Partnership for Long-Term Care

LONG-TERM CARE INSURANCE UNIFORM DATA SET

Reporting Requirements and Documentation

Revised
January 2023

Maintained collaboratively by the four participating States

California • Connecticut • Indiana • New York

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INTRODUCTION

This revised document presents the Uniform Data Set (UDS) reporting requirements and documentation as of Quarter 4, 2005 for insurers participating in the Partnership for Long-Term Care. The Partnership originated as a demonstration program under a grant from the Robert Wood Johnson Foundation (RWJF).

The UDS was developed collaboratively among the four states participating in the Partnership program, participating insurers, the National Program Office at the Center on Aging, University of Maryland, and the Program Evaluator, Laguna Research Associates. The UDS provides information important for program monitoring, provides information on assessment and service utilization, and provides quarterly and cumulative data for analysis by each of the participating states.

The UDS was negotiated by the four participating State programs in an effort to accommodate insurers who may wish to participate in more than one state. The State programs are:

- California Partnership for Long-Term Care
- Connecticut Partnership for Long-Term Care
- Indiana Long Term Care Program
- New York State Partnership for Long-Term Care

An overview of the reporting requirements and general reporting procedures are presented below. The remainder of the document provides detailed file information, file formats, and data field descriptions.

Overview of the Requirements

Four (4) data files are required from each insurer. Insurers will submit data directly to each state program in which they are participating. The file names to be used in transmission of the data from the insurer to the states and the frequency of reporting required are listed below. All reporting periods are based on the calendar year.

	File Contents	File Name	Frequency
1.	Registry of New Insureds	REGISTRY	Quarterly
2.	Insureds Who Have Changed/Dropped Their Policies	CHANGE	Quarterly
3.	Insureds Assessed for Long-Term Care Benefit Eligibility	ASSESS	Quarterly
4.	Service Payments & Utilization	SERVICES	Quarterly

General Reporting Procedures

Files should be transmitted by email and are due at the respective state program offices 30 days after the close of the reporting quarter. Data should be transmitted utilizing file encryption or zipped files or a secure email message service that satisfies the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

Data files are to be formatted into fixed-length text files, with a carriage return at the end of each line. Each record must contain the exact number of characters specified in the file format.

Data files are to be accompanied by a UDS data transmittal form (see Figure 1 on page 3 for a sample form) that gives the insurer's name, the quarter end date, the number of records transmitted in each file, the total number of applications received during the reporting period, the total number of applications with a denial date during the reporting period, and the total number of policies in force as of the end of the reporting period. If no data are transmitted for one or more of the files, the record count for those files should be reported as 0 (zero) on the form.

Figure 1

LONG-TERM CARE INSURANCE
UNIFORM DATA SET
DATA TRANSMITTAL FORM

State Reporting: _____

Quarter Ending: _____

Company Name: _____

Submitted By: _____

Telephone #: _____

Email Address: _____

Number of UDS Data Files Transmitted: _____

	FILE NAME	**FREQUENCY**	**NUMBER OF RECORDS TRANSMITTED**
1.	REGISTRY	Quarterly	_____
2.	CHANGE	Quarterly	_____
3.	ASSESS	Quarterly	_____
4.	SERVICES	Quarterly	_____

Applications Received (Total number of applications that arrive at the company office during the reporting period: _____

Applications Denied (Total number of applications with a denial date during the reporting period): _____

Total Policies In Force at End of Quarter (A snapshot count of all policies in force as of the end of the reporting period): _____

UDS data files and any related materials are to be submitted to the state contact person listed below. Any questions regarding submission to the state should be addressed to the contact person listed.

State	Contact Person/ Telephone Number	Address
California	Raul Moreno ph. (916) 713-8297 fax (916) 552-8989	California Department of Health Care Services Integrated Systems of Care Division California Partnership for Long-Term Care 1501 Capitol Avenue, MS 4502 P.O. Box 997437 Sacramento, CA 95899-7437 Email: raul.moreno@dhcs.ca.gov
Connecticut	Cody Clark ph. (860) 418-6318 fax (860) 706-1448	Connecticut Partnership for Long-Term Care Office of Policy and Management 450 Capitol Avenue, MS#52LTC Hartford, CT 06106-1379 Email: OPM.CTPartnership@ct.gov
Indiana	Rebecca Vaughan ph. (317) 232-2187 fax (317) 232-5251	Indiana Long Term Care Partnership Office Indiana Department of Insurance 311 W. Washington Street, Suite 300 Indianapolis, IN 46204-2787 Email: rvaughan@idoi.in.gov
New York	Courtney Karl ph. (518) 474-0662 fax (518) 474-1428	New York State Partnership for Long-Term Care Department of Health Room 1620 One Commerce Plaza 99 Washington Avenue Albany, NY 12210 Email: Courtney.Karl@health.ny.gov

FILE INFORMATION, FILE FORMAT AND FIELD DEFINITIONS

This section presents the following type of information for each of the four (4) files that are part of the Uniform Data Set:

- File Information: Frequency of submission, record definition, and event that triggers a record to be submitted.
- File Format: Listing of fields, including the field number, field name, field position, field type, and field length.
- Field Definitions: Each definition contains the field number, field name, field type and length (in parentheses), field definition and coding definitions. Some field definitions contain state-specific instructions to insurers.

Below are some general field coding instructions that apply across all of the four files.

Field Type: Three types of fields are used in this documentation. They are:

A = Alphanumeric (accepts both alpha and numeric codes)
N = Numeric (accepts only numeric codes; for computational fields)
D = Date

Field Length: The length of each field is indicated by a number following the Field Type indicator. For example, a field that is Alphanumeric and three digits long would be indicated as "A-3".

Data Entry: How the data is entered into the fields depends upon type of field. Instructions for how each Field Type is filled are given below:

Type	Justification	Fill	Instructions
A	Left	Blanks	Alpha characters in caps
N	Right	Zeros	No commas
D	N/A	N/A	Format: MMDDYYYY or MMYYYY

Fields that are Not Applicable: As indicated in the field definitions below, some fields may not be applicable to certain insurers or to certain States. The symbol "8" is used through the Uniform Data Set to indicate that the reported field is not applicable.

State-Specific Appendices: Throughout the field definitions below, some fields have one or more superscripted state abbreviations to the left of the field number. These abbreviations indicate the state(s) for which there is additional documentation for that particular field in the corresponding State-Specific Appendix, located at the end of this document. If there is a state abbreviation located to the left of a field number, carriers should look to the appropriate State-Specific Appendix for further instructions on reporting that field in that state.

File 1: Registry of New Insureds

File Information

Frequency: Quarterly, on a calendar year basis. Reports are due 30 days after the close of the reporting period.

Record Definition: One record for each applicant who passes underwriting during the reporting period. Information should be for the insured only and not the purchaser, if the purchaser is someone other than the insured. Each spouse/partner covered under any type of multi-life or joint-life or shared benefit policy must be reported individually.

Trigger: Favorable underwriting decision made on applicant.

File 1: Registry of New Insureds

File Format

	Field Name	Position	Field Type/Length
1.	Option Type	1	A-1
2.	Company Code	2	N-3
3.	Policy Form Number	5	N-8
4.	Original Effective Policy Date	13	D-8
5.	Policy Category	21	A-1
6.	Social Security Number	22	A-9
7.	First Name	31	A-15
8.	Middle Initial	46	A-1
9.	Last Name	47	A-20
10.	Date of Birth	67	D-8
11.	Sex	75	A-1
12.	Marital Status	76	A-1
13.	Day Phone	77	A-10
14.	Evening Phone	87	A-10
15.	Address Line 1	97	A-35
16.	Address Line 2	132	A-35
17.	City	167	A-25
18.	State	192	A-2
19.	Zip Code	194	A-9
20.	Purchase Type	203	A-1
21.	Policy Type (NH/HC)	204	A-1
22.	Elimination Period (Days): NH	205	N-3
23.	Elimination Period (Days): HC	208	N-3
24.	Percentage of Costs	211	N-3
25.	Maximum Per Diem: NH	214	N-5
26.	Maximum Amount: NH	219	N-7
27.	Maximum Length (Days): NH	226	N-4
28.	Maximum Per Diem: HC	230	N-5
29.	Maximum Amount: HC	235	N-7
30.	Maximum Length (Days): HC	242	N-4
31.	Maximum Amount: Total	246	N-7
32.	Maximum Length (Days): Total	253	N-4
33.	Respite Service Days	257	N-2
34.	Care Management Days	259	N-2
35.	Non-Forfeiture Benefit	261	A-1
36.	Options or Riders In Force - 1	262	A-1
37.	Options or Riders In Force - 2	263	A-1

	Field Name	Position	Field Type/Length
38.	Options or Riders In Force - 3	264	A-1
39.	Options or Riders In Force - 4	265	A-1
40.	Inflation Protection Mode: Daily Benefit	266	A-1
41.	Inflation Protection Percentage: Daily Benefit	267	N-2
42.	Inflation Protection Mode: Lifetime Maximum Benefit	269	A-1
43.	Inflation Protection Percentage: Lifetime Maximum Benefit	270	N-2
44.	Annualized Premium	272	N-7
45.	Type of Premium	279	A-1
46.	Premium Payment Mode	280	A-1
47.	Lapse Contact Designated	281	A-1
Total Record Length:		281	

File 1: Registry of New Insureds

Field Definitions

1. Option Type (A-1): Report this field as 8 = Not Applicable.

   8 = Not applicable

2. Company Code (N-3): Unique, confidential company identifier issued to insurers by project staff. The company code is the same for each company across the states.

CA,CT,IN,NY 3. Policy Form Number (N-8): Unique policy identifier issued to insurers by project staff.

4. Original Effective Policy Date (D-8): Original effective date of the policy. For group policies, this date should be defined as the effective date of coverage of the individual certificate (as opposed to the effective date of coverage of the group policy).

   The Original Effective Policy Date as reported in the UDS is used as a unique identifier and should never change, even if there are subsequent changes to the policy that result in a policy re-issue. This date should remain the same for a given policyholder and policy across all files.

   MMDDYYYY

CA 5. Policy Category (A-1): This field provides information related to two dimensions of the policy: 1) how the policy is filed with the state insurance department, and 2) how the policy is marketed.

   A = Individual Policy is filed as an "Individual" policy with the state insurance department and *each insured receives an individual policy*. Policy marketed and issued directly from the insurer to the insured.

   B = Group Policy is filed with the state insurance department as a "Group" policy. Group policy contracts are made with an employer or other entity (e.g. association) that covers a group of persons identified as individuals by reference to their relationship to the entity. The actual policy is held by the employer or other entity. Each *insured receives a certificate* under the policy, rather than an individual policy. The policy is marketed and sold through the group.

C = Organization Sponsored Policy is filed as an "Individual" policy with the state insurance department and *each insured receives an individual policy*. This category differs from the "Individual" category in that the policies are marketed to insureds through an organization (e.g., employer or association). This organizational involvement could be minimal or extensive. Such involvement might include organizational endorsement, participation in promotion of the product, negotiation of premium discounts for members, facilitation of enrollment, payroll deductions, etc. This category of policy is sometimes referred to as "List Bill Rate" or "Franchise."

IN 6. Social Security Number (A-9): Insured's social security number.

All insureds reported in the UDS should have valid social security numbers. Applicants without a social security number should be instructed to obtain one from the Social Security Administration. For new insureds who have not yet received a valid social security number, the insurance company should call the data contact person at the state to get a unique dummy social security number assigned by the state during the interim. Once the valid social security number has been received, the new social security number should be reported in File 2 (Field 7), and all subsequent records for this insured should be reported with the updated social security number. A valid Railroad Number, which begins with the number seven (7) and follows the same 3-digit - 2-digit - 4-digit format of a social security number, can be used in place of a social security number.

7. First Name (A-15): First name of insured.

8. Middle Initial (A-1): Middle initial in name of insured.

9. Last Name (A-20): Last name of insured.

10. Date Of Birth (D-8): Birth date of insured.

MMDDYYYY

IN 11. Sex (A-1): Gender of insured.

M = Male
F = Female
U = Unknown

CT, IN 12. Marital Status (A-1): Marital status of insured at time of application.

A = Not Married
B = Married
C = Civil Union or Domestic Partner
U = Unknown

IN 13. Day Phone (A-10): Area code and daytime telephone number of insured. Place area code in the first three digits. Do not include parentheses or hyphen.

Example: 4152223456 = (415)222-3456

IN 14. Evening Phone (A-10): Area code and evening telephone number of insured. Place area code in the first three digits. Do not include parentheses or hyphen.

Example: 4152223456 = (415)222-3456

15. Address Line 1 (A-35): Insured's residence address within the Partnership State at time of purchase, line 1.

16. Address Line 2 (A-35): Insured's residence address within the Partnership State at time of purchase, line 2.

17. City (A-25): City of insured's residence address within the Partnership State at time of purchase.

18. State (A-2): Two-letter postal abbreviation for the Partnership State of insured's residence address.

19. Zip Code (A-9): Postal zip code of insured's residence address within the Partnership State at time of purchase.

    Nine digits are provided for this field. Begin filling in from left to right. Do not include a hyphen.

Example:	94105	=	94105
	941050412	=	94105-0412

20. Purchase Type (A-1): Indicator of whether purchase reported in this record is a first time purchase, a policy conversion within the same company, or a replacement of a policy issued by another company.

    A = Upgrade Insured has converted *within the same company* from a non-partnership policy to a partnership policy.

    B = Replacement Insured has replaced *another company's* partnership or non-partnership policy with the reporting company's partnership policy.

    C = Conversion from Group to Individual Insured switches from a partnership group certificate to a partnership individual policy *within the same company*. This will be used only when the group policy is *non-portable*. If the group policy is portable, the policyholder would retain their certificate.

    D = New Purchase First-time purchaser of long-term care insurance when there is no knowledge that a replacement has occurred.

    E = Conversion from Individual to Group Insured switches from a partnership individual policy to a partnership group policy *within the same company*.

CA,NY 21. Policy Type (NH/HC) (A-1):

    A = Nursing Home Only - Single-Life Policies that cover nursing home care only. This code should only be used for policies that provide coverage for *one individual*.

    B = Nursing Home and Home Care - Single-Life Policies that cover both nursing home and home care, either through the base policy or through additional riders. This code should only be used for policies that provide coverage for *one individual*.

C = Nursing Home Only - Multi-Life Policies that cover nursing home care only. This code should only be used for policies that provide coverage for *more than one individual*. If a couple purchases two Nursing Home Only policies, each should be coded separately as Policy Type = A (Nursing Home Only - Single Life), irrespective of whether purchased at a spousal/partner discount premium.

D = Nursing Home and Home Care - Multi-Life Policies that cover both nursing home and home care, either through the base policy or through additional riders. This code should only be used for policies that provide coverage for *more than one individual*. If a couple purchases two Nursing Home and Home Care policies, each should be coded separately as Policy Type = B (Nursing Home and Home Care - Single Life), irrespective of whether purchased at a spousal/partner discount premium.

CA,NY 22. Elimination Period (Days): NH (N-3): Policy elimination period in days for nursing home benefit. The method for calculating number of days may vary by insurer (e.g., calendar days, service days).

Three digits are provided for this field. Example: 030 = 30 days

CA,NY 23. Elimination Period (Days): HC (N-3): Policy elimination period in days for home care benefit. The method for calculating the number of days may vary by insurer (e.g., calendar days, service days).

Three digits are provided for this field. Example: 030 = 30 days

CA 24. Percentage Of Costs (N-3): This field is only applicable for policies that pay a percentage of costs *without* a daily or monthly cap. Report the percentage of costs that the policy pays.

Three digits are provided for this field. Example: 080 = 80 percent

888 = Not applicable

CA 25. Maximum Per Diem: NH (N-5, include cents): Maximum daily nursing home benefit (in dollars) payable to insured under the policy. Not applicable for policies that pay a percentage of costs.

Five digits are provided for this field. Example: 10000 = $100.00

88888 = Not applicable

CA,IN 26. Maximum Amount: NH (N-7, do not include cents): Maximum benefit (in dollars) payable under the policy for nursing home care.

Seven digits are provided for this field. Example: 0100000 = $100,000

8888888 = Not applicable
9999999 = Unlimited benefit

CA,IN 27. Maximum Length (Days): NH (N-4): Maximum benefit (in days) payable under the policy for nursing home care. For policies that apply benefits interchangeably between nursing home and home care, this field should report the maximum benefit length (in days) if only nursing home care were used.

Four digits are provided for this field. Example: 0365 = 365 days

8888 = Not applicable
9999 = Unlimited benefit

28. Maximum Per Diem: HC (N-5, include cents): Maximum per diem home care benefit (in dollars) payable to insured under the policy. Not applicable for policies that pay a percentage of costs. For policies that specify a monthly maximum amount rather than a per diem amount, the monthly maximum should be divided by 30 when reporting this field.

Five digits are provided for this field. Example: 05000 = $50.00

88888 = Not applicable

CA,IN 29. Maximum Amount: HC (N-7, do not include cents): Maximum lifetime benefit (in dollars) payable under the policy for home care.

Seven digits are provided for this field. Example: 0050000 = $50,000

8888888 = Not applicable
9999999 = Unlimited benefit

CA,IN 30. Maximum Length (Days): HC (N-4): Maximum lifetime benefit (in days) payable under the policy for home care. For policies that apply benefits interchangeably between nursing home and home care, this field should report the maximum benefit length (in days) if only home care were used.

Four digits are provided for this field. Example: 0365 = 365 days

8888 = Not applicable
9999 = Unlimited benefit

CA,IN 31. Maximum Amount: Total (N-7, do not include cents): Maximum possible lifetime benefit (in dollars) payable under the policy. For policies that apply a separate policy benefit amount for nursing home care and for home care, this field should report the sum of the two separate benefit amounts. For policies with interchangeable benefits, the amount entered in this field should be equal to the amount entered in Fields 26 and 29, or whichever is greater.

