (UDS) Requirements and Documentation manual, as well as any documentation replacement pages or revisions that may be released throughout our participation in the Connecticut Partnership for Long-Term Care."

For all reports sent to OPM, variables should be reported following the format listed in the **UDS.**

Reports to be provided to OPM as part of the UDS include:

File Contents	**File Name**	**Frequency**
Registry of New Insureds	REGISTRY	Quarterly
Insureds Who Have Changed/Dropped Their Policies	CHANGE	Quarterly
Insureds Assessed for Long-Term Care Benefit Eligibility	ASSESS	Quarterly

(Please note that the reporting on Activities of Daily Living for this report refers to the State's Activities of Daily Living (see Section 38a-475-2(e) of the regulation) plus any other ADLs that are included in the policy.)

Service Payments and Utilization	SERVICES	Quarterly

These required files may change over time. Please refer to the current version of the UDS manual for the most recent reporting requirements.

<u>UDS Test File Requirements</u>:

As part of the Plan of Action submission, each company is required to submit test files (containing dummy data) demonstrating an understanding of UDS File 1 (Registry) and UDS File 2 (Change). Companies already participating in other Partnership states may use existing data stripped of all personal identifiers. These test files must reflect benefit information specific to your company's Connecticut Partnership filing. For example, if a 60-day elimination period is not available under the product that has been filed for Partnership approval, 060 should not appear in the elimination period fields in any of the test records.

The Registry test file must include an adequate number of records (not less than three) to demonstrate that the carrier clearly understands how to report the various features available under their proposed Partnership policy, including, but not limited to: elimination periods, benefit levels and lengths, respite care and case management, non-forfeiture options, available riders, inflation factors and premium information.

The Change File is used to report any type of change triggered by the actions specified on page 23 of the UDS Reporting Requirements and Documentation. These include, but are not limited to, drops (lapses), reinstatements, changes to benefits/riders and shorter coverage options.

The Change test file should include an adequate number of records (not less than three, each of which must report a different type of change) to demonstrate a clear understanding of Change File reporting. At a minimum, the test file must include the three examples of Change activity described below.

For test file purposes, please assume that at least one additional reporting quarter has passed since the Registry data was reported, for example, if you are reporting the Registry data for Q1, report the Change data as if the activity occurred in Q2. At a minimum, please report change records that reflect the following three scenarios.

1. *One of the policyholders reported in your Registry file reviewed his/her coverage during the 30-day free-look period, chose not to take the policy and returned it to the company. Please create a drop record.*

2. *Another of the policyholders reported on the Registry file has reassessed his/her ability to pay the policy's annual premium and contacted his/her agent with the intention of lapsing the policy. In turn, the agent recommended that the insured exercise the shorter coverage option available under the policy. Please report a change record that would meet the CT Partnership shorter coverage option criteria. (Hint: criteria appear in the UDS manual Connecticut Appendix, on page CT-1).*

3. *Yet another of the policyholders has reassessed his/her benefit levels, determined that the NH and HC daily benefit amounts are insufficient and has decided to increase the policy's daily benefits. At the same time, the policyholder has chosen to decrease the policy's total benefit amount. Please create a record that reflects these changes in all of the affected fields.*

Connecticut Partnership staff will thoroughly review the UDS test files and provide comprehensive feedback in writing. You may be asked to revise and resubmit the test files if extensive errors are present.

Four manual reports to be provided quarterly to OPM:

1) UDS Data Transmittal Form **(included in UDS)**
2) Coordination With Other Benefits Report **(see Appendix B) (need only be sent when there is COB to report)**
3) Copies of Asset Protection Reports sent to policyholders in benefit **(see Appendix C)**
4) Copies of Service Summary Reports sent to policyholders who have exhausted their benefits or have requested a copy **(see Appendix C)**

Reports to be provided to Policyholders in benefit (with copies sent to OPM) (see Appendix C for samples):

1) Asset Protection Report
2) Service Summary Report

For the **Asset Protection Report** and **Service Summary Report** to be provided to policyholders, ***please include in the Plan of Action samples of the letters and reports that will be utilized***. These reports should always appear on company letterhead, with a contact name and telephone number. For both of these reports, please include the language and format found in the samples in **Appendix C**.

