CA

58077 Issuer Reporting Requirements

Unless otherwise noted, the requirements of this Sectionrefer to Issuer documentation and reporting requirements for PartnershipPolicies and Certificates. Reports are due thirty (30) days after the close ofreporting periods specified for the respective reports. Issuers shall submitthe following reports, which are all part of the Long-Term Care InsuranceUniform Data Set.

(a)

Report on new purchasers. Each Issuer shall maintain a registry of new purchasers and submit on a Quarterly basis aligned with the State Fiscal Year, a report to the Department of Health Services that will include the following information on all individuals who purchased a Partnership Policy or Certificate during the reporting period:(1) name, address, telephone number, date of birth, sex, marital status, and Social Security number; (2) Policy or Certificate identification information, including the following: (A) Policy or Certificate form number; (B) Policy or Certificate category (individual, organization-sponsored, or group); (C) effective date of coverage; (D) Policy type (Nursing Facility and Residential Care Facility Only; Comprehensive Benefit; Single Life; or Multi-Life); (3) Policy or Certificate Elimination Period in days; (4) the maximum daily benefit for nursing facility care and monthly benefit for home and community-based care; (5) maximum lifetime benefit amount in dollars; (6) any options and riders in force; (7) purchase type (upgrade from non-Partnership policy or certificate of reporting company,

conversion, replacement of another company's policy or certificate, or new issue); (8) for expense-incurred Policies or Certificates, the percentage of expenses payable; (9) the annual premium for the Policy or Certificate, the premium payment mode (also known as the "premium frequency"), and the type of premium (level, indexed, or lump sum); and (10) the name and address of the Authorized Designee to be notified in the event that the Policy is in danger of lapsing due to unpaid premium.

(1)

name, address, telephone number, date of birth, sex, marital status, and Social Security number;

(2)

Policy or Certificate identification information, including the following: (A) Policy or Certificate form number; (B) Policy or Certificate category (individual, organization-sponsored, or group); (C) effective date of coverage; (D) Policy type (Nursing Facility and Residential Care Facility Only; Comprehensive Benefit; Single Life; or Multi-Life);

(A)

Policy or Certificate form number;

(B)

Policy or Certificate category (individual, organization-sponsored, or group);

(C)

effective date of coverage;

(D)

Policy type (Nursing Facility and Residential Care Facility Only; Comprehensive Benefit; Single Life; or Multi-Life);

(3)

Policy or Certificate Elimination Period in days;

(4)

the maximum daily benefit for nursing facility care and monthly benefit for home and community-based care;

(5)

maximum lifetime benefit amount in dollars;

(6)

any options and riders in force;

(7)

purchase type (upgrade from non-Partnership policy or certificate of reporting company, conversion, replacement of another company's policy or certificate, or new issue);

(8)

for expense-incurred Policies or Certificates, the percentage of expenses payable;

(9)

the annual premium for the Policy or Certificate, the premium payment mode (also known as the "premium frequency"), and the type of premium (level, indexed, or lump sum); and

(10)

the name and address of the Authorized Designee to be notified in the event that the Policy is in danger of lapsing due to unpaid premium.

(b)

Report on persons who changed or dropped their Policies or Certificates. For the purposes of this Chapter, a Policy change shall include the following: upgrades, reduced coverage option, reinstatement, inflation upgrade, changes to benefits, riders, premium series rerate, Policy category changes, inflation catch-up, Social Security number change, conversion to single/multi-life, non-forfeiture or

partnership status lost. Each Issuer shall submit on a Quarterly basis aligned with the State Fiscal Year and in a format specified by the State of California, a report to the Department of Health Services that will include the following information on all individuals who have changed or dropped Partnership Policies or Certificates during the reporting period:(1) name, address, telephone number, and Social Security number; (2) effective date of original Policy which is reported in Section 58077(a)(2)(C); (3) effective date of the Policy or Certificate change or drop; (4) if applicable, a description of the new Policy or Certificate or amended Policy or Certificate as described in Section 58051(h); (5) if applicable, the reason the Policy or Certificate was dropped, including any of the following: (A) death of insured; (B) converted Policy or Certificate; (C) benefits exhausted; (D) recision; (E) voluntarily; (F) certified status of the Policy or Certificate lost; (G) other; and (H) unknown.

(1)

name, address, telephone number, and Social Security number;

(2)

effective date of original Policy which is reported in Section 58077(a)(2)(C);

(3)

effective date of the Policy or Certificate change or drop;

(4)

if applicable, a description of the new Policy or Certificate or amended Policy or Certificate as described in Section 58051(h);

(5)

if applicable, the reason the Policy or Certificate was dropped, including any of the following: (A) death of insured; (B) converted Policy or Certificate; (C) benefits exhausted; (D) recision; (E) voluntarily; (F) certified status of the Policy or Certificate

lost; (G) other; and (H) unknown.

