

**NEW YORK STATE
INSURANCE DEPARTMENT**

**SECOND AMENDMENT TO REGULATION NO. 144
(11 NYCRR 39)**

**MINIMUM STANDARDS FOR THE NEW YORK STATE PARTNERSHIP
FOR LONG-TERM CARE PROGRAM**

I, GREGORY V. SERIO, Superintendent of Insurance, pursuant to the authority granted by Sections 201, 301, 3201, 3217, 3221, 3229, 4235, 4237 and Article 43 of the Insurance Law and Section 367-f of the Social Services Law, do hereby promulgate the Second Amendment to Part 39 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York to take effect upon publication in the State Register.

(NEW MATTER IS UNDERSCORED. MATTER IN BRACKETS IS DELETED.)

The title of Part 39 of Title 11 is amended as follows:

MINIMUM STANDARDS FOR THE NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE PROGRAM [ESTABLISHED UNDER CHAPTER 454 OF THE LAWS OF 1989, AS AMENDED BY CHAPTER 659 OF THE LAWS OF 1997]

The table of contents of Part 39 of Title 11 is amended as follows:

Sec.	
39.0	Preamble
39.1	Approval of qualified policies/certificates under the [project] <u>program</u>
39.2	General conditions governing the [project] <u>program</u>
39.3	Minimum benefit standards for qualified policies/certificates <u>for the 3/6/50 plan design.</u>
<u>39.4</u>	<u>Minimum benefit standards for qualified policies/certificates for the 1.5/3/50 plan design.</u>
<u>39.5</u>	<u>Minimum benefit standards for qualified policies/certificates for the 4/4/100 plan design.</u>
<u>39.6</u>	<u>Minimum benefit standards for qualified policies/certificates for the 2/2/100 plan design.</u>

Section 39.0 is amended to read as follows:

§ 39.0 Preamble.

The [Long Term Care Security Demonstration Project] New York State Partnership for Long Term Care Program, hereafter called the [project] program, was established under chapter 454 of the Laws of 1989 and made permanent under chapter 659 of the Laws of 1997. The purpose of the legislation is to offer citizens of New York State who purchase a long term care insurance policy/certificate qualifying under this Part and who exhaust benefits under such policy/certificate special eligibility for long term care protection through the New York State Medicaid program. The special eligibility for long term care protection through the New York State Medicaid program may vary depending upon the particular plan design purchased by the insured.

Section 39.1 is amended to read as follows:

§ 39.1 Approval of qualified policies/certificates under the [project] program.

- (a) Policies/certificates sold in conjunction with the [project] program must be approved by the Superintendent of Insurance of New York State as meeting the minimum standards required under this Part and other pertinent authority as required by law. Policies/certificates approved as meeting the requirements stated herein shall be designated as qualified by the presence of a [project] program logo that shall be displayed on any products advertised, marketed, offered, or sold. The [project] program logo on each policy/certificate sold shall be numbered. In addition, each approved policy/certificate sold will include a notice to the insured stating that the policy/certificate qualifies under the [project] program.
- (b) Except as otherwise stated in this Part, all definitions, requirements, and regulations applicable to the marketing, issuance, offering, administration, advertising, and maintenance of long term care insurance policies/certificates as contained in Part 52 of this Title, the Insurance Law, and other statutes shall apply to a policy/certificate sold under the [project] program.

Section 39.2 is amended to read as follows:

§ 39.2 General conditions governing the [project] program.

Participation in the [project] program shall be open to residents of New York State and insurers licensed to do business in the State. Qualified policies/certificates sold under the [project] program shall provide that benefits are payable regardless of the insured's residence at the time of eligibility for policy/certificate benefits subject to policy/certificate provisions relating to limitations on coverage outside of the United States and its possessions. However, the special eligibility for long term care protection through the New York State Medicaid program shall be void unless the insured is eligible to receive approved services under the New York State Medicaid program when such special eligibility occurs. This fact shall be prominently disclosed on the face page of the policy/certificate.

Section 39.3 is amended to read as follows:

§ 39.3 Minimum benefit standards for qualified policies/certificates for the 3/6/50 plan design.