In addition, insurers should include the following statement in the Plan of Action:

> **"(Name of Company) agrees to allow staff of the Office of Policy and Management to work with (Name of Company) systems staff to resolve any reporting issues that may arise. As the UDS is revised, (Name of Company) agrees to revise its internal systems accordingly."**

According to the regulation (**Sec. 38a-475-5(b)**), insurers must retain all information on all policyholders who have ever received benefits, for at least five years after the policy is no longer in force. Please include in your Plan of Action the insurer's plan for retention of records.

G) Step-Down Coverage

The regulation requires that insurers proactively offer policyholders who are about to lapse their policy the option to switch their coverage to a lower amount **(see Section 38a-475-4(c)(11) of the regulation**). The Plan of Action should include a sample letter that the insurer will send to policyholders to comply with this regulation **(see Appendix D).** The policyholder should receive this letter before their policy lapses. Please include an explanation of how your company will proactively offer the reduced benefit option, including when these letters would be sent and how your system will be able to track whether the letter has been sent.

H) Denied Survey

As part of its research and evaluation of the Partnership, the State conducts several surveys. One survey is the **Survey of Persons Denied Insurance**. This survey is required to be sent out by insurers 2-3 days after sending out their own denial or deferral letter **(see Section 38a-475-4(c)(8) of the regulation)**. OPM supplies surveys, cover letters, return envelopes and State of Connecticut envelopes; insurers cover the cost of mailing the survey. Please include in the Plan of Action the name, mailing address, telephone number and email address of the person who will be responsible for handling the Denied Survey. A description of the system that will be used to assure that all applicants denied coverage will be sent the survey should also be included. For example, indicate which department will be responsible for sending out the survey and what mechanism will be in place to know the survey has been sent.

I) Agent/Producer Training

In order for a producer (agent or broker) to be able to sell a Partnership policy, they must complete seven hours of training on long-term care insurance and the Partnership **(see Section 38a-475-4(c)(10) of the regulation)**. Please describe the procedure your company will follow to keep track of which producers have completed the Partnership certification training. For example, when a Partnership application is submitted, describe how you will know whether the producer who signed the application has been properly certified by the Partnership.

Please complete and sign the Producer Training Certificate Authorization Form. (**See Appendix H**). This Authorization Form allows the Partnership office to sign producer training certificates on State letterhead on behalf of the participating insurance companies.

J) Purchaser Residency Issues

Only Connecticut residents can purchase a Partnership policy. Residency means that they have a bona-fide (i.e., not a P.O. Box) Connecticut residence address. An individual does not need to live in Connecticut a certain number of days each year in order to be considered a resident for Partnership purposes. Please explain how your company will check that the applicant is a Connecticut resident. A Connecticut address for the applicant must be included in the application. A statement on the application can also be included that says a person must be a Connecticut resident in order to purchase a Connecticut Partnership policy. This statement can act as a reminder to producers and consumers regarding the residency requirement.

K) Minimum Daily Benefits

The Insurance Department regulation governing Partnership policies requires that there be minimum daily benefits for nursing home care and home and community-based care. The minimums go up 5% compounded each year and apply to policies applied for in a calendar year. Please also note that in order for a policy to remain Partnership-approved it must meet or exceed the minimum daily benefit requirements each year. This is accomplished with the required 5% compounded inflation protection feature. However, a policyholder may request that his or her daily benefit level be reduced. It is your responsibility to make sure the daily benefit level is not reduced below the minimum level allowable for that year. If the daily benefit is reduced below the minimum level allowable, the new contract will not be Partnership-approved.

Please describe in the Plan of Action the system you have in place to assure that the minimum daily benefits requirements are met not only for new issues but also for active policies where the policyholder may wish to reduce his or her daily benefit.

L) Participation Agreement

As part of the Plan of Action submission, **Section 38a-475-5(e)(9)** of the Insurance Department regulation requires each insurer to sign a Participation Agreement. (**See Appendix F**.) Please print the Participation Agreement on your company letterhead, replace the words "YOUR COMPANY" with your company name and have an officer of your company sign the Agreement. The Connecticut Partnership Director will then sign the Agreement and return a copy to you.

M) Producer Kit

As part of the Partnership's required Agent Certification training, agents are provided with a "Producer Kit", which includes various materials to help producers in their marketing efforts. These items have been pre-approved by the Partnership and all of the participating companies for use by the producers. **Appendix G** includes a link to these items. Please review these and note your approval of these items, for use by producers, in your Plan of Action. If you have any questions about the materials, please call the Connecticut Partnership for Long-Term Care at (860) 418-6318.