Seven digits are provided for this field. Example: 0050000 = $50,000

8888888 = Not applicable
9999999 = Unlimited benefit

CA,IN,NY 32. Maximum Length (Days): Total (N-4): Maximum lifetime benefit (in days) payable under the policy. For policies that do not have an interchangeable benefit between nursing home care and home care, this field should report the sum of the separate nursing home care and home care benefit amounts (in days). For policies with interchangeable benefits, report the maximum benefit length (in days) if only nursing home care were used. For policies that have unlimited policy benefits for nursing home care and/or home care, use the unlimited benefit code below (9999).

Four digits are provided for this field. Example: 0365 = 365 days

8888 = Not applicable
9999 = Unlimited benefit

CA 33. Respite Service Days (N-2): Number of respite service days available to insured per calendar year. For policies that specify a dollar amount maximum to be allocated for this benefit, the dollar amount maximum should be divided by the nursing home maximum benefit per day, and rounded off to the nearest integer. This number should be reported as the number of respite service days available to the insured per calendar year. If the policy defines respite service days in terms of a dollar equivalent of a specified number of home care and community care benefit days, the dollar amount maximum should be divided by the nursing home maximum benefit per day, and rounded off to the next integer. For policies that do not include this

benefit, or policies that build this benefit into their administrative costs, report 88 = Not Applicable.

Two digits are provided for this field. Example: 05 = 5 days

88 = Not applicable

CA,IN 34. Care Management Days (N-2): Number of "care management days" available to insureds. This field is applicable to policies that provide a dollar equivalent of a specified number of nursing home days per benefit year to the insured for care management services. For policies that include this benefit, either as a basic benefit or as a rider, insurers are required to report the specified number of nursing home days per benefit year that are used to determine the dollar amount allocated for care management services. If the policy defines care management days in terms of a dollar equivalent of a specified number of home care and community care benefit days, the dollar amount maximum should be divided by the nursing home maximum benefit per day, and rounded off to the nearest integer. This number should be reported as the number of care management days available to the insured per calendar year. For policies that do not have a care management benefit that is calculated based on a dollar equivalent of the service benefit (e.g., policies that build this benefit into their administrative costs), report 88 = Not Applicable.

Two digits are provided for this field. Example: 02 = 02 days

88 = Not applicable

NY 35. Non-Forfeiture Benefit (A-1): Indicator of the type of non-forfeiture benefit that is a part of the base policy or added through riders. For cases in which a non-forfeiture benefit combines one or more of the non-forfeiture benefits listed in the UDS documentation, report G = Other. [Note: A death benefit is distinct from a non-forfeiture benefit and should not be counted as a non-forfeiture benefit when reporting Field 35.]

A = None No benefit is provided when insured lapses.

B = Shortened Benefit Period Benefit provides continued lifetime coverage with the full daily benefit amount payable for a period shorter than that provided while the policy is in a premium paying status.

C = Benefit Bank Benefit provides an account established by the insurer for use by the insured. The amount available to the account is similar to that specified in D below. Disbursements from the account can only be for long-term care expenses and must be in accordance with the terms of the policy.

D = Cash Benefit providing any one of the three following types of cash benefits: 1) a specified cash surrender value (CSV), 2) a return of all or a portion of premiums to the insured (RPU), or 3) a life annuity providing regular payments to the insured.

E = Reduced Paid Up Benefit provides continued lifetime coverage with a reduced daily benefit amount.

F = Extended Term Benefit provides continued coverage for a specified period after lapse.

G = Other Provides any other type of benefit not described above.

H = Benefit Bank + Return of Premium This code applies to non-forfeiture benefits that provide an account established by the insurer for use by the insured (as in option C) and a return of premium to a designated beneficiary upon the death of the policyholder.

NY 36. Options Or Riders In Force - 1 (A-1): This field is used to indicate benefits that are not built into the policy, but are purchased as an option or rider. Fields 36 - 39 allow for the reporting of up to four (4) options or riders in force for the insured reported in this record.

A = Non-Forfeiture Any type of benefit that is paid after the policy holder lapses his or her policy.

B = Restoration of Benefits A benefit that restores a policyholder's benefits, either fully or partially, after benefits have already been paid out. Benefits are restored according to a formula specified in the policy.

C = Home Care Rider Home care benefit is not built into the policy, but must be purchased as a rider. When this code is utilized, Field 21 - Policy Type should be coded as B= Nursing Home and Home Care - Single-Life or D= Nursing Home and Home Care - Multi-Life.

D = Death Benefit Cash payment payable upon the death of the insured.

E = Spousal/Partner Benefit Enhancement A rider that provides benefits in excess of those offered under the base policy, such as a rider that allows a spouse/partner who has exhausted his/her policy to access benefits remaining under his/her spouse's/partner's policy, or a rider that provides an additional benefit pool accessible to both spouses/partners once their respective individual base policy benefits are exhausted. [This code is not to be used to report multi-life policies, defined as a single policy that covers more than one individual. Refer to UDS File 1, Field 21, codes 'C' and 'D' to report multi-life policies.]

Z = Other Riders should be used when some other type of rider is purchased.

8 = Not applicable No options or riders to report.

NY 37. Options Or Riders In Force - 2 (A-1): Same field definition as Field 36. Not applicable if there are no additional options or riders to report.

NY 38. Options Or Riders In Force - 3 (A-1): Same field definition as Field 36. Not applicable if there are no additional options or riders to report.

NY 39. Options Or Riders In Force - 4 (A-1): Same field definition as Field 36. Not applicable if there are no additional options or riders to report.

CA,IN,NY 40. Inflation Protection Mode: Daily Benefit (A-1): Mode used to increase the policy's daily benefit level to adjust for inflation.

A = Percent of Charges Policy pays on an expense-incurred basis using a specified percent of the service charge. This code should not be used for policies with a specified daily benefit.

B = Automatic Compound Annual Increases Policy has a specified compounded inflation adjustment to the daily benefit on an annual basis, which the insured cannot decline.

C = Periodic Increases Policy offers a scheduled inflation adjustment to the daily benefit, either annually or on a periodic basis, which the insured can decline.

D = None No scheduled inflation adjustments to the daily benefit.

E = Automatic Simple Annual Increases: Policy has a specified simple inflation adjustment to the daily benefit on an annual basis, which the insured cannot decline.

CA,IN 41. Inflation Protection Percentage: Daily Benefit (N-2): Percentage used to increase the daily benefit either on a yearly or on a periodic basis.

01 - 50 = Inflation adjustment percentage

88 = Not applicable
99 = CPI Daily benefit amount is scheduled to increase in accordance with the Consumer Price Index.

CA,IN,NY 42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): Mode used to increase the policy's lifetime maximum benefit to adjust for inflation.

A = Unlimited Benefit Policy has an unlimited lifetime benefit.

B = Automatic Compound Annual Increases Policy has a specified compounded inflation adjustment to the lifetime maximum benefit on an annual basis, which the insured cannot decline.

C = Periodic Increases Policy offers a scheduled inflation adjustment to the lifetime maximum benefit, either annually or on a periodic basis, which the insured can decline.

D = None No scheduled inflation adjustments to the lifetime maximum benefit.

E = Automatic Simple Annual Increases Policy has a specified simple inflation adjustment to the lifetime maximum benefit on an annual basis, which the insured cannot decline.

CA,IN,NY 43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2): Percentage used to increase the lifetime maximum benefit either on a yearly or on a periodic basis.

01-50 = Inflation adjustment percentage

88 = Not applicable
99 = CPI Lifetime maximum benefit is scheduled to increase in accordance with the Consumer Price Index.

CA,CT,IN 44. Annualized Premium (N-7, include cents): Total amount of premium due on an annual basis. If premiums are paid by some method other than annual payment (e.g., quarterly, monthly), convert premium to an annual amount (including cents).

Seven digits are provided for this field. Example: 0120000 = $1,200.00

NY,IN 45. Type Of Premium (A-1):

A = Lifetime - Level Lifetime premium is based on the age of the policyholder at the time of purchase and does not increase for that individual over the life of the policy, unless the premium is increased for a class of policies.

B = Lifetime - Indexed Premium increases according to a pre-set schedule.

C = 20 Year - Level Premium is based on the age of the policyholder at the time of purchase and does not increase for that individual over the life of the policy, unless the premium is increased for a class of policies. Entire premium is paid after 20 years.

D = 20 Year - Indexed Premium increases according to a pre-set schedule. Entire premium is paid after 20 years.

E = Lump Sum Entire premium paid at time of purchase. No subsequent premium payments required.

F = 1 year up to 5 years Paid-Up Equal payments over a specified period of 1 year up to 5 years until paid up.

G = >5 years up to 10 years Paid-Up Equal payments over a specified period of greater than 5 years up to 10 years until paid up.

H = >10 years Paid-Up Equal payments over a specified time period of greater than 10 years until paid up.

Z = Other Should be used when reporting a type of premium other than those listed above.

46. Premium Payment Mode (A-1): Number of times premiums are payable in a policy year (also known as "premium frequency").

    A = Monthly, or any other payment mode in which the number of payments made during a policy year is greater than 6. This includes semi-monthly, bi-weekly, and 10-month payments.
    B = Quarterly
    C = Semi-Annually
    D = Annually
    E = Lump Sum (Entire premium paid at time of purchase. No subsequent premium payments required.)

NY 47. Lapse Contact Designated (A-1): Indicates whether insured has designated a person to be contacted in the event that the premium goes unpaid for a specified period of time. Not applicable if insurer does not allow insureds to designate a lapse contact.

    Y = Yes
    N = No

File 2: Insureds Who Have Changed/Dropped Their Policies

File Information

Frequency: Quarterly, on a calendar year basis. Reports are due 30 days after the close of the reporting period.

Record Definition: One record for each type of change listed below that is processed during the reporting period. One full record for each type of change made for each insured is required. Therefore, an insured with three types of changes made in a quarter would have three separate records. Data in each record should reflect the insured's most up-to-date demographic and policy information.

Trigger: Any one of the following changes to the insured's policy coverage:

- -Dropped
- -Upgrade
- -Shorter Coverage Option
- -Reinstatement
- -Inflation Upgrade*
- -Changes to Benefits/Riders or Premium amount
- -Premium Series Re-rate
- -Policy Category Change
- -Non-forfeiture (partnership status intact)
- -Conversion to Multi-Life
- -Conversion to Single-Life
- -Inflation Catch-Up
- -Social Security Number Change

These changes are defined below. Changes to areas *not* listed above do *not* trigger a change record, but should be updated and reported with the next change record.

* Inflation upgrade records are to be reported only on policyholders who have been determined eligible to receive benefits under their Partnership policy. Refer to the definition under File 2, Field 19 Type of Change, code ‘E’ for additional information.

File 2: Insureds Who Have Changed/Dropped Their Policies

File Format

	Field Name	Position	FieldType/Length
1.	Option Type	1	A-1
2.	Company Code	2	N-3
3.	Policy Form Number	5	N-8
4.	Original Effective Policy Date	13	D-8
5.	Policy Category	21	A-1
6.	Social Security Number	22	A-9
7.	Updated Social Security Number	31	A-9
8.	First Name	40	A-15
9.	Middle Initial	55	A-1
10.	Last Name	56	A-20
11.	Day Phone	76	A-10
12.	Evening Phone	86	A-10
13.	Address Line 1	96	A-35
14.	Address Line 2	131	A-35
15.	City	166	A-25
16.	State	191	A-2
17.	Zip Code	193	A-9
18.	Date of Change	202	D-8
19.	Type of Change	210	A-1
20.	Reason Dropped	211	A-1
21.	Policy Type (NH/HC)	212	A-1
22.	Elimination Period (Days): NH	213	N-3
23.	Elimination Period (Days): HC	216	N-3
24.	Percentage of Costs	219	N-3
25.	Maximum Per Diem: NH	222	N-5
26.	Maximum Amount: NH	227	N-7
27.	Maximum Length (Days): NH	234	N-4
28.	Maximum Per Diem: HC	238	N-5
29.	Maximum Amount: HC	243	N-7
30.	Maximum Length (Days): HC	250	N-4
31.	Maximum Amount: Total	254	N-7
32.	Maximum Length (Days): Total	261	N-4
33.	Respite Service Days	265	N-2
34.	Care Management Days	267	N-2
35.	Non-Forfeiture Benefit	269	A-1
36.	Options Or Riders In Force - 1	270	A-1
37.	Options Or Riders In Force - 2	271	A-1
38.	Options Or Riders In Force - 3	272	A-1

	Field Name	Position	Field Type/Length
39.	Options Or Riders In Force - 4	273	A-1
40.	Inflation Protection Mode: Daily Benefit	274	A-1
41.	Inflation Protection Percentage: Daily Benefit	275	N-2
42.	Inflation Protection Mode: Lifetime Maximum Benefit	277	A-1
43.	Inflation Protection Percentage: Lifetime Maximum Benefit	278	N-2
44.	Annualized Premium	280	N-7
45.	Type Of Premium	287	A-1
46.	Premium Payment Mode	288	A-1
47.	Lapse Contact Designated	289	A-1
Total Record Length:		289	

File 2: Insureds Who Have Changed/Dropped Their Policies

Field Definitions

1. Option Type (A-1): Report this field as 8 = Not Applicable.

   8 = Not applicable

2. Company Code (N-3): Unique, confidential company identifier issued to insurers by project staff. The company code is the same for each company across the states.

CA,NY 3. Policy Form Number (N-8): Unique policy identifier issued to insurers by project staff.

4. Original Effective Policy Date (D-8): Original effective date of the policy. For group policies, this date should be defined as the effective date of coverage of the individual certificate (as opposed to the effective date of coverage of the group policy).

   The Original Effective Policy Date as reported in the UDS is used as a unique identifier and should never change, even if there are subsequent changes to the policy that result in a policy re-issue. This date should remain the same for a given policyholder and policy across all files.

   MMDDYYYY

CA 5. Policy Category (A-1): This field provides information related to two dimensions of the policy: 1) how the policy is filed with the state insurance department, and 2) how the policy is marketed.

   A = Individual Policy is filed as an "Individual" policy with the state insurance department and *each insured receives an individual policy*. Policy marketed and issued directly from the insurer to the insured.

   B = Group Policy is filed with the state insurance department as a "Group" policy. Group policy contracts are made with an employer or other entity (e.g. association) that covers a group of persons identified as individuals by reference to their relationship to the entity. The actual policy is held by the employer or other entity. Each *insured receives a certificate* under the policy, rather than an individual policy. The policy is marketed and sold through the group.

C = Organization Sponsored Policy is filed as an "Individual" policy with the state insurance department and *each insured receives an individual policy*. This category differs from the "Individual" category in that the policies are marketed to insureds through an organization (e.g., employer or association). This organizational involvement could be minimal or extensive. Such involvement might include organizational endorsement, participation in promotion of the product, negotiation of premium discounts for members, facilitation of enrollment, payroll deductions, etc. This category of policy is sometimes referred to as "List Bill Rate" or "Franchise."

6. Social Security Number (A-9): Insured's social security number. If an insured's social security number is changed or corrected, the updated social security number should be reported in File 2 (Field 7), and File 2 (Field 6) should retain its original value.

CT 7. Updated Social Security Number (A-9): This field should be used when an insured's social security number is changed or corrected. For insureds who did not have a valid social security number at the time of policy purchase but who have since received a valid social security number, the new social security number should be reported in this field, and File 2 (Field 6) should retain its original value. All subsequent records for this insured should be reported with the updated social security number.

888888888 = No update to social security number

8. First Name (A-15): First name of insured.

9. Middle Initial (A-1): Middle initial in name of insured.

10. Last Name (A-20): Last name of insured.

IN 11. Day Phone (A-10): Area code and daytime telephone number of insured. Place area code in the first three digits. Do not include parentheses or hyphen.

Example: 4152223456 = (415)222-3456

IN 12. Evening Phone (A-10): Area code and evening telephone number of insured. Place area code in the first three digits. Do not include parentheses or hyphen.

Example: 4152223456 = (415)222-3456

13. Address Line 1 (A-35): Insured's current residence address, line 1.

14. Address Line 2 (A-35): Insured's current residence address, line 2.

15. City (A-25): City of insured's current residence address.

16. State (A-2): Two-letter postal abbreviation for the State of insured's current residence address. When no U.S. postal designation exists, enter 88 to indicate a missing value.

17. Zip Code (A-9): Postal zip code of insured's current residence address.

Nine digits are provided for this field. Begin filling in from left to right. Do not include a hyphen.

Example:	94105	=	94105
	941050412	=	94105-0412

When no U.S. postal designation exists, enter 888888888 to indicate a missing value.

18. Date Of Change (D-8): This field should indicate the effective date of change. Multiple changes that occur on the same day should be reported sequentially by the insurers. The actual date of the first change should be used to record that change, and subsequent changes should be reported, one per day, on each ensuing day. This will allow for the updating of insured policy information in the proper sequence.

For example, if an insured were to add a rider to a policy and obtain an inflation upgrade on the same day, the following sequential reporting would be appropriate:

1. Report the Changes to Benefits/Riders (option "F") in File 2 (Field 19) on the effective date of this change.
2. The *following* day, report the Inflation Upgrade of the policy (option "E") in File 2 (Field 19).

MMDDYYYY

CT,NY 19. Type Of Change (A-1):

A = Dropped Policy is no longer in-force as a partnership policy within the reporting period. If a drop and a reinstatement occur for the same policy holder during the same reporting quarter, report neither the drop nor the reinstatement for that quarter.

B = Upgrade (new version of policy) Insured upgrades to a different generation of the existing policy and is issued a new "Policy Form Number". The new "Policy Form Number" assigned by the project staff for the new generation of product would be entered in Field 3 of this record. This record should reflect the insured's upgraded policy benefits.

C = Shorter Coverage Option Insured on the verge of lapsing picks up a lesser amount of coverage (i.e., shorter policy duration or reduction in total benefit dollars) as a way of reducing their premium.