- (a) *Basic [project] program minimum coverage requirements.* All [project] program participating insurers issuing this plan design must offer a basic policy/certificate providing minimum coverage under this [Part] section. Additional products which exceed the basic policy/certificate minimum coverage will be permitted. The insurer selling a policy/certificate providing minimum coverage under this section must offer a policy/certificate providing the basic 1.5/3/50 minimum plan design and the basic 2/2/100 minimum plan design under sections 39.4 and 39.6 of this Part to the prospective insured at the same time.
- (b) *Minimum benefit standards for the 3/6/50 plan design.* To be approved as a qualified policy/certificate under this [Part] section, a policy/certificate shall provide coverage on an expense incurred, indemnity, prepaid, or other basis and provide at least the following benefits:
 - (1) Nursing home care. Nursing home care coverage shall be provided for not less than a lifetime maximum total of 36 months for each covered person. A covered person must be permitted to substitute home care benefits for nursing home care benefits on the basis of two home care days for one nursing home day. Coverage of nursing home care shall consist of payment for skilled nursing care, intermediate care, and custodial care in nursing homes of at least [\$163] \$171 per day. Payment for nursing home care services may be limited to services rendered in a nursing

home licensed by the jurisdiction in which it is located. The minimum nursing home daily benefit shall be increased each year on the first day of January beginning in [2004] 2005. Policies/certificates sold after January 1, [2004] 2005 shall provide benefits at the increased minimum standard in the year sold. Minimum daily benefits for the next 10 years shall be as follows:

- [(i)] January 1, 2003 - \$163 (nursing home), \$82 (home care - 50 percent);
- [(ii)] (i) January 1, 2004 - \$171 (nursing home), \$86 (home care - 50 percent);
- [(iii)] (ii) January 1, 2005 - \$180 (nursing home), \$90 (home care - 50 percent);
- [(iv)] (iii) January 1, 2006 - \$189 (nursing home), \$95 (home care - 50 percent);
- [(v)] (iv) January 1, 2007 - \$198 (nursing home), \$99 (home care - 50 percent);
- [(vi)] (v) January 1, 2008 - \$208 (nursing home), \$104 (home care - 50 percent);
- [(vii)] (vi) January 1, 2009 - \$218 (nursing home), \$109 (home care - 50 percent);
- [(viii)] (vii) January 1, 2010 - \$229 (nursing home), \$115 (home care - 50 percent);
- [(ix)] (viii) January 1, 2011 - \$241 (nursing home), \$121 (home care - 50 percent);
- [(x)] (ix) January 1, 2012 - \$253 (nursing home), \$127 (home care - 50 percent);
- (x) January 1, 2013 - \$265 (nursing home), \$133 (home care - 50 percent).

(2) Home care. Home care coverage shall be provided when services are rendered in the insured's place of residence, in a group setting such as an adult day care center, or where human assistance is required by the insured to aid in necessary travel, such as to a physician's office.

- (i) Home care benefits shall be [payable] provided for at least the following services: skilled nursing care, home health care, personal care, assisted living and adult day care, provided that such services are rendered by entities licensed and/or certified by the Department of Health or agencies exempt from licensure or certification in accordance with articles 28 and/or 36 of the Public Health Law [or section 505.14 of the Social Services Law] and regulations promulgated thereunder or section 505.14 of Part 505 of Title 18 of the New York Codes, Rules and Regulations. Payment for home care services received outside of New York State may be limited to services rendered by an entity licensed to provide such services in the jurisdiction where the services were rendered. It is also required that the insured [patient] has incurred expense for the cost of a covered service.
- (ii) For the purpose of special eligibility for long term care protection through the New York State Medicaid program under a qualified policy/certificate, a covered person must be permitted to substitute home care benefits for nursing home care benefits on the basis of two home care days for one nursing home day. Complete substitution of home care benefits for nursing home care benefits would result in a lifetime maximum total of 72 months of home care benefits.
- (iii) The minimum home care coverage to be offered will be [payable]provided in an amount of at least 50 percent of the current minimum nursing home care benefit as stated in this [Part] section. This minimum home care coverage amount shall continue to be the minimum home care benefit standard regardless of the amount of nursing home coverage actually purchased.
- (iv) Home care coverage which exceeds the minimum benefit standards shall not affect the requirement for a lifetime maximum total of 72 months of home care benefits. However, at the discretion of the insurer, it shall be permissible to combine benefit days to pay an amount in excess of the daily benefit amount set forth in the policy/certificate. In no case where benefit days have been combined shall the equivalent of more than 31 days of home care benefits be [paid] provided in any one-month period.