N) Primary Partnership Liaison

In addition to the other contacts requested in this Plan of Action, please include the name, job title, mailing address, telephone number and e-mail address for the individual who will be the primary contact with the Partnership once the policy is approved. This person will be the main liaison regarding all Partnership matters from advertising to auditing and should also be responsible for the dissemination of Partnership information to all of the appropriate staff in their company.

O) **Rate Revision Requests**

As part of the Plan of Action, the insurer must agree to send any rate revision requests to the Office of Policy and Management at the same time the request is made to the Connecticut Insurance Department.

Please review the "Contact Checklist" at the end of the Plan of Action Checklist on Page 16.

III. CHANGES TO THE PLAN OF ACTION:

Whenever changes are necessary to the Plan of Action, insurers should submit a revised Plan of Action for approval to OPM.

IV. PLAN OF ACTION REQUIREMENTS CHECKLIST:

⇒ **I. Process for Submission and Review:**

- ❑ Plan of Action copies sent to OPM.
- ❑ Policy Form number used for policy filing included.
- ❑ Name and telephone number included for insurer's contact for Plan of Action questions.

⇒ **II. A. Location of and Access to Records:**

- ❑ Cost Auditing Agreement and statement (Page 2) in Plan of Action (if records are not kept in Connecticut).
- ❑ Name, job title, mailing address, telephone and fax numbers and email address of person who will act as liaison for matters regarding auditing and reporting of information.
- ❑ Statement agreeing to give access to the Department of Social Services for auditing purposes (Page 2).

⇒ **II. B. Documentation of the Insured Event:**

- ❑ Method(s) to be used.
- ❑ Who will conduct assessments.
- ❑ Assessment forms to be used (functional, cognitive and behavioral information).
- ❑ Detailed description of insurer's insured event and how benefit triggers will be measured.

⇒ **II. C. Description of Services:**

- ❑ Description of how information about each service provider will be collected.
- ❑ Description of how information will be collected on services provided - type of service, date of service, unit of service, amount charged and amount paid.
- ❑ All forms used to collect the above information.
- ❑ List of services covered under the policy.

⇒ **II. D. Access Agency and Assessment Information:**

- ❑ Description of how information about the Access Agency will be made available.
- ❑ Description of how all information regarding plans of care will be collected.
- ❑ Description of how all assessments and reassessments information will be collected.
- ❑ All forms which will be used to collect the above information.
- ❑ Contact person for each Access Agency to be utilized with the policy.

⇒ **II. E. Payment and Asset Protection Determination Mechanism:**

- ❑ Description of how policy will determine when benefits are to be paid.
- ❑ Description of how the amount of benefits will be calculated.
- ❑ Description of how Coordination With Other Benefits will be monitored (include language on page 5).
- ❑ Description of when benefits will earn asset protection (see language on pages 6-8).

⇒ **II. F. Description of Systems and Reporting Requirements:**

- ❑ Name, job title, mailing address, telephone and fax numbers, and e-mail address of UDS reporting contact.
- ❑ COB Report.
- ❑ Asset Protection Report.
- ❑ Service Summary Report.
- ❑ Description of procedures to be used for maintaining and reporting required information.
- ❑ Statements regarding UDS (Pages 8 and 11).
- ❑ Test UDS Diskette.

⇒ **II. G. Step-Down Coverage**

- ❑ Sample of Step-Down letter.
- ❑ Explanation of how insurer will proactively offer the Step-Down Coverage.

⇒ **II. H. Denied Survey**

- ❑ Include name, mailing address, telephone number and email address of person responsible for handling the Denied Survey.
- ❑ Description of system to assure surveys are sent.

⇒ **II. I. Producer Training**

- ❑ Description of process to keep track of agents/producers who have been Partnership certified.
- ❑ Please print the Producer Training Certificate Authorization Form (found in Appendix H) on company stationary, replace "NAME OF COMPANY" with your company name throughout, have the "company representative" complete their section, and have an officer of the company sign the Authorization Form.

⇒ **II. J. Purchaser Residency Issues**

- ❑ Description of process to insure that applicants are Connecticut residents.

⇒ **II. K. Minimum Daily Benefits**

- ❑ Description of system to insure that minimum daily benefit requirements are met.