D = Reinstatement Insured was reported as dropped, but is then reinstated in a subsequent reporting quarter (usually due to non-payment of premium). If a drop and a reinstatement occur for the same policy holder during the same reporting quarter, report neither the drop nor the reinstatement for that quarter.

E = Inflation Upgrade Daily Benefit or Lifetime Maximum is increased due to scheduled, annual or periodic inflation adjustment. File 2 inflation upgrade records are submitted once a policyholder is determined eligible for benefits under the policy's insured event. The initial inflation upgrade record is due at the end of the reporting quarter during which the eligibility determination is made. Subsequent inflation upgrade records for that policyholder are generated annually on the policy anniversary irrespective of benefit status, until the policy benefit is exhausted, the policy is dropped, or the policyholder dies. The inflation upgrade record is to contain all current policy information including appropriately inflated benefit amounts.

F = Changes to Benefits/Riders or Premium Amount Benefits or premiums increased or decreased, or riders/options added or dropped [any changes to File 2 (Fields 21 through 45)]. Note that this code should not be used in place of codes C, E, or L.

G = Premium Series Re-rate Premium is changed for a *whole class of insureds*. When this re-rate occurs there should be a change record submitted for each insured who has his or her premium changed.

H = Policy Category Change Insured's "Policy Category" (Field 5) has been changed.

I = Non-Forfeiture (Partnership Status Intact) Insured's policy goes into non-forfeiture status. Policy benefits still meet the state partnership standards. If the non-forfeiture benefit does not meet these standards, then the insured should be reported in this field as A = Dropped and as Reason Dropped (Field 20) = H (Non-forfeiture, Partnership Status Lost).

J = Conversion to Multi-Life Individual converts from a policy covering a single individual to one that covers more than one.

K = Conversion to Single-Life Individual converts from a policy covering more than one individual to one that covers a single individual.

L = Inflation Catch-Up Unscheduled inflation upgrade that is implemented in addition to other scheduled inflation increases.

M = Social Security Number Change Presence of an updated Social Security Number in Field 7 (Updated Social Security Number) of this file.

N = Delayed First Payment The 30-day free-look or initial grace period expired prior to the payment of the first premium. The insurer agrees to accept the past-due premium, retains the original effective policy date, and puts the policy in force again. This activity shall be reported only when the policy is dropped in one reporting quarter and reactivated in a later quarter. When this activity occurs within the same reporting quarter, no change/drop records are to be reported.

O = Purposely omitted - do not use

P = Policy Tax-Qualified Status Changed from Non-Qualified to Qualified The tax-qualified status of this policy has been changed from Non-Qualified to Qualified. This does not apply to Grandfathered policies, which are by definition Qualified.

Q = Policy Tax-Qualified Status Changed from Qualified to Non-Qualified The tax-qualified status of this policy has been changed from Qualified to Non-Qualified.

NY 20. Reason Dropped (A-1): This field is only applicable for insured's with Field 19 (Type of Change) = A (Dropped).

A = Died Insured is known to have died. If a policyholder dies during the free-look period, this field should be reported as A = Died and not as D = Not Taken Up.

B = Dropped Voluntarily Insured or insured's representative has notified the insurer that the policy is being dropped for reason other than death of the insured.

C = Unknown Differs from "Dropped Voluntarily" in that insured stops paying premiums, but the insurer received no notice from the insured or the insured's representative.

D = Not Taken Up Insured returns policy for a refund during the 30-day free-look period. Insureds falling into this category should be reported in File 1, Registry of New Insureds, as having purchased a policy, and then reported in this file (File 2) as having dropped. If a policyholder dies during the free-look period, this field should be reported as A = Died and not as D = Not Taken Up.

E = Converted Insured gives up policy in converting from a non-portable partnership group policy to a partnership individual policy or from a partnership individual policy to a partnership group policy. Insureds falling into this category should be reported in this file as "Dropped" and then subsequently reported in File 1, Registry of New Insureds, with Field 20 (Purchase Type) = C (Conversion from Group to Individual) or = E (Conversion from Individual to Group).

F = Exhausted Benefits Insured's policy is no longer in force because all policy benefits have been exhausted.

G = Partnership Status Lost Insured's policy loses its partnership status for reasons other than non-forfeiture (see H below). For example, the insured does not maintain their inflation protection and their daily benefit goes below the minimum level set by the State for that year.

H = Non-Forfeiture (Partnership Status Lost) Insured's policy goes into non-forfeiture status and the policy loses its partnership status because the non-forfeiture benefit does not meet the state partnership standards.

I = Multi-Life Status Change Insured changes from a Multi-Life policy to a Single-Life policy or from a Single-Life policy to a Multi-Life policy. Subsequent to reporting this drop, insured should be reported in File 1 as a New Purchase (Field 20 Code = D).

J = Rescission The insurer cancels the policy within the two-year contestable period after the insurer discovers a material misrepresentation in the application. A material misrepresentation in the application refers to a condition which, had it been disclosed on the application, the insurer would not have issued a policy.

8 = Not applicable No drop reported.

CA,NY 21. Policy Type (NH/HC) (A-1):

A = Nursing Home Only - Single-Life Policies that cover nursing home care only. This code should only be used for policies that provide coverage for *one individual*.

B = Nursing Home and Home Care - Single-Life Policies that cover both nursing home and home care, either through the base policy or through additional riders. This code should only be used for policies that provide coverage for *one individual*.

C = Nursing Home Only - Multi-Life Policies that cover nursing home care only. This code should only be used for policies that provide coverage for *more than one individual*. If a couple purchases two Nursing Home Only policies, each should be coded separately as Policy Type = A (Nursing Home Only - Single Life), irrespective of whether purchased at a spousal/partner discount premium.

D = Nursing Home and Home Care - Multi-Life Policies that cover both nursing home and home care, either through the base policy or through additional riders. This code should only be used for policies that provide coverage for *more than one individual*. If a couple purchases two Nursing Home and Home Care policies, each should be coded separately as Policy Type = B (Nursing Home and Home Care - Single Life), irrespective of whether purchased at a spousal/partner discount premium.

CA,NY 22. Elimination Period (Days): NH (N-3): Policy elimination period in days for nursing home benefit. The method for calculating number of days may vary by insurer (e.g., calendar days, service days).

Three digits are provided for this field. Example: 030 = 30 days

CA,NY 23. Elimination Period (Days): HC (N-3): Policy elimination period in days for home care benefit. The method for calculating the number of days may vary by insurer (e.g., calendar days, service days).

Three digits are provided for this field. Example: 030 = 30 days

CA 24. Percentage Of Costs (N-3): This field is only applicable for policies that pay a percentage of costs *without* a daily or monthly cap. Report the percentage of costs that the policy pays.

Three digits are provided for this field. Example: 080 = 80 percent

888 = Not applicable

CA 25. Maximum Per Diem: NH (N-5, include cents): Maximum daily nursing home benefit (in dollars) payable to insured under the policy. Not applicable for policies that pay a percentage of costs.

Five digits are provided for this field. Example: 10000 = $100.00

88888 = Not applicable

CA,IN 26. Maximum Amount: NH (N-7, do not include cents): Maximum benefit (in dollars) payable under the policy for nursing home care.

Seven digits are provided for this field. Example: 0100000 = $100,000

8888888 = Not applicable
9999999 = Unlimited benefit

CA,IN 27. Maximum Length (Days): NH (N-4): Maximum benefit (in days) payable under the policy for nursing home care. For policies that apply benefits interchangeably between nursing home and home care, this field should report the maximum benefit length (in days) if only nursing home care were used.

Four digits are provided for this field. Example: 0365 = 365 days

8888 = Not applicable
9999 = Unlimited benefit

28. Maximum Per Diem: HC (N-5, include cents): Maximum per diem home care benefit (in dollars) payable to insured under the policy. Not applicable for policies that pay a percentage of costs. For policies that specify a monthly maximum amount rather than a per diem amount, the monthly maximum should be divided by 30 when reporting this field.

Five digits are provided for this field. Example: 05000 = $50.00

88888 = Not applicable

CA,IN 29. Maximum Amount: HC (N-7, do not include cents): Maximum lifetime benefit (in dollars) payable under the policy for home care.

Seven digits are provided for this field. Example: 0050000 = $50,000

8888888 = Not applicable
9999999 = Unlimited benefit

CA,IN 30. Maximum Length (Days): HC (N-4): Maximum lifetime benefit (in days) payable under the policy for home care. For policies that apply benefits interchangeably between nursing home and home care, this field should report the maximum benefit length (in days) if only home care were used.

Four digits are provided for this field. Example: 0365 = 365 days

8888 = Not applicable
9999 = Unlimited benefit

CA,IN 31. Maximum Amount: Total (N-7, do not include cents): Maximum possible lifetime benefit (in dollars) payable under the policy. For policies that apply a separate policy benefit amount for nursing home care and for home care, this field should report the sum of the two separate benefit amounts. For policies with interchangeable benefits, the amount entered in this field should be equal to the amount entered in Fields 26 and 29, or whichever is greater.

Seven digits are provided for this field. Example: 0050000 = $50,000

8888888 = Not applicable
9999999 = Unlimited benefit

CA,IN,NY 32. Maximum Length (Days): Total (N-4): Maximum lifetime benefit (in days) payable under the policy. For policies that do not have an interchangeable benefit between nursing home care and home care, this field should report the sum of the separate nursing home care and home care benefit amounts (in days). For policies with interchangeable benefits, report the maximum benefit length (in days) if only nursing home care were used. For policies that have unlimited policy benefits for nursing home care and/or home care, use the unlimited benefit code below (9999).

Four digits are provided for this field. Example: 0365 = 365 days

8888 = Not applicable
9999 = Unlimited benefit

CA 33. Respite Service Days (N-2): Number of respite service days available to insured per calendar year. For policies that specify a dollar amount maximum to be allocated for this benefit, the dollar amount maximum should be divided by the nursing home maximum benefit per day, and rounded off to the nearest integer. This number should be reported as the number of respite service days available to the insured per calendar year. If the policy defines respite service days in terms of a dollar equivalent of a specified number of home care and community care benefit days, the dollar amount maximum should be divided by the nursing home maximum benefit per day, and rounded off to the next integer. For policies that do not include this benefit, or policies that build this benefit into their administrative costs, report 88 = Not Applicable.

Two digits are provided for this field. Example: 05 = 5 days

88 = Not applicable

CA,IN 34. Care Management Days (N-2): Number of "care management days" available to insureds. This field is applicable to policies that provide a dollar equivalent of a specified number of nursing home days per benefit year to the insured for care management services. For policies that include this benefit, either as a basic benefit or as a rider, insurers are required to report the specified number of nursing home days per benefit year that are used to determine the dollar amount allocated for care management services. If the policy defines care management days in terms of a dollar equivalent of a specified number of home care and community care benefit days, the dollar amount maximum should be divided by the nursing home maximum benefit per day, and rounded off to the nearest integer. This number should be reported as the number of care management days available to the insured per calendar year. For policies that do not have a care management benefit that is calculated based on a dollar equivalent of the service benefit (e.g., policies that build this benefit into their administrative costs), report 88 = Not Applicable.

Two digits are provided for this field. Example: 02 = 02 days

88 = Not applicable

NY 35. Non-Forfeiture Benefit (A-1): Indicator of the type of non-forfeiture benefit that is a part of the base policy or added through riders. For cases in which a non-forfeiture benefit combines one or more of the non-forfeiture benefits listed in the UDS documentation, report G = Other. [Note: A death benefit is distinct from a non-forfeiture benefit and should not be counted as a non-forfeiture benefit when reporting Field 35.]

A = None No benefit is provided when insured lapses.

B = Shortened Benefit Period Benefit provides continued lifetime coverage with the full daily benefit amount payable for a period shorter than that provided while the policy is in a premium paying status.

C = Benefit Bank Benefit provides an account established by the insurer for use by the insured. The amount available to the account is similar to that specified in D below. Disbursements from the account can only be for long-term care expenses and must be in accordance with the terms of the policy.

D = Cash Benefit providing any one of the three following types of cash benefits: 1) a specified cash surrender value (CSV), 2) a return of all or a portion of premiums to the insured (RPU), or 3) a life annuity providing regular payments to the insured.

E = Reduced Paid Up Benefit provides continued lifetime coverage with a reduced daily benefit amount.

F = Extended Term Benefit provides continued coverage for a specified period after lapse.

G = Other Provides any other type of benefit not described above.

H = Benefit Bank + Return of Premium This code applies to non-forfeiture benefits that provide an account established by the insurer for use by the insured (as in option C) and a return of premium to a designated beneficiary upon the death of the policyholder.

NY 36. Options Or Riders In Force - 1 (A-1): This field is used to indicate benefits that are not built into the policy, but are purchased as an option or rider. Fields 36 - 39 allow for the reporting of up to four (4) options or riders in force for the insured reported in this record.

A = Non-Forfeiture Any type of benefit that is paid after the policy holder lapses his or her policy.

B = Restoration of Benefits A benefit that restores a policyholder's benefits, either fully or partially, after benefits have already been paid out. Benefits are restored according to a formula specified in the policy.

C = Home Care Rider Home care benefit is not built into the policy, but must be purchased as a rider. When this code is utilized, Field 21 - Policy Type should be coded as B=Nursing Home and Home Care - Single-Life or D=Nursing Home and Home Care - Multi-Life.

D = Death Benefit Cash payment payable upon the death of the insured.

E = Spousal Benefit Enhancement A rider that provides benefits in excess of those offered under the base policy, such as a rider that allows a spouse who has exhausted his/her policy to access benefits remaining under his/her spouse's policy, or a rider that provides an additional benefit pool accessible to both spouses once their respective individual base policy benefits are exhausted. [This code is not to be used to report multi-life policies, defined as a single policy that covers more than one individual. Refer to UDS File 1, Field 21, codes 'C' and 'D' to report multi-life policies.]

Z = Other Riders should be used when some other type of rider is purchased.

8 = Not applicable No options or riders to report.

NY 37. Options Or Riders In Force - 2 (A-1): Same field definition as Field 36. Not applicable if there are no additional options or riders to report.

NY 38. Options Or Riders In Force - 3 (A-1): Same field definition as Field 36. Not applicable if there are no additional options or riders to report.

NY 39. Options Or Riders In Force - 4 (A-1): Same field definition as Field 36. Not applicable if there are no additional options or riders to report.

CA,IN,NY 40. Inflation Protection Mode: Daily Benefit (A-1): Mode used to increase the policy's daily benefit level to adjust for inflation.

A = Percent of Charges Policy pays on an expense-incurred basis using a specified percent of the service charge. This code should not be used for policies with a specified daily benefit.

B = Automatic Compound Annual Increases Policy has a specified compounded inflation adjustment to the daily benefit on an annual basis, which the insured cannot decline.

C = Periodic Increases Policy offers a scheduled inflation adjustment to the daily benefit, either annually or on a periodic basis, which the insured can decline.

D = None No scheduled inflation adjustments to the daily benefit.

E = Automatic Simple Annual Increases Policy has a specified simple inflation adjustment to the daily benefit on an annual basis, which the insured cannot decline.

CA,IN 41. Inflation Protection Percentage: Daily Benefit (N-2): Percentage used to increase the daily benefit either on a yearly or on a periodic basis.

01 - 50 = Inflation adjustment percentage

88 = Not applicable
99 = CPI Daily benefit amount is scheduled to increase in accordance with the Consumer Price Index.

CA,IN,NY 42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): Mode used to increase the policy's lifetime maximum benefit to adjust for inflation.

A = Unlimited Benefit Policy has an unlimited lifetime benefit.

B = Automatic Compound Annual Increases Policy has a specified compounded inflation adjustment to the lifetime maximum benefit on an annual basis, which the insured cannot decline.

C = Periodic Increases Policy offers a scheduled inflation adjustment to the lifetime maximum benefit, either annually or on a periodic basis, which the insured can decline.

D = None No scheduled inflation adjustments to the lifetime maximum benefit.

E = Automatic Simple Annual Increases Policy has a specified simple inflation adjustment to the lifetime maximum benefit on an annual basis, which the insured cannot decline.

CA,IN,NY 43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2): Percentage used to increase the lifetime maximum benefit either on a yearly or on a periodic basis.

01-50 = Inflation adjustment percentage

88 = Not applicable
99 = CPI Lifetime maximum benefit is scheduled to increase in accordance with the Consumer Price Index.

CA,CT,IN 44. Annualized Premium (N - 7, include cents): Total amount of premium due on an annual basis. If premiums are paid by some method other than annual payment (e.g., quarterly, monthly), convert premium to an annual amount (including cents).

Seven digits are provided for this field. Example: 0120000 = $1,200.00

NY,IN 45. Type Of Premium (A-1):

A = Lifetime - Level Lifetime premium is based on the age of the policyholder at the time of purchase and does not increase for that individual over the life of the policy, unless the premium is increased for a class of policies.

B = Lifetime - Indexed Premium increases according to a pre-set schedule.

C = 20 Year - Level Premium is based on the age of the policyholder at the time of purchase and does not increase for that individual over the life of the policy, unless the premium is increased for a class of policies. Entire premium is paid after 20 years.

D = 20 Year - Indexed Premium increases according to a pre-set schedule. Entire premium is paid after 20 years.

E = Lump Sum Entire premium paid at time of purchase. No subsequent premium payments required.

F = 1 year up to 5 years Paid-Up Equal payments over a specified period of 1 year up to 5 years until paid up.

G = >5 years up to 10 years Paid-Up Equal payments over a specified period of greater than 5 years up to 10 years until paid up.

H = >10 years Paid-Up Equal payments over a specified time period of greater than 10 years until paid up.

Z = Other Should be used when reporting a type of premium other than those listed above.

46. Premium Payment Mode (A-1): Number of times premiums are payable in a policy year (also known as "premium frequency").

    A = Monthly, or any other payment mode in which the number of payments made during a policy year is greater than 6. This includes semi-monthly, bi- weekly, and 10-month payments.
    B = Quarterly
    C = Semi-Annually
    D = Annually
    E = Lump Sum (Entire premium paid at time of purchase. No subsequent premium payments required.)