(3) Nursing Home Care Bed Reservation (holds nursing home bed when must leave the nursing home for a time period). The minimum nursing home bed reservation coverage benefit shall be

provided in an amount equal to the nursing home daily benefit amount in effect under the policy/certificate for at least 20 days annually.

[(3)] (4) Respite care. Respite care, meaning nursing home and/or home care services provided in lieu of informal caregiver services, for at least 14 days coverage, shall be renewable annually. Covered days of respite care need not be consecutive and shall be [paid] provided at a daily amount equal to that provided for nursing home care under the policy or certificate regardless of where the respite care services are actually rendered and regardless of the actual cost of such services. Payment for respite care services may be conditioned upon the following:

- (i) a covered person's eligibility to receive policy/certificate benefits for a period not to exceed six consecutive months without regard to receipt of formal nursing home and/or home care services and without regard to satisfaction of policy/certificate waiting periods;
- (ii) expenses for respite services qualifying under the policy/certificate are incurred;
- (iii) once the requirement of subparagraph (i) of this paragraph has been met an insurer may not impose another such requirement unless the covered person is no longer eligible to receive policy/certificate benefits; or the policy/certificate is lapsed or cancelled; or benefits under the policy/certificate are exhausted.

(5) Hospice care. The minimum hospice care coverage benefit shall be provided in an amount equal to the nursing home daily benefit in effect under the policy/certificate in an inpatient setting and at the home care daily benefit in effect under the policy/certificate in all other settings.

[(4)] (6) Alternate care. Where an otherwise covered person is unable to obtain access to nursing home care or home care services, and the covered person is in a hospital setting awaiting the availability of such services, and has been determined by the attending physician to be in alternate care status, such covered person shall, for the purpose of benefit eligibility including the satisfaction of any elimination period, be deemed to be receiving the nursing home care or home care services for which such covered person is awaiting placement. Benefit payments while the covered person is in alternate care status shall be the nursing home daily benefit in effect under the policy/certificate.

(7) Care Management: The minimum care management coverage benefit shall be provided in an amount equal to the nursing home daily benefit in effect under the policy/certificate for at least 2 days per year.

[(5)] (8) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection no less than five percent compounded on an annual calendar or policy year basis. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.

[(6)] (9) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of Insurance for all persons covered by a specific policy/certificate form.

[(7)] (10) Replacement. If a long term care insurance policy/certificate qualified under this Part replaces another qualified long term care insurance policy/certificate under this Part, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, and probationary periods in the new long term care policy/certificate to the extent such time has elapsed under the original policy/certificate. The insurer may, however, exercise any

legal rights available with regard to alleged fraud or material misrepresentation in obtaining the replacement policy/certificate.

[(8)] (11) Policy/certificate modification provision in the event of a national long term care program. Qualified policies/certificates shall include a provision for modification of such policies/certificates in the event of enactment of a national long term care program using public funds which program duplicates coverage provided under qualified policies/certificates. The modification provision must state that the policy/certificate will be amended to the extent possible to provide benefits appropriately interrelated with the national program. In the event of modification or, if necessary, termination the insurer must submit a plan to the superintendent providing for any premium adjustment or refund required as a result of modification or termination.

[(9)] (12) Elimination periods. Elimination periods no greater than 100 days are permitted in qualified policies/certificates. Only a single elimination period for all covered services will be permitted. The commencement of a new elimination period is permitted only when a period of care is separated from another period of care by more than six months.

(13) A long term care policy/certificate providing coverage under this section on an indemnity, prepaid, or any basis other than expense incurred may be sold in this State. However, the insurer selling such a policy or certificate must offer a policy/certificate providing coverage on an expense incurred basis at the same time to the prospective insured.

Part 39 is amended by adding new Sections 39.4, 39.5 and 39.6 to read as follows:

§ 39.4 Minimum benefit standards for qualified policies/certificates for the 1.5/3/50 plan design.