⇒ **II. L. Participation Agreement**

- ❑ Print Agreement (found in Appendix F) on company stationery, replace "YOUR COMPANY" with your company name and have an officer of the company sign the Agreement.

⇒ **II. M. Producer Kit**

- ❑ Note in Plan of Action approval of items in Appendix G to be used in the Partnership's Producer Kit.

⇒ **II. N. Primary Partnership Liaison**

- ❑ Please include the name, job title, mailing address, telephone number and e-mail for the individual who will be the primary contact with the Partnership once the policy is approved.

Contact Checklist

There are several points in the Plan of Action Requirements where specific contact people have been requested. Please be sure that the following contacts are included in the Plan of Action:

- ❑ Person responsible for questions regarding the Plan of Action. (See bottom of page 1.)
- ❑ Person primarily responsible for the maintenance and reporting of the required information and who shall act as a liaison with OPM regarding matters of auditing and reporting of information. (See middle of page 2.)
- ❑ Person responsible for reporting the quarterly data to OPM. (See of page 8.)
- ❑ Person who will be the primary contact with the Partnership once the policy is approved. This person will be the main liaison regarding all Partnership matters from advertising to auditing and should also be responsible for the dissemination of Partnership information to all of the appropriate staff in their company. (See Section N on page 13.)

APPENDIX A

Put on company letterhead:

AUDITING COST AGREEMENT

(Company Name) will be responsible for the reasonable expenses, according to the State of Connecticut's standard out-of-state per diem allowance, for State of Connecticut audit personnel, when conducting an audit outside of Connecticut for the Connecticut Partnership for Long-Term Care policies. The audit will be completed within a reasonable period of time taking into account the number of records to be reviewed.

The signature below shall constitute acceptance of this letter as an accurate reflection of our concurrence.

_____
Name of officer

_____
Date

_____
Company

APPENDIX B

Coordination with Other Benefits Report

PLEASE PROVIDE THE FOLLOWING INFORMATION:

REPORT QUARTER: _____

COMPANY NAME: _____

CONTACT PERSON: _____

PHONE NUMBER: _____

	CURRENT QUARTER	TO DATE
Total Number of Policyholders Affected by COB Provisions*		
Total Dollar Amount Due to COB Provisions♦		

***** This number should include all policyholders who had any payments reduced under their Partnership policy due to any COB provision (i.e. Partnership policy pays after other insurance pays).

♦This number should include the portion of any bill that your company **did <u>not</u> pay** due to COB provisions. For example: assume a Partnership policy is scheduled to pay up to $100 for a particular service, but not more than the actual charge. The service provided actually cost $150. Other insurance covered $75. The Partnership policy would pay out $75, and the amount reported in this column for this quarter would be $25.

APPENDIX C

ASSET PROTECTION REPORT (Sample)

To be sent quarterly to each insured for whom benefits have been paid during the reporting period. *A copy of this report must be included with the quarterly UDS data submission to the Office of Policy and Management.* This report should appear on company letterhead and include the contact name and telephone number of the person who generated the report.

Policyholder Name
Street Address
Town, State Zip Code

Date:_____
Policy/Certificate #: _____
Quarter Reported: mm/dd/yyyy to mm/dd/yyyy

Dear *Name of policyholder*:

As a Connecticut Partnership for Long-Term Care policyholder, we are providing you with a summary of quarterly and cumulative asset protection activity under the policy/certificate number shown above:

Cumulative Prior Amount of Qualified Asset Protection: $_____

Amount of Asset Protection Earned this Quarter: $_____

Cumulative Total Amount of Qualified Asset Protection: $_____

This report provides you with the total amount of insurance payments, to date, which count toward asset protection for Medicaid eligibility purposes. Please examine this report and carefully compare the cumulative total amount shown above with your current asset total. If your asset protection level is close to the amount of the assets you currently have, you *may be* eligible for the Medicaid program. It is your responsibility to make application to the Connecticut Department of Social Services for the Medicaid program, or the Medicaid program in the state you reside; upon completion of your application an eligibility determination will be made. (*Please note: contact the Connecticut Department of Social Services regarding other exclusions of assets in addition to the earned asset protection listed above.)*

Please bring this report with you at the time of applying for Medicaid. If you have any questions, please feel free to call the State of Connecticut's Partnership office at 800-547-3443 (toll-free anywhere in Connecticut) or 860-418-6318 from out of state.