NY 47. Lapse Contact Designated (A-1): Indicates whether insured has designated a person to be contacted in the event that the premium goes unpaid for a specified period of time. Not applicable if insurer does not allow insureds to designate a lapse contact.

    Y = Yes
    N = No

File 3: Insureds Assessed For Long-Term Care Benefit Eligibility

File Information

Frequency: Quarterly, on a calendar year basis. Reports are due 30 days after the close of the reporting period.

Record Definition: One record for each assessment or reassessment on which an eligibility decision has been reached.

Eligibility determinations based on information provided by a physician, other clinicians, nursing home staff or any other acceptable source in the absence of a traditional assessment/reassessment must also be reported in the assessment file.

Trigger: An initial assessment or reassessment that occurs for the purpose of determining an insured's initial or continued eligibility for benefits has been completed during the reporting quarter. An assessment or reassessment is considered to be completed when a decision on eligibility for benefits has been reached.

File 3: Insureds Assessed For Long-Term Care Benefit Eligibility

File Format

	Field Name	Position	Field Type/Length
1.	Option Type	1	A-1
2.	Company Code	2	N-3
3.	Policy Form Number	5	N-8
4.	Original Effective Policy Date	13	D-8
5.	Social Security Number	21	A-9
6.	First Name	30	A-15
7.	Middle Initial	45	A-1
8.	Last Name	46	A-20
9.	Day Phone	66	A-10
10.	Evening Phone	76	A-10
11.	Address Line 1	86	A-35
12.	Address Line 2	121	A-35
13.	City	156	A-25
14.	State	181	A-2
15.	Zip Code	183	A-9
16.	Marital Status	192	A-1
17.	Living Arrangement	193	A-1
18.	Sex	194	A-1
19.	Benefit Contact	195	A-1
20.	Medicare Status	196	A-1
21.	Other Insurance Status	197	A-1
22.	Assessment Date	198	D-8
23.	Performed by Whom	206	A-5
24.	Policy Insured Event Met	211	A-1
25.	State Insured Event Met	212	A-1
26.	Pre-Admission Screening Met	213	A-1
27.	Eligibility Decision Date	214	D-8
28.	Effective Date of Disability	222	D-8
29.	Dressing Deficiency	230	A-1
30.	Bathing Deficiency	231	A-1
31.	Eating/Feeding Deficiency	232	A-1
32.	Toileting Deficiency	233	A-1
33.	Transferring Deficiency	234	A-1
34.	Continence Deficiency	235	A-1
35.	Ambulating Deficiency	236	A-1
36.	Cognitive Impairment	237	A-1
37.	MSQ Test Score	238	N-2
38.	Score on Folstein Test	240	N-2

	Field Name	Position	Field Type/Length
39.	Wandering	242	A-1
40.	Abusive/Assaultive	243	A-1
41.	Poor Judgment	244	A-1
42.	Bizarre Hygiene	245	A-1
43.	Complex Unstable Medical Condition	246	A-1
Total Record Length:		246	

CT **File 3: Insureds Assessed For Long-Term Care Benefit Eligibility**

Field Definitions

1. Option Type (A-1): Report this field as 8 = Not Applicable.

   8 = Not applicable

2. Company Code (N-3): Unique, confidential company identifier issued to insurers by project staff. The company code is the same for each company across the states.

NY 3. Policy Form Number (N-8): Unique policy identifier issued to insurers by project staff.

4. Original Effective Policy Date (D-8): Original effective date of the policy. For group policies, this date should be defined as the effective date of coverage of the individual certificate (as opposed to the effective date of coverage of the group policy).

   The Original Effective Policy Date as reported in the UDS is used as a unique identifier and should never change, even if there are subsequent changes to the policy that result in a policy re-issue. This date should remain the same for a given policyholder and policy across all files.

   MMDDYYYY

5. Social Security Number (A-9): Insured's social security number.

6. First Name (A-15): First name of insured.

7. Middle Initial (A-1): Middle initial in name of insured.

8. Last Name (A-20): Last name of insured.

IN 9. Day Phone (A-10): Area code and daytime telephone number of insured. Place area code in the first three digits. Do not include parentheses or hyphen.

   Example: 4152223456 = (415)222-3456

IN 10. Evening Phone (A-10): Area code and evening telephone number of insured. Place area code in the first three digits. Do not include parentheses or hyphen.

Example: 4152223456 = (415)222-3456

11. Address Line 1 (A-35): Insured's residence address, line 1.

12. Address Line 2 (A-35): Insured's residence address, line 2.

13. City (A-25): City of insured's residence address.

14. State (A-2): Two-letter postal abbreviation for the State of insured's residence address. When no U.S. postal designation exists, enter 88 to indicate a missing value.

15. Zip Code (A-9): Postal zip code of insured's residence address.

Nine digits are provided for this field. Begin filling in from left to right. Do not include a hyphen.

Example:	94105	=	94105
	941050412	=	94105-0412

When no U.S. postal designation exists, enter 888888888 to indicate a missing value.

CT, IN 16. Marital Status (A-1): Marital status of insured at time of assessment.

A = Not Married
B = Married
C = Civil Union or Domestic Partner
U = Unknown

17. Living Arrangement (A-1): Living arrangement of insured at time of assessment.

A = Alone
B = With spouse
C = With other relatives
D = Other
E = With Civil Union Partner or Domestic Partner
U = Unknown

IN 18. Sex (A-1): Gender of insured.

M = Male
F = Female
U = Unknown

NY 19. Benefit Contact (A-1): Indicator of whether the insured has designated a contact person to notify regarding eligibility for benefits.

Y = Yes
N = No

20. Medicare Status (A-1): Indicator of insured's Medicare coverage at the time of assessment for long-term care benefits.

A = Part A only
B = Parts A and B
C = No Medicare coverage

21. Other Insurance Status (A-1): Indicator of other insurance coverage of insured at the time of assessment for long-term care benefits.

A = Medicare Supplemental Policy Policy that provides supplemental health coverage to Medicare benefits. This includes policies that provide capitated acute care and preventive services that supplement Medicare benefits and policies that provide coverage under a Medicare Select contract under Section 1876 or 1833 of the Social Security Act.

B = Other Health Insurance Policy Health insurance policies approved by the Department of Insurance that are not designated to supplement Medicare. Examples of such policies are hospital indemnity policies, specific disease policies (e.g., cancer policies), and specific services policies (e.g., long-term care policies, pharmacy policies).

C = Both A and B

D = None of the above

U = Unknown

IN, NY 22. Assessment Date (D-8): Date that the face-to-face assessment or reassessment was performed. In the event that this date is not collected for reassessments, this field should be 8-filled.

MMDDYYYY

CA,CT,IN,NY

23. Performed by Whom (A-5): State-specific indicator for the assessment team that performed the assessment. Refer to state-specific documentation for the coding options for each state.

IN

24. Policy Insured Event Met (A-1): Indicator for whether insured meets policy insured event criteria at assessment.

    Y = Yes, policy insured event met
    N = No, policy insured event not met

CA,CT,IN,NY

25. State Insured Event Met (A-1): Indicator for whether insured meets State program insured event criteria at assessment.

    Y = Yes, State program insured event met
    N = No, State program insured event not met
    8 = Not applicable

CT,IN,NY

26. Pre-Admission Screening Met (A-1): Indiana allows insurers to use the Indiana Preadmission Screening Program for assessment of insureds when determining benefit eligibility. This field is not applicable for reports to states other than Indiana.

    Y = Yes, pre-admission screening criteria met
    N = No, pre-admission screening criteria not met
    8 = Not applicable

NY

27. Eligibility Decision Date (D-8): Date that insurer makes decision regarding insured's eligibility for long-term care benefits. In the event that a discrete decision date for reassessments is not available, this field should be 8-filled for reassessments.

    MMDDYYYY

28. Effective Date of Disability (D-8): Date that the insured meets the policy insured event criteria. Not applicable if insured does not meet the policy insured event criteria. For policies with elimination periods, this date should be the start of the elimination period. For reassessments within the same episode, this date should be the original effective date of disability.

    MMDDYYYY

    88888888 = Not applicable

CT, NY 29. Dressing Deficiency (A-1): Indicator of whether insured is found deficient in this activity using the State program insured event definition.

Y = Yes
N = No
8 = Not applicable

CT, NY 30. Bathing Deficiency (A-1): Indicator of whether insured is found deficient in this activity using the State program insured event definition.

Y = Yes
N = No
8 = Not applicable

CT, NY 31. Eating/Feeding Deficiency (A-1): Indicator of whether insured is found deficient in this activity using the State program insured event definition.

Y = Yes
N = No
8 = Not applicable

CT, NY 32. Toileting Deficiency (A-1): Indicator of whether insured is found deficient in this activity using the State program insured event definition.

Y = Yes
N = No
8 = Not applicable

CT, NY 33. Transferring Deficiency (A-1): Indicator of whether insured is found deficient in this activity using the State program insured event definition.

Y = Yes
N = No
8 = Not applicable

CT, NY 34. Continence Deficiency (A-1): Indicator of whether insured is found deficient in this activity using the State program insured event definition.

Y = Yes
N = No
8 = Not applicable

NY 35. Ambulating Deficiency (A-1): Indicator of whether insured is found deficient in this activity using the State program insured event definition.

Y = Yes
N = No
8 = Not applicable

NY 36. Cognitive Impairment (A-1): Indicator of whether insured is found to be cognitively impaired as defined by the State program insured event criteria definition.

Y = Yes
N = No
8 = Not applicable

CT 37. MSQ Test Score (N-2): The number of correct responses on the MSQ test.

0 - 10
97 = Test not given
98 = Refused to take test
99 = Too impaired to take test

CT 38. Score on Folstein Test (N-2):

0 - 30
97 = Test not given
98 = Refused to take test
99 = Too impaired to take test

NY 39. Wandering (A-1): Aimless, potentially dangerous movement within or outside the home.

Y = Yes
N = No
8 = Not applicable

NY 40. Abusive/Assaultive (A-1): Physically causing harm to self or others, including verbal assaults.

Y = Yes
N = No
8 = Not applicable

NY 41. Poor Judgment (A-1): Inability to follow medication or dietary regime without supervision, exhibiting poor judgement which is potentially harmful to self or others.

Y = Yes
N = No
8 = Not applicable

NY 42. Bizarre Hygiene (A-1): Gross and unacceptable hygiene or eating habits, disrobing in inappropriate situations, making inappropriate or dangerous sexual advances.

Y = Yes
N = No
8 = Not applicable

CT,NY 43. Complex Unstable Medical Condition (A-1): Individual requires twenty-four (24) hours a day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital. This field does not apply to Connecticut and New York.

Y = Yes
N = No
8 = Not applicable

File 4: Service Payments & Utilization

File Information

Frequency: Quarterly, on a calendar year basis. Reports are due 30 days after the close of the reporting period.

Record Definition: Each record reports a summation (of utilization and payments) by insured for each service code (Field 7) for which a claim was paid during the reporting period. If the payment is for a service received during a prior reporting period, a separate record is generated for each quarter during which a service was received.

For example, assume that the following services were paid in the first quarter of 2005:

1 home health aide service received in 12/04,
1 home health aide services received in 1/05, and
1 home health aide service received in 3/05

At the end of the 1st quarter of 2005, 2 records would be submitted, one for the two home health aide services received in the 1st quarter of 2005 and one for the home health aide service received in the 4th quarter of 2004.

File 4 should include case management or counseling services for which payment is reported as an **administrative** cost. These services are identified in Appendix 1 (Long-Term Care Service Codes and Definitions) as 78xx- for administrative-cost case management services and 79xx- for administrative-cost counseling services. Case management and counseling services for which payment is reported as a **benefit** cost are identified by service codes72xx- and 74xx-, respectively.

Trigger: Claim payment (including benefit-cost case management/counseling services or administrative-cost case management/counseling services) during the reporting period.

File 4: Service Payments & Utilization

File Format

	Field Name	Position	Field Type/Length
1.	Option Type	1	A-1
2.	Company Code	2	N-3
3.	Policy Form Number	5	N-8
4.	Original Effective Policy Date	13	D-8
5.	Social Security Number	21	A-9
6.	Reporting Period	30	D-6
7.	Service Code	36	A-5
8.	Service Quarter	41	D-6
9.	Service Amount Billed	47	N-8
10.	Service Payment Amount	55	N-8
11.	Service Payment Amount Protected	63	N-8
12.	Units of Service	71	N-6
13.	Days of Service Rendered	77	N-3
14.	Remaining Benefit Dollars	80	N-9
15.	Maximum Remaining Benefit Days (NH)	89	N-8
16.	Maximum Remaining Benefit Days (HC)	97	N-8
Total Record Length:		104	

File 4: Service Payments & Utilization

Field Definitions

1. Option Type (A-1): Report this field as 8 = Not Applicable.

   8 = Not applicable

2. Company Code (N-3): Unique, confidential company identifier issued to insurers by project staff. The company code is the same for each company across the states.

NY 3. Policy Form Number (N-8): Unique policy identifier issued to insurers by project staff in each state.

4. Original Effective Policy Date (D-8): Original effective date of the policy. For group policies, this date should be defined as the effective date of coverage of the individual certificate (as opposed to the effective date of coverage of the group policy).

   The Original Effective Policy Date as reported in the UDS is used as a unique identifier and should never change, even if there are subsequent changes to the policy that result in a policy reissue. This date should remain the same for a given policyholder and policy across all files.

   MMDDYYYY

5. Social Security Number (A-9): Insured's social security number

6. Reporting Period (D-6): Last month of the three-month reporting period reported in this record.

   MMYYYY Month = 03, 06, 09, or 12

CA,CT,IN 7. Service Code (A-5): 5-digit service code indicating the type of service received by insured. Service codes to be used are listed in Appendix 1, Long-Term Care Service Codes and Definitions.

8. Service Quarter (D-6): Last month of the three month reporting period during which the reported services were delivered.

   MMYYYY month = 03, 06, 09, 12

CA 9. Service Amount Billed (N-8, include cents): Total amount billed on claims paid by insurer during the reporting period. Amount should be totaled by "Service Code" (Field 7) and "Service Quarter" (Field 8). Services that have been billed, but not yet paid in the reporting period, should not be included in this report.

Eight digits are provided for this field. Example: 00500000 = $5000.00

CA 10. Service Payment Amount (N-8, include cents): Total amount paid by insurer during the reporting period for services received. Amount should be totaled by "Service Code" (Field 7) and "Service Quarter" (Field 8).

Eight digits are provided for this field. Example: 00500000 = $5000.00

IN 11. Service Payment Amount Protected (N-8, include cents): This field should indicate the portion of the amount reported in "Service Payment Amount" (Field 10) that counts towards asset protection.

Eight digits are provided for this field. Example: 00500000 = $5000.00

12. Units of Service (N-6): Total number of service units paid by insurer during the reporting period. Units should be totaled by "Service Code" (Field 7) and "Service Quarter" (Field 8). Type of units (days, hours, visits, etc.) will be determined by "Service Code" (Field 7).

Data in this field will be reported with an implied decimal, such that the last two digits will be to the right of the decimal point. Services reported in hourly units will end in 00, 25, 50, or 75 only. Services reported in units other than hours will always end in 00 (zeros).

REPORTING EXAMPLES:

Code*	Service	Units of Service
11003	Nursing Home	009100 = 91.00 days
32001	Home Health Aide Services	031050 = 310.50 hours
31202	Physical Therapy	000300 = 3.00 visits
46401	Chore Services	001775 = 17.75 hours
43206	Home Delivered Meals	006000 = 60.00 meals

* See Appendix 1, Long-Term Care Service Codes and Definitions

13. Days of Service Rendered (N-3): Total number of days of service paid for by insurer during the reporting period. Days should be totaled by "Service Code" (Field 7) and "Service Quarter" (Field 8).

    Three digits are provided for this field. Examples: 007 = 7 days
    024 = 24 days
    104 = 104 days

NY

14. Remaining Benefit Dollars (N-9, include cents): Remaining benefit (in dollars). This field indicates the total remaining benefits at the end of the reporting quarter indicated in Field 6.

    Nine digits are provided for this field. Example: 001000000 = $10,000.00

    888888888 = Not applicable
    999999999 = Unlimited Benefit

CA,CT,IN,NY

15. Maximum Remaining Benefit Days (NH) (N-8): Remaining nursing home benefit (in days). This field indicates the total remaining benefit days at the end of the reporting quarter indicated in Field 6. For policies that apply benefits interchangeably between nursing home and home care, this field should report the maximum remaining benefit (in days) if only nursing home care were used.

    Data in this field will be reported with an implied decimal, such that the last two digits will be to the right of the decimal point.

    Eight digits are provided for this field. Examples: 00036500 = 365.00 days
    00102850 = 1028.50 days

    88888888 = Not applicable

CA,CT,IN,NY

16. Maximum Remaining Benefit Days (HC) (N-8): Remaining home care benefit (in days). This field indicates the total remaining benefit days at the end of the reporting quarter indicated in Field 6. For policies that apply benefits interchangeably between nursing home and home care, this field should report the maximum remaining benefit (in days) if only home care were used.

    Data in this field will be reported with an implied decimal, such that the last two digits will be to the right of the decimal point.

    Eight digits are provided for this field. Examples: 00036500 = 365.00 days
    00102850 = 1028.50 days

    88888888 = Not applicable

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APPENDIX 1

LONG-TERM CARE SERVICE CODES AND DEFINITIONS

This document provides a systematic listing and coding of long-term care services for reporting utilization. Services are divided into sections, beginning with institutional and skilled care and progressing to less-skilled care and ancillary services. The coding system is presented in numerical order.

Each service category is identified by a four-digit service code. The fifth digit is reserved for indicating the unit of service. Unit codes are as follows:

1 = hour
2 = visit/assessment
3 = day
4 = week
5 = month
6 = meal
7 = miles
8 = $10
9 = other

For example, the four-digit service code for home health aid services is 3200-. If this service is reported on an hourly basis, the service code used would be 32001.