(a) Basic program minimum coverage requirements. All program participating insurers issuing this plan design must offer a basic policy/certificate providing minimum coverage under this section. Additional products which exceed the basic policy/certificate minimum coverage will be permitted, but no more than a 2.5/5/50 (maximums of 2.5 years of nursing home coverage and 5 years of home care coverage) plan design shall be offered under this section. The insurer selling a policy/certificate providing minimum coverage under this section must offer a policy/certificate providing the basic 2/2/100 minimum plan design under section 39.6 of this Part to the prospective insured at the same time.

(b) Minimum benefit standards for the 1.5/3/50 plan design. To be approved as a qualified policy/certificate under this section, a policy/certificate shall provide coverage on an expense incurred basis for at least the following benefits:

(1) Nursing home care. Nursing home care coverage shall be provided for not less than a lifetime maximum total of 18 months for each covered person. A covered person must be permitted to substitute home care benefits for nursing home care benefits on the basis of two home care days for one nursing home day. Coverage of nursing home care shall consist of payment for skilled nursing care, intermediate care, and custodial care in nursing homes of at least \$171 per day. Payment for nursing home care services may be limited to services rendered in a nursing home licensed by the jurisdiction in which it is located. The minimum nursing home daily benefit shall be increased each year on the first day of January beginning in 2005. Policies/certificates sold after January 1, 2005 shall provide benefits at the increased minimum standard in the year sold. Minimum daily benefits for the next 10 years shall be as follows:

- (i) January 1, 2004 - \$171 (nursing home), \$86 (home care - 50 percent);
- (ii) January 1, 2005 - \$180 (nursing home), \$90 (home care - 50 percent);

- (iii) January 1, 2006 - \$189 (nursing home), \$95 (home care - 50 percent);
 - (iv) January 1, 2007 - \$198 (nursing home), \$99 (home care - 50 percent);
 - (v) January 1, 2008 - \$208 (nursing home), \$104 (home care - 50 percent);
 - (vi) January 1, 2009 - \$218 (nursing home), \$109 (home care - 50 percent);
 - (vii) January 1, 2010 - \$229 (nursing home), \$115 (home care - 50 percent);
 - (viii) January 1, 2011 - \$241 (nursing home), \$121 (home care - 50 percent);
 - (ix) January 1, 2012 - \$253 (nursing home), \$127 (home care - 50 percent);
 - (x) January 1, 2013 - \$265 (nursing home), \$133 (home care - 50 percent).
- (2) Home care. Home care coverage shall be provided when services are rendered in the insured's place of residence, in a group setting such as an adult day care center, or where human assistance is required by the insured to aid in necessary travel, such as to a physician's office.
- (i) Home care benefits shall be provided for at least the following services: skilled nursing care, home health care, personal care, assisted living and adult day care, provided that such services are rendered by entities licensed and/or certified by the Department of Health or agencies exempt from licensure or certification in accordance with articles 28 and/or 36 of the Public Health Law and regulations promulgated thereunder or section 505.14 of Part 505 of Title 18 of the New York Codes, Rules and Regulations. Payment for home care services received outside of New York State may be limited to services rendered by an entity licensed to provide such services in the jurisdiction where the services were rendered. It is also required that the insured has incurred expense for the cost of a covered service.
 - (ii) For the purpose of special eligibility for long term care protection through the New York State Medicaid program under a qualified policy/certificate, a covered person must be permitted to substitute home care benefits for nursing home care benefits on the basis of two home care days for one nursing home day. Complete substitution of home care benefits for nursing home care benefits would result in a lifetime maximum total of 36 months of home care benefits.
 - (iii) The minimum home care coverage to be offered will be provided in an amount of at least 50 percent of the current minimum nursing home care benefit as stated in this section. This minimum home care coverage amount shall continue to be the minimum home care benefit standard regardless of the amount of nursing home coverage actually purchased.
 - (iv) Home care coverage which exceeds the minimum benefit standards shall not affect the requirement for a lifetime maximum total of 36 months of home care benefits.
- (3) Nursing Home Care Bed Reservation (holds nursing home bed when the insured must leave the nursing home for a time period). The minimum nursing home bed reservation coverage benefit shall be provided in an amount equal to the nursing home daily benefit in effect under the policy/certificate for at least 20 days annually.
- (4) Respite care. Respite care, meaning nursing home and/or home care services provided in lieu of informal caregiver services, for 14 days coverage, shall be renewable annually. Covered days of respite care need not be consecutive and shall be provided at a daily amount equal to that provided for nursing home care under the policy or certificate regardless of where the respite care services are actually rendered and regardless of the actual cost of such services. Payment for respite care services may be conditioned upon the following:
- (i) a covered person's eligibility to receive policy/certificate benefits for a period not to exceed six consecutive months without regard to receipt of formal nursing home and/or home care services and without regard to satisfaction of policy/certificate waiting periods;