***Medicaid Asset Protection Reciprocity*: Connecticut Partnership policyholders who relocate to another state may be eligible to receive dollar-for-dollar Medicaid Asset Protection. Two conditions must be met for a policyholder to be eligible for reciprocity in another state: (1) the policyholder must apply to and qualify under the other state's Medicaid program; and (2) at the time the policyholder applies to the other state's Medicaid program, Connecticut must have a reciprocal agreement with that state for the granting of Medicaid Asset Protection. For information on which states have reciprocal agreements with Connecticut, please call the State of Connecticut's Partnership office at 860-418-6318.**

[NOTE TO CONNECTICUT MEDICAID INTAKE WORKER: The Connecticut Partnership for Long-Term Care is summarized in policy transmittal No. UP-92-22 of the Connecticut Department of Social Services. The details of the program are described in the Department of Social Services Uniform Policy Manual, mainly in sections 4022.10, 4026.05, 4099.22, 7520.10 and 7525.10.]

If you have any questions or concerns regarding this report, please contact me at (800) 888-8888.
Sincerely,
Name and Title of the company contact who produced this Asset Protection Report

APPENDIX C

SERVICE SUMMARY REPORT (Sample)

To be sent when insured exhausts benefits, terminates the policy or requests this report. *A copy of each Service Summary Report generated during the reporting period must be included with the quarterly UDS data submission to the Office of Policy and Management.* This report should appear on company letterhead and include the contact name and telephone number of the person who generated the report.

Policyholder Name
Street Address
Town, State Zip Code

Date:_____
Policy/Certificate #: _____
Quarter Reported: mm/dd/yyyy to mm/dd/yyyy

Dear *Name of policyholder*:

As a Connecticut Partnership for Long-Term Care policyholder, we are providing you with important information pertaining to the asset protection earned under the policy/certificate number shown above:

Total Amount of Asset Protection Earned To Date: $_____

This report provides you with the total amount of insurance payments, to date, which count toward asset protection for Medicaid eligibility purposes. Please examine this report and carefully compare the amount shown above with your current asset total. If your asset protection level is close to the amount of the assets you currently have, you *may be* eligible for the Medicaid program. It is your responsibility to make application to the Connecticut Department of Social Services for the Medicaid program, or the Medicaid program in the state you reside; upon completion of your application an eligibility determination will be made. (*Please note: contact the Connecticut Department of Social Services regarding other exclusions of assets in addition to the earned asset protection listed above.)*

Please bring this report with you when applying to the Medicaid program. If you have questions pertaining to the Connecticut Medicaid program, please feel free to call the State of Connecticut's Partnership office at 800-547-3443 (toll-free anywhere in Connecticut) or 860-418-6318 from out of state.

***Medicaid Asset Protection Reciprocity*: Connecticut Partnership policyholders who relocate to another state may be eligible to receive dollar-for-dollar Medicaid Asset Protection. Two conditions must be met for a policyholder to be eligible for reciprocity in another state: (1) the policyholder must apply to and qualify under the other state's Medicaid program; and (2) at the time the policyholder applies to the other state's Medicaid program, Connecticut must have a reciprocal agreement with that state for the granting of Medicaid Asset Protection. For information on which states have reciprocal agreements with Connecticut, please call the State of Connecticut's Partnership office at 860-418-6318.**

[NOTE TO CONNECTICUT MEDICAID INTAKE WORKER: The Connecticut Partnership for Long-Term Care is summarized in policy transmittal No. UP-92-22 of the Connecticut Department of Social Services. The details of the program are described in the Department of Social Services Uniform Policy Manual, mainly in sections 4022.10, 4026.05, 4099.22, 7520.10 and 7525.10.]

If you have any questions or concerns regarding this report, please contact me at (800) 888-8888.

Sincerely,

Name and Title of the company contact who produced this Service Summary Report

APPENDIX D

NOTIFICATION OF OPTION TO REDUCE COVERAGE TO SHORTER BENEFIT PERIOD

To be sent to policyholders proactively when they are about to lapse their coverage due to non-payment of premium. This report should be on company stationery.

Date: _____
Policy/Certificate #: _____

Dear _____:

Our records indicate that your Long-Term Care insurance is about to be terminated for non-payment of premium.