This listing is intended to be comprehensive and to include the range of services expected to be available under this program. Not all services listed will be available in each state or under each insurance policy. States or insurers may use all or a subset of the codes as appropriate for their state program.

If a new service code is needed, please notify partnership staff. A new code and definition will be developed and disseminated to all the participating insurers so that consistency in the data set can be maintained.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICES

Code	Service
1000-	Institutional Care
1100-	Nursing Home
1110-	Hospital Bed Hold
1120-	Other Bed Hold
1500-	Alternate Level of Care
1900-	Other Institutional
2000-	Alternative Housing
2100-	Assisted Living Facility
2200-	Adult/Elderly Foster Care
2900-	Other Alternative Housing
3000-	Home Health Care Services
3100-	Home Health Skilled Services
3110-	Skilled Nursing Services
3120-	Physical Therapy
3130-	Speech Therapy
3140-	Respiratory Therapy
3150-	Occupational Therapy
3200-	Home Health Aide Services
3500-	Other Provider Services
3510-	Nutritionist/Dietician
3520-	Audiologist
3530-	Chemotherapy
3800-	Paramedical Services
3900-	Other Home Health Care Services
4000-	Personal Support Services
4200-	Day Care
4220-	Adult Day Care (Health)

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICES

4240- Social Day Care
4250- Adult Day Care (Health & Social)

4300- Meals
4310- Congregate Meals
4320- Home-Delivered Meals
4330- Restaurant Meal Allowance

4600- Home-based Personal Support
4609- Attendant Care
4610- Companion Services
4620- Personal Care
4630- Homemaker (non-personal care)
4640- Chore Services
4650- Laundry Services

4700- Home-based Other Support
4710- Housing Improvement/Modifications
4720- Teaching and Demonstration Services
4790- Other home-based support services

4800- Personal Emergency Response System
4810- Personal Emergency Response System Installation Fee
4900- Other Personal Support Services

5000- Respite Services
5200- Respite Care
5220- In-home
5230- Out-of-home

5400- Hospice
5420- In-home
5430- Out-of-home

7000- Case Management & Counseling
7200- Case Management (reported as benefit cost)
7210- Assessment and Care Planning (reported as benefit cost)

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICES

7211- Assessment (reported as benefit cost)
7212- Care Planning (reported as benefit cost)
7230- Coordination, Monitoring, Reassessment (reported as benefit cost)
7231- Coordination (reported as benefit cost)
7232- Monitoring (reported as benefit cost)
7233- Reassessment (reported as benefit cost)

7400- Counseling Services (reported as benefit cost)
7410- Mental health counseling (reported as benefit cost)
7420- Social worker (reported as benefit cost)
7430- Legal counseling (reported as benefit cost)

7500- Care Management (New York State Only)

7800- Case Management (reported as administrative cost)
7810- Assessment and Care Planning (reported as administrative cost)
7811- Assessment (reported as administrative cost)
7812- Care Planning (reported as administrative cost)
7830- Coordination, Monitoring, Reassessment (reported as administrative cost)
7831- Coordination (reported as administrative cost)
7832- Monitoring (reported as administrative cost)
7833- Reassessment (reported as administrative cost)

7900- Counseling Services (reported as administrative cost)
7910- Mental health counseling (reported as administrative cost)
7920- Social worker (reported as administrative cost)
7930- Legal counseling (reported as administrative cost)

8000- Other Supportive Services
8200- Transportation
8210- Transportation, Non-Emergency, Medical
8220- Transportation, Ambulance
8230- Transportation, Social
8290- Transportation, Other

8400- Equipment and Supplies
8420- Durable Medical Equipment
8440- Medical Supplies

9000- Other Long-Term Care Services

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
1000-	Institutional Care
1100- Nursing Home	A licensed, extended care facility which acts as a supportive living environment that provides medical and nursing supervision on a 24 hour per day basis for persons requiring rehabilitation or custodial care. Institutions are defined as medical assistance Skilled Nursing Facilities (SNF), and Intermediate Care Facilities (ICF).
1110- Hospital Bed Hold	Days of nursing home care paid for by the carrier while the insured is in an inpatient hospital setting.
1120- Other Bed Hold	Days of nursing home care paid for by the carrier while the insured is in another setting other than nursing home or inpatient hospital.
1500- Alternate Level of Care	Alternate Level of Care (ALC) refers to that portion of a hospital stay following the determination that a patient's medical condition or status no longer warrants acute hospital care. ALC status is most commonly associated with patients who remain in the hospital beyond the medically necessary stay while awaiting nursing home placement or the provision of home care services. The number of ALC days (ALCLOS) is the difference between the total length of stay (TLOS) and the medical length of stay (MLOS), or ALCLOS = TLOS - MLOS. Alternatively, ALC days is the number of days spanning the effective date of the PSRO or medical review committee's determination that acute care is no longer warranted and the hospital discharge date. The hospital's reimbursement rate for ALC days is at a lower rate, usually the nursing home or chronic-care rate. It is

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
	important to note that ALC status is a function of the patient, not the site of care. A patient who remains in the hospital and whose medical LOS has been determined to have ended is deemed to be in ALC status, independent of the type of bed, wing, or facility in which the patient resides.
1900-	Other Institutional.
2000-	Alternative Housing
2100- Assisted Living Facility	An assisted living facility is a facility licensed, where required, by the appropriate licensing agency to serve persons who require assistance with activities of daily living but do not require continuous medical or nursing care. Examples of assisted living facilities are licensed Homes for the Aged, rest homes, custodial care facilities, and personal care facilities.
2200- Adult/Elderly Foster Care	Elderly Foster Care provides an individual with continuous monitoring, supervision, and coordination of daily living and management of overall health and welfare. These services are provided on a 24 hour per day basis in a private non-related family residence, and whenever necessary to prevent or delay institutionalization. Room and board are not reimbursable services.
2900-	Other Alternative Housing.
3000-	Home Health Care Services
3100-	Home Health Skilled Services

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
3110- Skilled Nursing Services	Services include the services of a licensed Registered Nurse (RN) or a licensed Practical Nurse (LPN) employed by or under contract to a home health agency, or when no home health agency exists in the area, a Registered Nurse licensed to practice in the State. These services include, but are not restricted to: physical nursing care or teaching of nursing care; administration and supervision of medications; supervision of dietary regime; supervision of home health aides; and, diabetic teaching. A skilled nursing visit is a visit of less than or equal to 2 hours. This is to distinguish this service from an extended nursing care visit that is paid on an hourly basis.
3120- Physical Therapy	Covered services include the services of a licensed Physical Therapist who provides treatment to restore, maintain, or improve muscle tone, joint mobility, and/or physical function.
3130- Speech Therapy	Covered services include the services of a licensed Speech Pathologist or Therapist who provides evaluation, program recommendations, treatment and training in expressive language, voice, articulation, and fluency.
3140- Respiratory Therapy	Respiratory Therapies are those treatments which act to preserve or improve pulmonary function.
3150- Occupational Therapy	Covered services include the services of a licensed Occupational Therapist or a certified/licensed occupational therapist assistant who functions under the general supervision of the occupational therapist. Occupational Therapists or their assistants function to direct an individual in select activities to restore, maintain, or improve functional skills.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
3200- Home Health Aide Services	Covered services include the services of a home health aide employed by or under contract to a home health agency and under the supervision of a registered nurse. Home Health Aide services are those home-based services which are medically necessary and physician or case management ordered and delivered by a licensed home health aide agency or a licensed home health aid. A home health aide functions to provide intermittent health maintenance, continued treatment or monitoring of a health condition, or can provide non-medical assistance to meet essential, personal, and physical needs (i.e. assist with showering, toileting, dressing, transferring, eating, and routine skin and hair care).
3500-	Other Provider Services
3510- Nutritionist/ Dietician	A Nutritionist or Dietitian can provide the following services: an assessment of the nutritional needs of an individual; set up a plan of nutritional care or intervention; provide nutritional counseling and education in health and disease; develop, implement, and manage a food service or nutrition service system.
3520- Audiologist	A certified audiologist who will provide a detailed evaluation using programs qualified or registered with the Professional Services Board of the American Speech and Hearing Association.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
3530- Chemotherapy	
3800- Paramedical	Non-skilled providers of Personal care assistance who have received special training. Paramedic services include injections, catheter care, ostomy, tube-feeding, changing of dressing, movement to prevent atrophy, respiratory suctioning.
3900- Other Home Health Care Services	
4000-	Personal Support Services
4200- Day Care	
4220- Adult Day Care (Health)	Adult Day Care (Health) is defined as a program of services provided in a congregate care setting for a scheduled number of hours per week for individuals who require 24-hour care. Elements of an adult day health program are directed toward meeting the supervision, health maintenance and restoration needs of the participant. In order to receive payment for services, an adult day health services provider must provide, at minimum, nursing services, social work services, dietary services to meet specialized dietary needs as prescribed by health care personnel, personal care services, recreational therapy, and transportation services for individuals to and from their homes. Note that transportation to and from the Adult Day Health Program is included in the unit of service for this category. Do not count this type of transportation under any other unit of service.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
4240- Social Day Care	Emphasizes social and recreational activities in a group setting, with some health monitoring. Includes: assistance with walking, mealtime activities, grooming, nutrition services, and planned recreational and social activities designed to encourage physical and mental exercise and stimulate social interaction.
4250- Adult Day Care (Health and Social)	Adult Day Care (Health and Social) is the provision of a structured, comprehensive program which provides a variety of health, social and related supportive services in a protective setting. This community-based service is designed to meet the needs of functionally impaired adults through an individualized service plan, including personal care and supervision, provision of meals as long as the meals do not meet a full daily nutritional regimen, medical care, transportation to and from the site, and social, health, and recreational activities. In addition, Adult Day Care will include the provision of meals and snacks as appropriate.
4300- Meals	
4310- Congregate Meals	Provides nutritional meals in a group setting. Focuses on reducing isolation as well as promoting better health through improved nutrition.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
4320- Home-Delivered Meals	Home delivered meals, or "meals on wheels", includes the preparation and delivery of one (1) or two (2) meals for persons who are unable to prepare or obtain nourishing meals on their own. Home delivered meals may include, but are not required to include, the services of a Nutritionist or Dietitian, as a component of the program. Each meal is to meet the standard of providing a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Science -- National Research Council.
4330- Restaurant Meal Allowance	
4600- Home-based Personal Support	
4609- Attendant Care	Attendant Care services primarily involve "hands-on" assistance with a client's physical dependency needs. This service includes Companion Services (46100) and Personal Care (46200) as defined below. Attendant Care includes incidental homemaker activities which are essential to the client's health needs to prevent or postpone institutionalization and which are not furnished in isolation. Meal planning, preparation and clean-up are allowable activities.
4610- Companion Services	Companion Services are home-based supervision and monitoring activities which assist and/or instruct an individual in maintaining a safe environment, when the person is unable to maintain a safe environment for him/herself or when the person

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
	primarily responsible for monitoring and supervising is absent or unable to perform such activities. These home-based supervision and monitoring activities include, but are not limited to, escorting an individual to recreational activities or to necessary medical, dental, and business appointments, reading to or for an individual, supervising or monitoring ADLs, reminding to take self administered medication, assisting with telephone calls and written communications, reporting changes in needs or condition to supervisor or case manager.
4620- Personal Care	Provides non-medical assistance to meet essential personal physical needs. The personal care attendant may assist with showering, toileting, dressing, transferring, eating, and routine skin and hair care.
4630- Homemaker Services (non-personal care)	Homemaker services are general household management activities provided in the home to assist and/or instruct an individual in managing a household when the person is unable to manage the home for her/himself or when the individual primarily responsible is absent or unable to perform such management activities. These services are provided on a part-time or intermittent basis. Activities include, but are not limited to, changing linens, dishwashing, shopping, meal planning and preparation, light housekeeping, money management (specifically limited to check writing and balancing, bank deposits, paying bills, and budgeting for the purpose of daily household expenses and personal needs, not including long term financial planning or investment), correspondence, communication of health or other problems to supervisor, laundry, and mending.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
4640- Chore Services	Chore services include the performance of heavy indoor or outdoor work or household tasks to individuals who are unable to do these tasks for themselves because of frailty or other conditions. These services are necessary to maintain and promote a healthy and safe environment for individuals in their own residence.
4650- Laundry Services	Ordinarily to be provided by a commercial laundry company or an adult day health center and is designed to serve persons who have no other means of having laundry cleaned. Dry cleaning is not included in laundry services.
4700- Home-based Other Support	
4710- Housing Improvement/ Modifications	Selected internal and external modifications to the home environment which will assist clients to increase their functional ability and enhance the client's safety and well-being so that they can remain in their current living situation, rather than be admitted to nursing facilities.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
4720- Teaching and Demonstration Services	Training of client or non-skilled providers in care techniques (e.g. training in paramedic services - see code 38000) to enable client to maintain independence in the home.
4790-	Other home-based support services
4800- Personal Emergency Response System	Personal Emergency Response System (PERS) (a/k/a Emergency Call Service, or Home Medical Alert System), is an in-home 24-hour electronic alarm system activated by a signal to a central switchboard. PERS enables a high-risk individual to secure immediate help in the event of medical, physical, emotional, or environmental emergency. These services are provided on a 24-hour basis when necessary to prevent or delay institutionalization of an individual.
4810- Personal Emergency Response System Installation Fee	The one-time fee charged for installation of a Personal Emergency Response System (PERS) as defined under Service Code 4800-.
4900- Other Personal Support Services	

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
5000-	Respite Services
5200- Respite Care	Respite Care services provide short-term relief from the continuous care of an elderly individual for the individual's family or other primary caregiver.
5220- In-home Respite Care	An in-home respite care provider is an individual who has received special training as well as experience in providing home care for elderly persons. In home providers of respite care shall include, but not be limited to, companions, homemakers, home health aides, and other home health care personnel.
5230- Out-of-home Respite Care	An out-of-home respite care provider is an organized facility licensed, certified, or otherwise operating under the guidelines of other State agencies to provide respite care appropriately as defined in these regulations. Out-of-home providers may include, but are not restricted to, rest homes with nursing supervision, chronic and convalescent nursing facilities, adult day care centers, homes for the aged, or elderly foster care providers.
5400- Hospice	Palliative and supportive care for terminally ill clients and their families or caregivers, either in an in-home or in-patient setting. Includes nursing, respite, bereavement, reassurance, and information and referral.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
5420- In-home Hospice	Home Hospice care means a program of care for terminally ill patients that is ordered by a physician, and received in the client's home. Home is considered to be the client's home, assisted living facility, or any facility where the client resides, but is not a hospital or nursing home.
5430- Out-of-home Hospice	Care received in a Hospice Facility, which is a licensed facility that provides a formal program of care for terminally ill patients, and is provided on an inpatient basis and directed by a physician.
7000-	Case Management & Counseling
7200- Case Management	Case management services shall include, but not be limited to the development of an assessment (which means a written evaluation of an individual's medical, psychosocial and economic status, degree of functional impairment and related service needs), and a Plan of Care for the coordination of appropriate services and the monitoring of the delivery of such services. **This code should be used for case management services that are reported as benefit costs and not as administrative costs by the insurer.**
7210- Assessment and Care Planning	Initial client assessment and development of care plan. **This code should be used for assessment and care planning services that are reported as benefit costs and not as administrative costs by the insurer.**

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
7211- Assessment	Initial written evaluation of an individual's medical, psychosocial and economic status, degree of functional impairment and related service needs. **This code should be used for assessment services that are reported as benefit costs and not as administrative costs by the insurer.**
7212- Care Planning	A written plan of care for the coordination of appropriate services. **This code should be used for care planning services that are reported as benefit costs and not as administrative costs by the insurer.**
7230- Coordination, Monitoring, Reassessment	Coordination of services, monitoring of services, and any reassessments. **This code should be used for coordination, monitoring, and reassessment services that are reported as benefit costs and not as administrative costs by the insurer.**
7231- Coordination	Coordination of service delivery. **This code should be used for coordination services that are reported as benefit costs and not as administrative costs by the insurer.**
7232- Monitoring	Monitoring the delivery of services. **This code should be used for monitoring services that are reported as benefit costs and not as administrative costs by the insurer.**
7233- Reassessment	Periodic reassessments of client and service needs. **This code should be used for reassessment services that are reported as benefit costs and not as administrative costs by the insurer.**

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
7400- Counseling Services	**This code should be used for counseling services that are reported as benefit costs and not as administrative costs by the insurer.**
7410- Mental Health Counseling	Mental Health Counseling services are professional counseling services provided to help resolve or enable the eligible individual to cope with individual, family, and/or environmentally related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation in the community, or re-entering the community or family. **This code should be used for mental health counseling services that are reported as benefit costs and not as administrative costs by the insurer.**
7420- Social worker	**This code should be used for social worker services that are reported as benefit costs and not as administrative costs by the insurer.**
7430- Legal counseling	**This code should be used for legal counseling services that are reported as benefit costs and not as administrative costs by the insurer.**
7500- Care Management (New York State Only)	Consultation Services, defined as assistance and advice in choosing and applying for long-term care services, based on the personal needs of the Participating Consumer. The consultation shall be given by an individual with professional training and experience arranging and managing long-term care services, and may be offered by the Participating Insurer. However, the Participating Consumer shall have the option to seek such services outside the Participating Insurer. Participating

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
	Consumers eligible for benefits shall be eligible to purchase care management benefits equal in value to a minimum of two (2) policy/certificate coverage nursing home days per year while in benefit status to pay for outside consultation services. Care management benefits shall be characterized as a claims cost; to the extent used by the Participating Consumer, the cost of care management services shall be deducted from the total pool of available benefits.
7800- Case Management	Case management services shall include, but not be limited to the development of an assessment (which means a written evaluation of an individual's medical, psychosocial and economic status, degree of functional impairment and related service needs), and a Plan of Care for the coordination of appropriate services and the monitoring of the delivery of such services. **This code should be used for case management services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7810- Assessment and Care Planning	Initial client assessment and development of care plan. **This code should be used for assessment and care planning services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7811- Assessment	Initial written evaluation of an individual's medical, psychosocial and economic status, degree of functional impairment and related service needs. **This code should be used for assessment services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
7812- Care Planning	A written plan of care for the coordination of appropriate services. **This code should be used for care planning services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7830- Coordination, Monitoring, Reassessment	Coordination of services, monitoring of services, and any reassessments. **This code should be used for coordination, monitoring, and reassessment services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7831- Coordination	Coordination of service delivery. **This code should be used for coordination services that are reported as <u>administrative costs</u> and not benefit costs by the insurer.**
7832- Monitoring	Monitoring the delivery of services. **This code should be used for monitoring services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7833- Reassessment	Periodic reassessments of client and service needs. **This code should be used for reassessment services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7900- Counseling Services	**This code should be used for counseling services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
7910- Mental Health Counseling	Mental Health Counseling services are professional counseling services provided to help resolve or enable the eligible individual to cope with individual, family, and/or environmentally related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation in the community, or re-entering the community or family. **This code should be used for mental health counseling services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7920- Social worker	**This code should be used for social worker services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
7930- Legal counseling	**This code should be used for legal counseling services that are reported as <u>administrative costs</u> and not as benefit costs by the insurer.**
<u>8000-</u>	<u>Other Supportive Services</u>
8200- Transportation	
8210- Transportation Non-Emergency	Medical transportation is the conveying of a recipient by vehicle, to or from a non-emergency service identified as medically necessary by the primary care physician.