(A)

death of insured;

(B)

converted Policy or Certificate;

(C)

benefits exhausted;

(D)

recision;

(E)

voluntarily;

(F)

certified status of the Policy or Certificate lost;

(G)

other; and

(H)

unknown.

(c)

Report on persons who were assessed for long-term care benefit eligibility. Each Issuer shall submit on a Quarterly basis aligned with the State Fiscal Year and in a format specified by the State of California, a report to the Department of Health Services that will include the following information on all individuals who were assessed for long-term care benefit eligibility during the reporting period:(1) name, address, telephone number, Social Security number, sex, marital status, and living arrangements (alone, with spouse, or with other relatives); (2) Medicare status (Part A, Part A and B, or none); (3) other insurance status (Medicare supplement,

prepaid health care, or none); (4) date the assessment was conducted; (5) benefit contact; (6) name, address, and telephone number of the person or company that performed the assessment and whether the claimant was found eligible for long-term care services and for Medi-Cal Property Exemption; (7) eligibility decision date; (8) effective date of disability; and (9) a listing of the Benefit Eligibility criteria met for all persons assessed, including deficiencies in Activities of Daily Living, and Severe Cognitive Impairment.

(1)

name, address, telephone number, Social Security number, sex, marital status, and living arrangements (alone, with spouse, or with other relatives);

(2)

Medicare status (Part A, Part A and B, or none);

(3)

other insurance status (Medicare supplement, prepaid health care, or none);

(4)

date the assessment was conducted;

(5)

benefit contact;

(6)

name, address, and telephone number of the person or company that performed the assessment and whether the claimant was found eligible for long-term care services and for Medi-Cal Property Exemption;

(7)

eligibility decision date;

(8)

effective date of disability; and

(9)

a listing of the Benefit Eligibility criteria met for all persons assessed, including deficiencies in Activities of Daily Living, and Severe Cognitive Impairment.

(d)

Report on service payments and utilization. Each Issuer shall submit on a Quarterly basis aligned with the State Fiscal Year and in a format specified by the State of California, a report (in the event the payment is for a service received during a prior reporting period, a separate record shall be generated for each quarter during which a service was received) to the Department of Health Services that will include the following information on the services or benefits paid each month during the reporting period for each insured person: (1) name and Social Security number of the beneficiary; (2) Policy or Certificate identification information, including the following: (A) the Policy or Certificate form number; (B) the original effective date of coverage; (3) service code; (4) number of units of service delivered during the reporting period; (5) the last month of the quarter in which the reported services were delivered; (6) the dollar amount of services or benefits paid by the Policy or Certificate and the amount paid that counts toward the Medi-Cal Property Exemption (Asset Protection); (7) the number of units of service paid by the Policy or Certificate during the reporting period; (8) the total number of days of service paid for by the Policy or Certificate during the reporting period for services received. (9) remaining benefit (in dollars) that indicates the total remaining benefit at the end of the reporting period; (10) remaining nursing home benefit (in days); (11) remaining home care benefit (in days).

(1)

name and Social Security number of the beneficiary;

(2)

Policy or Certificate identification information, including the following: (A) the Policy or Certificate form number; (B) the original effective date of coverage;

(A)

the Policy or Certificate form number;

(B)

the original effective date of coverage;

(3)

service code;

(4)

number of units of service delivered during the reporting period;

(5)

the last month of the quarter in which the reported services were delivered;

(6)

the dollar amount of services or benefits paid by the Policy or Certificate and the amount paid that counts toward the Medi-Cal Property Exemption (Asset Protection);

(7)

the number of units of service paid by the Policy or Certificate during the reporting period;

(8)

the total number of days of service paid for by the Policy or Certificate during the reporting period for services received.

(9)

remaining benefit (in dollars) that indicates the total remaining benefit at the end of the reporting period;

(10)

remaining nursing home benefit (in days);

(11)

remaining home care benefit (in days).

(e)

Report on applications received, denied and total Policies in force at end of the reporting period. Each Issuer shall report on a quarterly basis and in a format specified by the State of California, a single entry summary count of: (1) the total number of applications received at the Insurer's office during the reporting period. (2) the total number of applications denied during the reporting period. (3) the total number of Policies in force at the end of the reporting period.

(1)

the total number of applications received at the Insurer's office during the reporting period.

(2)

the total number of applications denied during the reporting period.

(3)

the total number of Policies in force at the end of the reporting period.

(f)

Issuers will respond to all errors within 30 days of receipt of notification from the Department of a file and/or data error.