In an effort to make your policy more affordable to you, you have the option to reduce your [Lifetime Maximum Benefit] and reduce your premium. You will have [30 days] after the end of the Grace Period to exercise this option. The premium for the new [Lifetime Maximum Benefit] amount will be based on your age at the time your policy [certificate] was originally issued. The reduced coverage amount will take into account any increases in coverage that have accrued due to the [Compound Benefit] provision in your policy [certificate]. For example, if your [Lifetime Maximum Benefit] grew from $100,000 to $200,000, the reduction must be taken from the $200,000 amount,

The [Daily, Weekly and Monthly Benefit] amounts will NOT be reduced, rather they will continue to increase according to the [Compound Benefit] provision. For example, if your [Daily Benefit] grew from $200 to $400, then after any reduction under this provision the [Daily Benefit] must be $400 and will continue to increase annually. All other provisions of your policy will remain the same.

Please call us at [telephone number] if you are interested in this option and we can provide you further details on how you can lower your premium.

APPENDIX E

ACCESS AGENCIES APPROVED FOR PARTICIPATION IN THE CONNECTICUT PARTNERSHIP FOR LONG-TERM CARE

Please visit the CT Partnership website at

https://portal.ct.gov/OPM/PDPD-HHS-Long-Term-Care/Insurer/Partnership-Insurer-Access-Agencies

to get the most up-to-date listing of approved Access Agencies.

APPENDIX F

Instructions: Please print this Participation Agreement on company stationery, replace the words ***{YOUR COMPANY}*** with your company name and have an officer of the company sign the Agreement.

Participation Agreement
Between
{YOUR COMPANY}
and the
State of Connecticut

Regarding {*YOUR COMPANY's*} Participation in the Connecticut Partnership for Long-Term Care

In addition to all Connecticut Partnership for Long-Term Care regulatory requirements, including provisions found in the Plan of Action, the {***YOUR COMPANY***} agrees to:

- Maintain a quality and competitive Partnership policy, including upgrading the Partnership plan no later than when the comparable non-Partnership plan is upgraded and keeping premiums comparable between the Partnership and non-Partnership plans for similar benefits. This includes filing Partnership and comparable non-Partnership policies for review with the Office of Policy and Management (OPM) and the Insurance Department.

- Adequately train ***{YOUR COMPANY}*** staff responsible for responding to information requests from the public regarding its Partnership policy, including staffing ***{YOUR COMPANY}*** toll-free Partnership information telephone number with personnel knowledgeable about the Partnership and ***{YOUR COMPANY}*** Partnership plan.

- Provide OPM with the required Partnership quarterly reports in a timely manner, as set forth in the Plan of Action and the Uniform Data Set, and review the data files for errors and inconsistencies prior to their submission to OPM.

- Continue to adhere to all Partnership requirements set forth in regulation and the Plan of Action relevant to existing Partnership policyholders if ***{YOUR COMPANY}*** decides to no longer market its Partnership policy.

_____ _____
{Title of Officer} Date
{YOUR COMPANY}

_____ _____
Connecticut Partnership for Long-Term Care Date
Office of Policy and Management
State of Connecticut

APPENDIX G

Instructions: *Please print this Authorization on company stationery, replace the words {YOUR COMPANY} with your company name, and have an officer of the company sign the Authorization.*

Producer Training Certificate Authorization

No producer will be authorized to market, sell, solicit or otherwise contact any person for the purposes of marketing a Partnership-approved long-term care insurance policy or certificate unless the producer has completed seven hours of training on long-term care insurance in general and the Connecticut Partnership for Long-Term Care specifically. Such assurances shall be in the form of a document signed by the producer and a representative of {***YOUR COMPANY***}. Such document shall be known as a "Producer Training Certificate".

- {***YOUR COMPANY***} authorizes the Director of the State of Connecticut's Partnership for Long-Term Care program to sign the "Producer Training Certificate" as the representative of {***YOUR COMPANY***}. {***YOUR COMPANY'S***} name shall not appear on the "Producer Training Certificate". By virtue of this authorization, the signature of the Director of the State of Connecticut's Partnership for Long-Term Care program on the "Producer Training Certificate" shall meet the requirement found in Insurance Department regulation Section 38a-475-4(c)(10) specifying that the "Producer Training Certificate" shall be signed by a representative of the insurance company.

  This authorization shall only be used for the purposes of meeting the Insurance Department requirement that a signature from an insurance company representative appear on the "Producer Training Certificate".

_____ _____

Name Date
{Title of Officer}
{YOUR COMPANY}