APPENDIX 1 (Continued)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
8220- Transportation, Ambulance	Emergency transportation to obtain medical services.
8230- Transportation, Social	Transportation services provide access to social services, community services, and appropriate social or recreational facilities, and are essential to help some individuals avoid institutionalization by enabling these individuals to retain their role as community members. These services are provided when transportation is required to promote and enhance independent living and self support. Transportation services may be provided by taxi, livery, bus, invalid coach, volunteer organization or individuals. They shall be reimbursed when they are necessary to provide access to needed community based services, or community activities as specified in the plan of care. NOTE, TRANSPORTATION TO AND FROM AN ADULT DAY HEALTH CARE SETTING IS NOT TO BE INCLUDED IN THIS UNIT OF SERVICE.
8290- Transportation, Other	
8400- Equipment and Supplies	

APPENDIX 1 (Concluded)

UNIFORM CODES FOR LONG TERM CARE SERVICE
DEFINITIONS

Service	Definition
8420- Durable Medical Equipment	Durable medical equipment is equipment needed to help promote or sustain an impaired person's functional abilities. It is equipment (rented or purchased), designed for repeated use in the diagnosis or treatment of an illness or injury; to improve the functions of a malformed body; or to prevent or retard further deterioration of the medical condition; and which is not useful in the absence of injury or illness.
8440- Medical Supplies	Medical supplies that are suitable for use in the home.
9000-	Other Long-Term Care Services

STATE-SPECIFIC APPENDICES

California Partnership for Long-Term Care

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Connecticut Partnership for Long-Term Care

•

Indiana Long Term Care Program

•

New York State Partnership for Long-Term Care

CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

California-specific field definitions that differ from the standard UDS field definitions are listed below by UDS file and field number. Fields that are not applicable should be coded by filling the field with 8s.

File 1: Registry of New Insureds

3. Policy Form Number (N-8): Consists of four components: (a) policy type (1 digit), (b) version number (2 digits), (c) risk pool indicator (1 digit), and (d) group code (2 digits). The remaining two columns (digits) are reserved for future use. The components should be coded as follows:

Note: The following instructions apply to NEW policies only. Other codes are applicable when reporting a change to an existing policy, such as when a policyholder chooses to step-down to a reduced benefits policy or converts from Non-Tax Qualified to Tax Qualified status, etc. For additional information, see the coding instructions in the section of the California state-specific appendix related to File 2: Insureds Who Have Changed/Dropped Their Policies.

- Policy type (1st digit), where the codes applicable to **new** policies are

  1 = comprehensive benefits policy
  2 = nursing facility only policy[1]

- Version (or revision/generation) number of policy (2nd-3rd digits);

  When a new version of a California Partnership policy is issued, a new version code (to be assigned by the California Partnership) should be used. For example, a tax-qualifying version of a California Partnership policy, should be coded (if it is a comprehensive policy and other things being equal) as "10100000". Therefore:

  00 = Non-Tax Qualified
  01 = Tax Qualified

- Risk pool identification (4th digit), where;
  1 = groups qualified to establish separate risk pools
  0 = all other group and individual policies

[1] "Nursing facility only policy" means "nursing facility and residential care facility only policy" as used in California Code of Regulations, Title 22, sections 58000-58082 (referred to as the California Partnership regulations in this document). "Residential care facility" is defined in section 58030 of the California Partnership regulation.

- Group code (5th-6th digits) is the numeric part of the group code assigned by the California Partnership. Please contact the California Partnership staff to obtain a group code for each sponsoring group/organization.

- Remaining columns (7th-8th digits) are reserved for future use should be filled with 0s (zeroes) until further specifications are determined.

5. Policy Category (A-1): Policies issued by the California Public Employees' Retirement System (PERS) should be reported using code "C" (Organization Sponsored).

21. Policy Type (NH/HC) (A-1): Nursing facility only policies under the California Partnership are classified as "A" or "C" (Nursing Home Only Policies) for the Uniform Data Set (UDS) reporting purpose, although these policies also cover stays in a residential care facility.

22. Elimination Period (Days): NH (N-3): The policy elimination periods allowed under the California Partnership are:

- 30 days = if the lifetime maximum benefits are less than 730 times the Average Daily Private Pay Rate for Nursing Facilities; or
- 30 or 90 days = if otherwise.

23. Elimination Period (Days): HC (N-3): **Should be coded as "888".** Since the policy elimination period is applicable to both NH and HC benefits, only the entry in Field 22 (Elimination Period for NH) is used for reporting.

24. Percentage Of Costs (N-3): **Should be coded as "888".** This field is currently not applicable to the California Partnership.

25. Maximum Per Diem: NH (N-5, include cents): The allowable range for the upcoming year is published annually in Long-Term Care Issuers' Bulletin by the California Partnership. The range for the policies issued in 1995 is: 80, 90, 100, 110, 120, or 130.

26. Maximum Amount: NH (N-7): **Should be coded as "8888888".** Breakdown of maximum benefit amounts into coverages for nursing facilities and home care is unnecessary. Field 31 "Total Maximum Amount" is the only field that must be reported in relation to the maximum benefit amounts.

27. Maximum Length (Days): NH (N-4): **Should be reported as "8888".** This field is not applicable because the Partnership policies in California are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

29. Maximum Amount: HC (N-7): **Should be coded as "8888888".** Breakdown of maximum benefit amounts into coverages for nursing facilities and home care is unnecessary, since Field 31 "Total Maximum Amount" is the only field that must be reported in relation to the maximum benefit amounts.

30. Maximum Length (Days): HC (N-4): **Should be coded as "8888".** This field is not applicable because the Partnership policies in California are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

31. Maximum Amount: Total (N-7, do not include cents): The allowable range for the upcoming year is published annually in Long-Term Care Issuers' Bulletin by the California Partnership. The range for the policies issued in 1997 is 29,200-237,250.

32. Maximum Length (Days): Total (N-4): **Should be coded as "8888".** This field is not applicable because the Partnership policies in California are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

33. Respite Service Days (N-2): **Should be coded as "88".** This field is currently not applicable to the California Partnership policies.

34. Care Management Days (N-2): **Should be coded as "88".** This field is currently not applicable to the California Partnership policies.

40. Inflation Protection Mode: Daily Benefit (A-1): This field must be coded either as "B" (Automatic Compound Annual Increases) or "E" (Automatic Simple Annual Increases) depending on the type of inflation protection that the policy has. All Partnership policies in California must include the 5% annual automatic inflation protection.

41. Inflation Protection Percentage: Daily Benefit (N-2): This field must be 5 (%).

42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): This field must be coded either as "B" (Automatic Compound Annual Increases) or "E" (Automatic Simple Annual Increases) depending on the type of inflation protection that the policy has. All Partnership policies in California must include the 5% annual automatic inflation protection.

43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2): This field must be 5 (%).

44. Annualized Premium (N-7, include cents): This field should report the premium payment (annualized) amounts. For example, each payment amount should be multiplied by 4 if the payment mode is quarterly and by 12 if the mode is monthly.

File 2: Insureds Who Have Changed/Dropped Their Policies

3. Policy Form Number (N-8): Consists of four components: (a) policy type (1 digit), (b) version number (2 digits), (c) risk pool indicator (1 digit), and (d) group code (2 digits). The remaining two columns (digits) are reserved for future use. The components should be coded as follows:

- Policy type (1st digit):
  Whereas the codes applicable to **new** policies are

  1 = comprehensive benefits policy
  2 = nursing facility only policy

  The codes applicable to **changed** policies are

  3 = **reduced (step-down) benefit** comprehensive benefits policy
  4 = **reduced (step-down) benefit** nursing facility only policy

  Codes 3 and 4 are used when a policyholder chooses to step down to a reduced-benefits policy. Section 58061 © of the Partnership regulations describes the option of reducing benefits (or "step-down").

  To report a change to a reduced-benefits policy, Field 19 (Type of Change) should be coded "C" (Shorter Coverage or Reduced Benefit Option) and the first digit of this field (Policy Form Number) should be changed to 3 or 4 (from the original codes of 1 or 2).

- Version (or revision/generation) number of policy (2nd-3rd digits);

  When a Non-Tax Qualified (NTQ) policy is converted to Tax Qualified (TQ) status, or a TQ policy is converted to an NTQ version of a California Partnership policy, a new version code (to be assigned by the California Partnership) should be used.

  03 = **conversion** from NTQ to TQ status
  04 = **conversion** from TQ to NTQ status

  Codes 03 and 04 are used when a policyholder chooses to convert the policy from Non-Tax Qualified to Tax Qualified or from Tax Qualified to Non-Tax Qualified, respectively.

  To report a change of this nature, Field 19 (Type of Change) should be coded "P" if the change is from Non-Tax Qualified to Tax Qualified. Note: This does not apply to Grandfathered policies, which by definition are qualified.

  - Risk pool identification (4th digit)

    1 = groups qualified to establish separate risk pools
    0 = all other group and individual policies

  - Group code (5th-6th digits) is the numeric part of the group code assigned by the California Partnership. Please contact the California Partnership staff to obtain a group code for each sponsoring group/organization.

  - Remaining columns (7th–8th digits) are reserved for future use and should be filled with 0s (zeroes) until further specifications are determined.

5. Policy Category (A-1): Policies issued by the California Public Employees' Retirement System (PERS) should be reported using code "C" (Organization Sponsored).

21. Policy Type (NH/HC) (A-1): Nursing facility only policies under the California Partnership are classified as "A" or "C" (Nursing Home Only Policies) for the Uniform Data Set (UDS) reporting purpose, although these policies also cover stays in a residential care facility.

22. Elimination Period (Days): NH (N-3): The policy elimination periods allowed under the California Partnership are:

  - 30 days = if the lifetime maximum benefits are less than 730 times the Average Daily Private Pay Rate for Nursing Facilities; or
  - 30 or 90 days = if otherwise.

23. Elimination Period (Days): HC (N-3): **Should be coded as "888".** Since the policy elimination period is applicable to both NH and HC benefits, only the entry in Field 22 (Elimination Period for NH) will be used for reporting.

24. Percentage Of Costs (N-3): **Should be coded as "888".** This field is currently not applicable to the California Partnership policies.

25. Maximum Per Diem: NH (N-5, include cents): The allowable range for the upcoming year is published annually in Long-Term Care Issuers' Bulletin by the California Partnership. The range for the policies issued in 1997 is: 80, 90, 100, 110, 120, or 130.

26. Maximum Amount: NH (N-7): **Should be coded as "8888888".** Breakdown of maximum benefit amounts into coverages for nursing facilities (NH) and home care (HC) is unnecessary. Field 31 "Total Maximum Amount" is the only field that must be reported in relation to the maximum benefit amounts.

27. Maximum Length (Days): NH (N-4): **Should be coded as "8888".** This field is not applicable because the Partnership policies in California are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

29. Maximum Amount: HC (N-7): **Should be coded as "8888888".** Breakdown of maximum benefit amounts into coverages for nursing facilities (NH) and home care (HC) is unnecessary. Field 31 "Total Maximum Amount" is the only field that must be reported in relation to the maximum benefit amounts.

30. Maximum Length (Days): HC (N-4): **Should be coded as "8888".** This field is not applicable because the Partnership policies in California are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

31. Maximum Amount: Total (N-7, do not include cents): The allowable range for the upcoming year is published annually in Long-Term Care Issuers' Bulletin by the California Partnership. The range for the policies issued in 1997 is 29,200-237,250.

32. Maximum Length (Days): Total (N-4): **Should be coded as "8888".** This field is not applicable because the Partnership policies in California are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

33. Respite Service Days (N-2): **Should be coded "88".** This field is currently not applicable to the California Partnership policies.

34. Care Management Days (N-2): **Should be coded as "88".** This field is currently not applicable to the California Partnership policies.

40. Inflation Protection Mode: Daily Benefit (A-1): This field must be coded either as "B" (Automatic Compound Annual Increases) or "E" (Automatic Simple Annual Increases) depending on the type of inflation protection that the policy has. All Partnership policies in California must include the 5% annual automatic inflation protection.

41. Inflation Protection Percentage: Daily Benefit (N-2): This field must be 5 (%).

42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): This field must be coded either as "B" (Automatic Compound Annual Increases) or "E" (Automatic Simple Annual Increases) depending on the type of inflation protection that the policy has. All Partnership policies in California must include the 5% annual automatic inflation protection.

43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2): This field must be 5 (%).

44. Annualized Premium (N-7, include cents): This field should report the premium payment (annualized) amounts. For example, each payment amount should be multiplied by 4 if the payment mode is quarterly and by 12 if the mode is monthly.

File 3: Insureds Assessed For Long-Term Care Benefit Eligibility

23. Performed by Whom (A-5): Codes valid in California are:

CA001 = California Networks
CA002 = Family Caring Network
CA003 = Capitated Health Care Services
CA004 = Long Term Solutions
CA005 = Evercare Connections
CA006 = Nation's Care Link

25. State Insured Event Met (A-1): **Should be coded as "8".** The policy insured event and state insured event are the same for the California Partnership policies.

File 4: Service Payments & Utilization

7. Service Code (A-5): Care management services are coded as

   - 7800-7999 if they are paid out of insurer' administrative costs, and
   - 7200-7499 if they are paid out of policyholders' benefit pool

9. Service Amount Billed (N-8, include cents): Service amounts reported in this field should include **all** care management services performed by care management provider agencies or their qualified official designee, although some of these services are paid out of insurers' administrative costs and therefore do not affect the insured's benefit pool.

10. Service Payment Amount (N-8, include cents): Disbursements reported in this field should include **all** payments for care management services performed by care management provider agencies or their qualified official designee, although some of these services are paid out of insurers' administrative costs and therefore do not affect the insured's benefit pool.

11. Service Payment Amount Protected (N-8, include cents): This field **should not include** the amount of service payments that are paid out of insurers' administrative costs (e.g., certain care management services).

15. Maximum Remaining Benefit Days (NH) (N-8): **Should be coded as "88888888**". This field is not applicable because the California Partnership policies are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

16. Maximum Remaining Benefit Days (HC) (N-8): **Should be coded as "88888888".** This field is not applicable because the California Partnership policies are issued with maximum benefits indicated in dollars rather than in length of time (days, months, or years).

CONNECTICUT PARTNERSHIP FOR LONG-TERM CARE

Connecticut-specific field definitions that differ from the standard UDS field definitions and any additional special instructions are listed below by UDS file and field number

File 1: Registry of New Insureds

3. Policy Form Number (N-8): A unique UDS policy form number will be assigned by Partnership staff at the time the policy filing is approved under the Partnership.

12. Marital Status (A-1): Connecticut does not accept U = Unknown as a coding option in this field. Participating insurers must report this field as A = Not Married, B = Married or C = Civil Union or Domestic Partner.

44. Annualized Premium (N-7, include cents): This field does not currently accommodate lump sum premium amounts in excess of $99,999.99. When reporting a lump sum premium of $100,000 or greater, report the Annualized Premium as 9999999.

File 2: Insureds Who Have Changed/Dropped Their Policies

7. Updated Social Security Number (A-9): Connecticut does not collect data in this field. If a social security number has been identified as incorrect or is changed for any reason, report the correct social security number by telephoning the Partnership office at the Office of Policy and Management. Code all instances **8-filled (888888888)**.

19. Type of Change (A-1): Special instructions related to Codes "C", "F", "I" and "M".

Code "C" = Shorter Coverage Option: For a reduction in benefits to qualify as a "Shorter Coverage Option" four criteria must be met:

- the policy was close to lapsing resulting in the company **offering** the insured a reduced benefit at a reduced premium
- this reduced premium must be offered at **original issue age**
- the policy's **lifetime benefit was reduced** to any lesser lifetime amount available
- the **daily, weekly or monthly benefits**, including all inflation protection earned to date on these benefits, **must remain intact**

Benefit reductions that do not meet these criteria should not be reported using Code "C" (use code "F" instead). In no event should a reduction in benefits ever result in the daily benefits dropping below the Partnership annual allowable minimums for nursing home and home care, nor should the compounded inflation protection earned during the life of the policy ever be lost.

Code "F" = Change to Benefits/Riders/Premium: Connecticut does not collect records that are triggered solely by a fluctuation in the annualized premium due to premium mode changes, fee structures or discounts that apply during the life of the policy . If a premium series re-rate has been instituted, report this activity using Code "G". Changes to the annualized premium, other than series re-rates, should be reported only in the context of

File 2 records generated due to one or more of the other legitimate File 2 record triggers listed on page 23 of the UDS manual.

Code "I" = Non-Forfeiture (Partnership Status Intact): A revision to the CPLTC Regulations on July 30, 1999, stated that all benefits paid through a non-forfeiture benefit will earn Medicaid Asset Protection, even if the benefit amount is below the Partnership required daily minimum. The remaining non-forfeiture benefit should be treated as a Partnership benefit, earning asset protection, and the reporting requirements should still be followed as long as the benefit is being paid out. If, however, the non-forfeiture benefit includes return of premium, then the Partnership status would be lost and the policy would be reported as a Drop with Reason Dropped – H (Non-Forfeiture Partnership Status Lost).

Code "M" = **Social Security Number Change** is not a valid code in Connecticut. **Use codes A through L and N only**.

44. Annualized Premium (N-7, includes cents): When reporting a change in Annualized Premium, Connecticut requires that at least one additional File 2 trigger must occur in order for a File 2 record to be generated. In other words, a change in Annualized Premium alone is not sufficient cause for a File 2 record to be generated when reporting in Connecticut. For example, a policy upgrade resulting in an increase to the premium constitutes dual triggers (the upgrade and the premium increase), causing the File 2 record to be generated.

    This field does not currently accommodate lump sum premium amounts in excess of $99,999.99. When reporting a lump sum premium of $100,000 or greater, report the Annualized Premium as 9999999.

File 3: Insureds Assessed For Long-Term Care Benefit Eligibility

The Connecticut Partnership requires that complete assessment information be reported. This means that, in cases where an Access Agency has performed the assessment or signed off on the Care Plan related to an assessment performed on the Access Agency's behalf (all claims for home and community-based care), the MSQ and Folstein scores must appear in Fields 37 and 38, respectively, and behavioral Fields 39, 40, 41 and 42 must be reported as 'Y' or 'N' (not '8').

In situations where an Access Agency is not involved in the assessment process (typically, claims for facility-based care), and the policyholder does not qualify for benefits based on ADL deficiencies, the assessment record must report the MSQ and Folstein test scores **as well as** the behavioral observations required in Fields 39 – 42 ('Y' or 'N' only, no '8' coding is permitted).

16. Marital Status (A-1): Connecticut does not accept U = Unknown as a coding option in this field. Participating insurers must report this field as A = Not Married, B = Married or C = Civil Union or Domestic Partner.

23. Performed by Whom (A-5): Codes valid in Connecticut are:

CT00A = CAM or Access Agency
CT00B = CHCPE (CT Home Care Program for Elders (formerly PAS/CBS))
CT00C = SNF or ICF
CT00D = Other

Please note: these codes contain zeros (00), not the letter O.

25. State Insured Event Met (A-1): Connecticut does **not** accept 8 = Not applicable in this field.

26. Pre-Admission Screening Met (A-1): Code all instances **8 = Not applicable.**

29. – 34. Dressing, Bathing, Eating/Feeding, Toileting, Transferring, Continence (A-1 each): These 6 fields represent the primary physical ADLs used to determine benefit eligibility under Partnership policies. Valid responses are "Y" or "N". Do not code these fields "8" = Not applicable.

37. & 38. MSQ Test Score (N-2) **and** Score on Folstein Test (N-2)**:** Under the Connecticut Partnership, the State insured event (reported in File 3, Field 25) is met in any one of the following three ways:

- the individual has a documented need for substantial human assistance, or supervision, with two or more of the following ADLs: bathing, dressing, eating, toileting, continence or transferring, **or**
- the individual has been assessed using the Mental Status Questionnaire (MSQ) and has 7 or more incorrect answers, **or**
- the individual exhibits specific behavior problems requiring daily supervision, including but not limited to wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, and extreme or bizarre personal hygiene habits; and has either taken the MSQ and has 4 or more incorrect responses or has taken the Folstein mini-mental examination and achieved a score of 23 or lower.

As indicated above, the MSQ and the Folstein are the required cognitive evaluation tools mandated by the Connecticut Partnership. Cognitive testing and behavioral evaluation is especially critical in determining benefit eligibility in cases where the insured does not qualify for benefits based on physical ADL limitations alone. Every assessment and reassessment record reported to the Connecticut Partnership should include a valid test score for either, or both, the MSQ (Field 37) and the Folstein (Field 38). Please note that in most cases, the State Insured Event (Field 25) and the Policy Insured Event (Field 24) criteria are identical.

39 – 42. Wandering (A-1), Abusive/Assaultive (A-1), Poor Judgment (A-1) and Bizarre Hygeine (A-1): 8 = Not Applicable is only valid in these fields when an Access Agency is **not** involved in the assessment/eligibility determination process (typically, claims for facility-

based care) **AND** the policyholder meets the insured event criteria based on physical ADL deficiencies. In all other cases, only codes Y or N are permitted in these fields.

45. Complex Unstable Medical Condition (A-1): Code all instances **8 = Not applicable**.

File 4: Service Payments & Utilization

7. Service Code (A-5): When reporting service codes to the Connecticut Partnership, **use the code that most specifically describes the service provided**. **Do not use vague codes** such as 1000_, 3000_, 3100_, 4000_, 5000_, 7000_, 7200_, 7800_, 7900_, etc. that do not adequately identify the specific type of service that was utilized.

Please contact the Connecticut Partnership office at the Office of Policy and Management for assistance if:

- you are uncertain as to which code best describes the service provided, *or*
- you anticipate any discrepancy between the units of service defined in Appendix 1 and your company's reporting practices, *or*
- a service has been provided for which no applicable code is listed.

15. Maximum Remaining Benefit Days (NH) (N-8): Code all instances **88888888 = Not applicable**.

16. Maximum Remaining Benefit Days (HC) (N-8): Code all instances **88888888 = Not applicable**.

INDIANA LONG TERM CARE PROGRAM

Indiana-specific field definitions that differ from the standard UDS field definitions are listed below by UDS file and field number.

File 1: Registry of New Insureds

3. Policy Form Number (N-8): A unique UDS policy form number will be assigned by Partnership staff at the time the policy filing is approved under the Partnership.

6. Social Security Number (A-9): Insured's social security number.

Applicants who will not provide a valid social security number will be issued a unique dummy social security number. The insurer will assign this number to them. The number if assigned must be continually used unless the insured provides a valid social security number. Then a change will be reported during the quarterly reporting on a change file.

11. Sex (A-1): **Valid responses are "M" = Male or "F" = Female. Do not use code "U" = Unknown**.

12. Marital Status (A-1): **Valid responses are "A" = Not Married or "B" = Married, only. Do not use "U" = Unknown**.

13. Day Phone (A-10): In cases where the insured does not have a phone number use all 8's in place of the phone number.

Example: 8888888888 = (888)888-8888

14. Evening Phone (A-10): In cases where the insured does not have a phone number use all 8's in place of the phone number.

Example: 8888888888 = (888)888-8888

26. Maximum Amount: NH (N-7): The ILTCP requires that, for policies that offer both nursing home and home health benefits, there be one maximum benefit amount available for either nursing home or home care. This should be reflected by entering the same dollar amounts in fields 26, 29, and 31. **If a nursing home and home care policy has been purchased, code with the same value as in field 29 and field 31. If a nursing home only policy has been purchased, code fields 26 and 31 with the same value and code field 29 as "8888888."**

27. Maximum Length (Days): NH (N-4): The ILTCP prohibits benefits being defined in days. **Code as "8888."**

29. Maximum Amount: HC (N-7): The ILTCP requires that, for policies that offer both nursing home and home health benefits, there be one maximum benefit amount available for either nursing home or home care. This should be reflected by entering the same dollar amounts in fields 26, 29, and 31. **If a nursing home and home care policy has been purchased, code with the same value as in field 29 and field 31. If a nursing home only policy has been purchased, code fields 26 and 31 with the same value and code field 29 as "8888888."**

30. Maximum Length (Days): HC (N-4): The ILTCP prohibits benefits being defined in terms of days. **Code as "8888."**

31. Maximum Amount: Total (N-7): The ILTCP requires that, for policies that offer both nursing home and home health benefits, there be one maximum benefit amount available for either nursing home or home care. This should be reflected by entering the same dollar amounts in fields 26, 29, and 31. **If a nursing home and home care policy has been purchased, code with the same value as in field 29 and field 31. If a nursing home only policy has been purchased, code fields 26 and 31 with the same value and code field 29 as "8888888."**

32. Maximum Length: Days (Total) (N-4): The ILTCP prohibits benefits being defined in days. **Code as "8888."**

34. Care Management Days (N-2): This field is not applicable. **Code as "88."**

40. Inflation Protection Mode: Daily Benefit (A-1): Inflation protection must be offered under the ILTCP. **Code only as "A" = Percent of Charges, "B" = Automatic Compound Annual Increases or "E" = Automatic Simple Annual Increases (only applies if insured was age 75 or older at time of purchase and this policy inflation benefit was filed and approved). This field may not be coded as "C" or "D".**

41. Inflation Protection Percentage (N-2):

This field must be reported as 05 (5%) or 99 (CPI) if the policy was filed and approved with CPI inflation.

42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): Inflation protection must be offered under the ILTCP. **Code only as "A" = Unlimited Benefit, "B" = Automatic Compound Annual Increases or "E"= Automatic Simple Annual Increases (only applies if insured was 75 or older at time of purchase and this policy inflation benefit was filed and approved). This field may not be coded as "C" or "D".**

43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2):

This field must be reported as 05 (5%) or 99 (CPI) if the policy was filed and approved with CPI inflation.

44. Annualized Premium (N-7, include cents): This field should report the premium payment (annualized) amounts. For example, each payment amount should be multiplied by 4 if the payment mode is quarterly and by 12 if the mode is monthly.

45. Type of Premium (A-1): The LPTCP requires level premiums. Therefore, this field may NOT be coded "B = Lifetime – Indexed" or "D = 20 Year – Indexed".

File 2: Insureds Who Have Changed/Dropped Their Policies

11. Day Phone (A-10): In cases where the insured does not have a phone number use all 8's in place of the phone number.

Example: 8888888888 = (888)888-8888

12. Evening Phone (A-10): In cases where the insured does not have a phone number use all 8's in place of the phone number.

Example: 8888888888 = (888)888-8888

26. Maximum Amount: NH (N-7): The ILTCP requires that, for policies that offer both nursing home and home health benefits, there be one maximum benefit amount available for either nursing home or home care. This should be reflected by entering the same dollar amounts in fields 26, 29, and 31. **If a nursing home and home care policy has been purchased, code with the same value as in field 29 and field 31. If a nursing home only policy has been purchased, code fields 26 and 31 with the same value and code field 29 as "8888888."**

27. Maximum Length (Days): NH (N-4): The ILTCP prohibits benefits being defined in days. **Code as "8888."**

29. Maximum Amount: HC (N-7): The ILTCP requires that, for policies that offer both nursing home and home health benefits, there be one maximum benefit amount available for either nursing home or home care. This should be reflected by entering the same dollar amounts in fields 26, 29, and 31. **If a nursing home and home care policy has**

been purchased, code with the same value as in field 29 and field 31. If a nursing home only policy has been purchased, code fields 26 and 31 with the same value and code field 29 as "8888888."

30. Maximum Length (Days): HC (N-4): The ILTCP prohibits benefits being defined in terms of days. **Code as "8888."**

31. Maximum Amount: Total (N-7): The ILTCP requires that, for policies that offer both nursing home and home health benefits, there be one maximum benefit amount available for either nursing home or home care. This should be reflected by entering the same dollar amounts in fields 26, 29, and 31. **If a nursing home and home care policy has been purchased, code with the same value as in field 29 and field 31. If a nursing home only policy has been purchased, code fields 26 and 31 with the same value and code field 29 as "8888888."**

32. Maximum Length: Days (Total) (N-4): The ILTCP prohibits benefits being defined in days. **Code as "8888."**

34. Care Management Days (N-2): This field is not applicable. **Code as "88."**

40. Inflation Protection Mode: Daily Benefit (A-1): Inflation protection must be offered under the ILTCP. **Code only as "A" = Percent of Charges, "B" = Automatic Compound Annual Increases or "E" = Automatic Simple Annual Increases (only applies if insured was age 75 or older at time of purchase and this policy inflation benefit was filed and approved). This field may not be coded as "C" or "D".**

41. Inflation Protection Percentage (N-2):

This field must be reported as 05 (5%) or 99 (CPI) if the policy was filed and approved with CPI inflation.

42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): Inflation protection must be offered under the ILTCP. **Code only as "A" = Unlimited Benefit, "B" = Automatic Compound Annual Increases or "E"= Automatic Simple Annual Increases (only applies if insured was 75 or older at time of purchase and this policy inflation benefit was filed and approved). This field may not be coded as "C" or "D".**

43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2):

This field must be reported as 05 (5%) or 99 (CPI) if the policy was filed and approved with CPI inflation.

44. Annualized Premium (N-7, include cents): This field should report the premium payment (annualized) amounts. For example, each payment amount should be multiplied by 4 if the payment mode is quarterly and by 12 if the mode is monthly.

45. Type of Premium (A-1): The LPTCP requires level premiums. Therefore, this field may NOT be coded "B = Lifetime – Indexed" or "D = 20 Year – Indexed".

File 3: Insureds Assessed For Long-Term Care Benefit Eligibility

9. Day Phone (A-10): In cases where the insured does not have a phone number use all 8's in place of the phone number.

Example: 8888888888 = (888)888-8888

10. Evening Phone (A-10): In cases where the insured does not have a phone number use all 8's in place of the phone number.

Example: 8888888888 = (888)888-8888

21. Marital Status (A-1): Valid responses are A = Not Married and B = Married, only. The response option U = Unknown is not acceptable.

22. Assessment Date (D-8): Indiana requires a valid date in every File 3 record. Do not use 8-fill (88888888). When reporting codes IN040 or IN041 in File 3 Field 23, use the eligibility decision date (Field 27) as the assessment date. When using all other codes in Field 23, use the actual assessment date.

23. Performed by Whom (A-5): Coding options for the ILTCP are listed below. As additional case management agencies are approved to perform assessments within the state, new codes will be assigned.

Code	**Assessor**
IN001	AREA AGENCY ON AGING 1
IN002	AREA AGENCY ON AGING 2
IN003	AREA AGENCY ON AGING 3
IN004	AREA AGENCY ON AGING 4
IN005	AREA AGENCY ON AGING 5
IN006	AREA AGENCY ON AGING 6
IN007	AREA AGENCY ON AGING 7
IN008	AREA AGENCY ON AGING 8
IN009	AREA AGENCY ON AGING 9

IN010	AREA AGENCY ON AGING 10
IN011	AREA AGENCY ON AGING 11
IN012	AREA AGENCY ON AGING 12
IN013	AREA AGENCY ON AGING 13
IN014	AREA AGENCY ON AGING 14
IN015	AREA AGENCY ON AGING 15
IN016	AREA AGENCY ON AGING 16
IN017	Visiting Nurse Service
IN018	Family Caring Network
IN019	Comprehensive Rehabilitation Associates, Inc.
IN020	Connecticut Community Care, Inc.
IN021	CHCS/National Care Management Partnership
IN022	Crawford & Company Health and Rehabilitation
IN023	Nation's CareLink
IN040	Insurance Company (telephone, face-to-face, or company forms)
IN041	Insurance Company using provider records/patient chart
IN042	Other

24. Policy Insured Event Met (A-1): The coding options entered in Field 24 and Field 25 should be the same.

25. State Insured Event Met (A-1): The coding options entered in Field 24 and Field 25 should be the same.

26. Pre-Admission Screening Criteria Met (A-1): Department of Insurance regulations allow the utilization of the Indiana pre-admission screening program to assess whether the insured event criteria have been met (760 IAC 2-20-36.) **If pre-admission screening is used for this purpose, code as either "Y" or "N." If another assessment method is used, code as "8."**

When pre-admission screening is used for the insured event assessment insurers should answer Fields 21 through 36 based on the eligibility screening tool. The following fields correspond to the following questions in section 2 of the eligibility screening tool:

FIELD	ELIGIBILITY SCREENING TOOL QUESTION
Field 29 Dressing Deficiency	Section 2, Question 12
Field 30 Bathing Deficiency	Section 2, Question 13
Field 31 Eating/Feeding Deficiency	Section 2, Question 10
Field 32 Toileting Deficiency	Section 2, Question 14
Field 33 Transferring Deficiency	Section 2, Question 11
Field 34 Cognitive Impairment	Section 2, Question 6
Field 43 Complex, unstable medical condition	Section 1

File 4: Service Payments & Utilization

7. Service Code (A-5): Insurers should report the following services in the units listed below. If the services listed below are collected in units other than those listed, contact the ILTCP for reporting instructions.

Insurers should refer to the Long-Term Care Uniform Data Set: Reporting Requirements and Documentation guidebook to determine how to report other services.

CODE	SERVICE	UNITS
11003	Nursing Home	Day
31101	Skilled Nursing Services	Hour
31201	Physical Therapy	Hour
31301	Speech Therapy	Hour
31401	Respiratory Therapy	Hour
31501	Occupational Therapy	Hour
32001	Home Health Aide Services	Hour
35201	Audiologist	Hour
42501	Adult Day Care (Health and Social)	Hour
43206	Home-Delivered Meal	Meal
46091	Attendant Care	Hour
46301	Homemaker (non-personal care)	Hour
47109	Housing Improvement/Modification	Per job
48005	Personal Emergency Response System (PERS)	Per month
52201	In-home Respite Care	Hour

52301	Out-of-home Respite Care	Day
72001 or 78001	Case Management	Hour
72102 or 78102	Case Management-Assessment	Per Assessment

11. Service Payment Amount Protected (N-8, include cents): Amount reported for asset protection should only include benefits paid from policy and should not include any administrative expenses.

15. Maximum Remaining Benefit Days (NH) (N-8): Under the ILTCP, benefits may not be offered in days. **Code as "88888888."**

16. Maximum Remaining Benefit Days (HC) (N-8): Under the ILTCP, benefits may not be offered in days. **Code as "88888888."**

NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE

New York-specific field definitions that differ from the standard UDS field definitions are listed below by UDS file and field number.

File 1: Registry of New Insureds

3. Policy Form Number (N-8): In New York, the Policy Form Number is an 8-byte matrix denoting certain types of policy features. Insurers participating in the New York Project will determine and input the appropriate Policy Form Number for their policies. The coding instructions for determining the Policy Form Number are depicted in Figure 1 on page NY-8, and figure 1a on pages NY-9, NY-10 and NY-11.

21. Policy Type (NH/HC) (A-1): Option "B = Nursing Home/Home Care - Single-Life" is the only valid code in New York.

22. Elimination Period (Days): NH (N-3): New York requires a single elimination period for satisfying the nursing home and home care deductible. Fields 22 and 23 should report the same single elimination period, in days.

23. Elimination Period (Days): HC (N-3): New York requires a single elimination period for satisfying the nursing home and home care deductible. Fields 22 and 23 should report the same single elimination period, in days.

32. Maximum Length (Days): Total (N-4): The value reported in this field should equal that reported in Field 27.

35. Non-Forfeiture Benefit (A-1): Option "D = Cash" is not a valid code (i.e., not allowed) in New York.

36. Options Or Riders In Force - 1 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

37. Options Or Riders In Force - 2 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

38. Options Or Riders In Force - 3 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

39. Options Or Riders In Force - 4 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

40. Inflation Protection Mode: Daily Benefit (A-1): Options "A" and "C" are not valid codes (i.e., not allowed) in New York.

42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): This field is not applicable to New York. **Code as "8."**

43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2): This field is not applicable to New York. **Code as "88."**

45. Type of Premium (A-1): Option "A = Lifetime Level" is the only valid code in New York.

47. Lapse Contact Designated (A-1): Note that carriers are obliged to provide the name, address, and telephone number of the lapse contact designee on request of the New York project staff.

File 2: Insureds Who Have Changed/Dropped Their Policies

3. Policy Form Number (N-8): In New York, the Policy Form Number is an 8-byte matrix denoting certain types of policy features. Insurers participating in the New York Project will determine and input the appropriate Policy Form Number for their policies. The coding instructions for determining the Policy Form Number are depicted in Figure 1 on page NY-8, and figure 1a on pages NY-9, NY-10 and NY-11.

19. Type of Change (A-1): Option "B = Upgrade" should be used in New York to denote any change which causes the Policy Form Number to change. Option "F = Changes to Benefits/ Riders/Policy Features" should not be used in New York when such change results in a change in Policy Form Number. Options "H, J, K, and L" are not valid codes in New York.

20. Reason Dropped (A-1): Option "I = Multi-Life Status Change" is not a valid code in New York.

21. Policy Type (NH/HC) (A-1): Option "B = Nursing Home/Home Care - Single-Life" is the only valid code in New York.

22. Elimination Period (Days): NH (N-3): New York requires a single elimination period for satisfying the nursing home and home care deductible. Fields 22 and 23 should report the same single elimination period, in days.

23. Elimination Period (Days): HC (N-3): New York requires a single elimination period for satisfying the nursing home and home care deductible. Fields 22 and 23 should report the same single elimination period, in days.

32. Maximum Length (Days): Total (N-4): The value reported in this field should equal that reported in Field 27.

35. Non-Forfeiture Benefit (A-1): Option "D = Cash" is not valid code (i.e., not allowed) in New York.

36. Options Or Riders In Force - 1 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

37. Options Or Riders In Force - 2 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

38. Options Or Riders In Force - 3 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

39. Options Or Riders In Force - 4 (A-1): This field should be used to report a free-standing death benefit (i.e., a return of premium to beneficiaries following the death of the insured which is not linked to the purchase of any other benefit, option or rider). Code “D” denotes such a death benefit.

40. Inflation Protection Mode: Daily Benefit (A-1): Options "A" and "C" are not valid codes (i.e., not allowed) in New York.

42. Inflation Protection Mode: Lifetime Maximum Benefit (A-1): This field is not applicable to New York. **Code as "8."**

43. Inflation Protection Percentage: Lifetime Maximum Benefit (N-2): This field is not applicable to New York. **Code as "88."**

45. Type of Premium (A-1): Option "A = Lifetime Level" is the only valid code in New York. **Code as "A."**

47. Lapse Contact Designated (A-1): Note that carriers are obliged to provide the name, address, and telephone number of the lapse contact designee on request of the New York project staff.

File 3: Insured Assessed For Long-Term Care Benefit Eligibility

3. Policy Form Number (N-8): In New York, the Policy Form Number is an 8-byte matrix denoting certain types of policy features. Insurers participating in the New York Project will determine and input the appropriate Policy Form Number for their policies. The coding instructions for determining the Policy Form Number are depicted in Figure 1 on page NY-8, and Figure 1a on pages NY-9, NY-10 and NY-11.

19. Benefit Contact (A-1): Note that carriers are obliged to provide the name, address, and telephone number of the benefit contact designee on request of the New York project staff.

22. Assessment Date (D-8): In New York, if no face-to-face assessment or reassessment is performed, this field should be 8-filled.

23. Performed by Whom (A-5): Use the following codes in New York:

NY001 - Assessment and eligibility determination, performed by in-house staff.
NY002 - Assessment by out-house staff; eligibility determination by in-house staff.
NY003 - Assessment by in-house staff; eligibility determination by out-house staff.
NY004 - Assessment and eligibility determination performed by out-house staff.

25. State Insured Event Met (A-1): This field is not applicable to New York. **Code as "8."**

26. Pre-Admission Screening Met (A-1): This field is not applicable to New York. **Code as "8."**

27. Eligibility Decision Date (D-8): In New York, carriers must provide a discrete eligibility decision date for the initial assessment and for each follow-up reassessment associated with the episode.

29. Dressing Deficiency (A-1): In New York, this field should employ the insurer's definition of this deficiency.

30. Bathing Deficiency (A-1): In New York, this field should employ the insurer's definition of this deficiency.

31. Eating/Feeding Deficiency (A-1): In New York, this field should employ the insurer's definition of this deficiency.

32. Toileting Deficiency (A-1): In New York, this field should employ the insurer's definition of this deficiency.

33. Transferring Deficiency (A-1): In New York, this field should employ the insurer's definition of this deficiency.

34. Continence Deficiency (A-1): In New York, this field should employ the insurer's definition of this deficiency.

35. Ambulating Deficiency (A-1): In New York, this field should employ the insurer's definition of this deficiency.

36. Cognitive Impairment (A-1): In New York, this field should employ the insurer's definition of this impairment.

39. Wandering (A-1): In New York, this field should employ the insurer's definition of this impairment.

40. Abusive/Assaultive (A-1): In New York, this field should employ the insurer's definition of this impairment.

41. Poor Judgment (A-1): In New York, this field should employ the insurer's definition of this impairment.

42. Bizarre Hygiene (A-1): In New York, this field should employ the insurer's definition of this impairment.

43. Complex Unstable Medical Condition (A-1): This field does not apply to New York. **Code as "8."**

File 4: Service Payments & Utilization

3. Policy Form Number (N-8): In New York, the Policy Form Number is an 8-byte matrix denoting certain types of policy features. Insurers participating in the New York Project will determine and input the appropriate Policy Form Number for their policies. The coding instructions for determining the Policy Form Number are depicted in Figure 1 on page NY-8, and figure 1a on pages NY-9, NY-10 and NY-11.

10. Service Payment Amount (N-8, include cents): Disbursements reported in this field should include payments to outside contractors who conduct benefit authorization review assessments/reassessments. Although these administrative costs do not affect the insured's benefit pool, they represent actual outlays by the carrier.

11. Service Payment Amount Protected (N-8, include cents): This field is not applicable to New York. **Code as "88888888."**

14. Remaining Benefit Dollars (N-9, include cents): This field, which must be reported in New York, reflects the inflation-adjusted lifetime pool of money remaining in the policy. For each payment record submitted, the inflation-adjusted lifetime pool of money remaining in the policy **as of the end of that payment quarter** should be reported. Carriers should 9-fill this field to report policyholders with lifetime benefits.

15. Maximum Remaining Benefit Days (NH) (N-8, include 2 decimal places): This field, which must be reported in New York, reflects the number of nursing home benefit days remaining until the insured can apply for Medicaid extended coverage under the Partnership. For each payment/utilization record submitted, the number of nursing home benefit days remaining **as of the end of that payment quarter** should be reported, even if the insured is using home care services at that time. Please note that, regardless of the coverage term of the private policy, all policyholders start with 1,095 nursing home days.

16. Maximum Remaining Benefit Days (HC) (N-8, include 2 decimal places): This field, which must be reported in New York, reflects the number of home care benefit days remaining until the insured can apply for Medicaid extended coverage under the Partnership. For each payment/utilization record submitted, the number of home care benefit days remaining **as of the end of that payment quarter** should be reported, even if the insured is using home care services at that time. Please note that, regardless of the coverage term of the private policy, all policyholders start with 2,190 home care days.

Figure 1

POLICY FORM NUMBER

In New York State, the policy form number has been designed to efficiently capture certain information on policy types and features, which would otherwise necessitate the inclusion of additional data elements to several files. The policy form number is an 8-byte vector in which each byte describes a policy feature. The structure of the vector, described below, will allow carriers to assign the appropriate policy form number to each policy issued.

BYTE #	POLICY FEATURE	VALUES
1	POLICY TYPE	1 = BASIC 2 = OPTIONAL BASIC 3 = BASIC PLUS
2	POLICY CATEGORY	Refer to NY Attachments 1 and 2 on pages NY-12, NY-13 and NY-14
3	WAIVER OF PREMIUM (NURSING HOME)	0 = NO WAIVER OF PREMIUM (NH) 1 = WAIVER OF PREMIUM (NH)
4	WAIVER OF PREMIUM (HOME CARE)	0 = NO WAIVER OF PREMIUM (HC) 1 = WAIVER OF PREMIUM (HC)
5	MEDICAL UNDERWRITING INDICATOR	1 = REGULAR / NORMAL / FULL 2 = LIMITED / SHORT-FORM 3 = GUARANTEED ISSUE
6	MULTIPLE-PURCHASER DISCOUNT INDICATOR	1 = DISCOUNT GIVEN 2 = DISCOUNT NOT GIVEN 8 = NOT APPLICABLE
7	ELIMINATION PERIOD TYPE	1 = CALENDAR DAY 2 = SERVICE DAY 3 = OTHER
8	RATE CLASS INDICATOR	1 = STANDARD 2 = SUB-STANDARD 3 = PREFERRED 8 = NOT APPLICABLE

Figure 1a

FILE DEFINITIONS FOR POLICY FORM NUMBER

A. Policy Type:

1 = Basic Policy is defined in Section III-A of the Insurer Participation Agreement. The policy should include:

a) 3 years of nursing home care;
b) 6 years of home care;
c) $100 (for 1993) for nursing home daily benefit: This benefit amount will increase annually at a 5% compounded rate.
d) $50 (for 1993) for home care daily benefit: This benefit amount will increase annually at a 5% compounded rate.
e) Inflation Protection: 5% compounded annually;
f) Elimination Period: 100 days;
g) No non-forfeiture benefit; and
h) Benefit standards stipulated in Insurance Department of the State of New York Regulation No. 144 (11 NYCRR 39) other than a) to f) should be provided that there is no or minimal (2% or less) premium impact from the premium cost without such enriched benefits.

2 = Optional Basic Policy is defined in Section III-B of the Insurer Participation Agreement.

3 = Basic Plus Policy is defined as policies offering benefit coverage beyond those prescribed in Sections III-A and III-B of the Insurer Participation Agreement.

B. Policy Category: Refer to NY Appendix Attachment 2.

C. Waiver of Premium (NH): Payment of premium is waived during a nursing home benefit period.

1 = Yes.
0 = No.

D. Waiver of Premium (HC): Payment of premium is waived during a home care benefit period.

1 = Yes.
0 = No.

Figure 1a (Continued)

FILE DEFINITIONS FOR POLICY FORM NUMBER

E. Medical Underwriting Indicator: Type of medical underwriting required to qualify for coverage.

1 = Regular / Normal / Full Medical Underwriting Applicant is required to undergo and pass the company's regular medical underwriting process for coverage approval.

2 = Limited / Minimal / Short-Form Underwriting Applicant is required to undergo and pass a medical underwriting process less rigorous than the company's standard process for coverage approval (i.e., such as for internal replacements).

3 = Guaranteed Issue Applicant is not required to undergo medical underwriting for coverage approval. (Most commonly applies to active members of group policy issues and to internal replacements who qualify for minimal underwriting, but where the company chooses to allow the upgrade without additional underwriting).

F. Multiple Purchaser Discount Indicator:

1 = Premium discount applied due to purchase of policies by two or more individuals from same household.

2 = Premium discount not applied, either because only one individual in household purchased a policy or because the second purchaser did not qualify for discount.

8 = Not Applicable Multiple Purchaser discount not offered by company.

G. Elimination Period Type:

1 = Calendar Day Elimination period is satisfied by the passage of time, regardless of the receipt of formal (paid) care by the insured.

2 = Service Day Elimination period is satisfied only by the receipt of formal services provided to the insured.

3 = Other Combination of calendar- and service-day options.

Figure 1a (Concluded)

FILE DEFINITIONS FOR POLICY FORM NUMBER

H. Rate-Class Indicator:

1 = Standard Applicant approved for coverage in a standard rate class.

2 = Sub-Standard Applicant approved for coverage in a sub-standard rate class.

3 = Preferred Applicant approved for coverage in a preferred rate class.

8 = Not Applicable Carrier has only one rate class.

ATTACHMENT 1

BYTE #	POLICY FEATURE	VALUES
2	POLICY CATEGORY	1=Grandfathered-TQ - INDIVIDUAL 2=Grandfathered-TQ - GROUP 3=Grandfathered-TQ - ORGANIZATION-SPONSORED 4=TQ - INDIVIDUAL 5=TQ - GROUP 6=TQ - ORGANIZATION-SPONSORED 7=Non-TQ - INDIVIDUAL 8=Non-TQ - GROUP 9=Non-TQ - ORGANIZATION-SPONSORED

ATTACHMENT 2

B. Policy Category:

1 = Grandfathered Tax-Qualifying (TQ) Individual Policy was approved as an individual policy by the New York State Department of Insurance **prior to 1/1/97**. Policy marketed and issued directly from the insurer to the insured. This code only applies to the policies issued prior to 1/1/97. The code '7' should be used for Non-Grandfathered/Non-TQ policies issued since 1/1/97.

2 = Grandfathered TQ Group Policy was approved as a group policy by the New York State Department of Insurance **prior to 1/1/97**. (**Note**: Until the US Department of Treasury clarifies the tax status for group policy certificates issued since 1/1/97 under any group policy contracts issued prior to 1/1/97, use this code for those group policy certificates.) Group policy contracts are made with an employer or other entity (e.g. association) that covers a group of persons identified as individuals by reference to their relationship to the entity. The actual policy is held by the employer or other entity. Each insured receives a certificate under the policy, rather than an individual policy. The policy is marketed through the group.

3 = Grandfathered TQ Organization-Sponsored Policy was approved as an individual policy by the New York State Department of Insurance **prior to 1/1/97**. This code only applies to the policies issued prior to 1/1/97. The code **'9'** should be used for Non-Grandfathered/Non-TQ policies issued since 1/1/97. This category differs from the "Individual" category in that the policies are marketed to insureds through an organization (e.g., employer or association). This organizational involvement could be minimal or extensive. Such involvement might include organizational endorsement, participation in promotion of the product, negotiation of premium discounts for members, facilitation of enrollment, payroll deduction, etc. This category of policy is sometimes referred to as "List Bill Rate" or "Franchise".

4 = TQ Individual Policy is filed as a **TQ** individual policy with the New York State Department of Insurance. Policy marketed and issued directly from the insurer to the insured.

5 = TQ Group Policy is filed as a **TQ** group policy with the New York State Department of Insurance. Group policy contracts are made with an employer or other entity (e.g., association) that covers a group of persons identified as individuals by reference to their relationship to the entity. The actual policy is held by the employer or other entity. Each insured receives a certificate under the policy, rather than an individual policy. The policy is marketed through the group.

6 = TQ Organization-Sponsored Policy is filed as a **TQ** individual policy with the New York State Department of Insurance. This category differs from the "Individual" category in that policies are marketed to insureds through an organization (e.g., employer or association). This organizational involvement could be minimal or extensive. Such involvement might include organizational endorsement, participation in promotion of the product, negotiation of premium discounts for members, facilitation of enrollment, payroll deduction, etc. This category of policy is sometimes referred to as "List Bill Rate" or "Franchise".

7 = Non-TQ Individual Policy is filed as a **Non-TQ** individual policy with the New York State Department of Insurance. Policy marketed and issued directly from the insurer to the insured. This code should also be used for individual policies approved by the New York State Department of Insurance **prior to 1/1/97** that have been issued **since 1/1/97**.

8 = Non-TQ Group Policy is filed as a **Non-TQ** group policy with the New York State Department of Insurance. Group policy contracts are made with an employer or other entity (e.g., association) that covers a group of persons identified as individuals by reference to their relationship to the entity. The actual policy is held by the employer or other entity. Each insured receives a certificate under the policy, rather than an individual policy. The policy is marketed through the group.

9 = Non-TQ Organization-Sponsored Policy is filed as a **Non-TQ** individual policy with the New York State Department of Insurance prior to 1/1/97. This code should also be used for individual policies approved by the New York State Department of Insurance **prior to 1/1/97** that have been issued **since 1/1/97**. This category differs from the "Individual" category in that the policies are marketed to insureds through an organization (e.g., employer or association). This organizational involvement could be minimal or extensive. Such involvement might include organizational endorsement, participation in promotion of the product, negotiation of premium discounts for members, facilitation of enrollment, payroll deduction, etc. This category of policy is sometimes referred to as "List Bill Rate" or "Franchise".