- (ii) expenses for respite services qualifying under the policy/certificate are incurred;
 - (iii) once the requirement of subparagraph (i) of this paragraph has been met an insurer may not impose another such requirement unless the covered person is no longer eligible to receive policy/certificate benefits; or the policy/certificate is lapsed or cancelled; or benefits under the policy/certificate are exhausted.
- (5) Hospice care. The minimum hospice care coverage benefit shall be provided in an amount equal to the nursing home daily benefit in effect under the policy/certificate in an inpatient setting and at the home care daily benefit in effect under the policy/certificate in all other settings.
- (6) Alternate care. Where an otherwise covered person is unable to obtain access to nursing home care or home care services, and the covered person is in a hospital setting awaiting the availability of such services, and has been determined by the attending physician to be in alternate care status, such covered person shall, for the purpose of benefit eligibility including the satisfaction of any elimination period, be deemed to be receiving the nursing home care or home care services for which such covered person is awaiting placement. Benefit payments while the covered person is in alternate care status shall be the nursing home daily benefit in effect under the policy/certificate.
- (7) Care Management: The minimum care management coverage benefit shall be provided in an amount equal to the nursing home daily benefit in effect under the policy/certificate for at least 2 days per year.
- (8) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection no less than five percent compounded on an annual calendar or policy year basis. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.
- (9) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of Insurance for all persons covered by a specific policy/certificate form.
- (10) Replacement. If a long term care insurance policy/certificate qualified under this Part replaces another qualified long term care insurance policy/certificate under this Part, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, and probationary periods in the new long term care policy/certificate to the extent such time has elapsed under the original policy/certificate. The insurer may, however, exercise any legal rights available with regard to alleged fraud or material misrepresentation in obtaining the replacement policy/certificate.
- (11) Policy/certificate modification provision in the event of a national long term care program. Qualified policies/certificates shall include a provision for modification of such policies/certificates in the event of enactment of a national long term care program using public funds which program duplicates coverage provided under qualified policies/certificates. The modification provision must state that the policy/certificate will be amended to the extent possible to provide benefits appropriately interrelated with the national program. In the event of modification or, if necessary, termination the insurer must submit a plan to the superintendent providing for any premium adjustment or refund required as a result of modification or termination.
- (12) Elimination periods. Elimination periods no greater than 60 days are permitted in qualified policies/certificates. Only a single elimination period for all covered services will be permitted.

The commencement of a new elimination period is permitted only when a period of care is separated from another period of care by more than six months.

- (c) Additional and optional feature. The following long term care payment feature may be offered in a qualified policy/certificate:
- (1) At the discretion of the insurer, it shall be permissible to combine home care benefit days to pay an amount in excess of the home care daily benefit amount set forth in the policy/certificate. In no case where home care benefit days have been combined shall the equivalent of more than 31 days of home care benefits be provided in any one-month period. If the insurer offers this payment feature, each prospective insured must also be offered a minimum 1.5/3/50 plan without this payment feature.
- (d) Tax qualification. Qualified policies/certificates for the 1.5/3/50 plan design shall meet the standards required under federal and New York State laws and regulations for favorable tax qualification status for an expense incurred policy/certificate. A policy/certificate offering coverage on a per diem or other periodic basis (as permitted by the Internal Revenue Code) does not meet the standard set forth in subdivision (b) of this section for expense incurred coverage and is not permitted for this plan design.

§ 39.5 Minimum benefit standards for qualified policies/certificates for the 4/4/100 plan design.

- (a) Basic program minimum coverage requirements. All program participating insurers issuing this plan design must offer a basic policy/certificate providing minimum coverage under this section. Additional products which exceed the basic policy/certificate minimum coverage will be permitted. The insurer selling a policy/certificate providing minimum coverage under this section must offer a policy/certificate providing the basic 2/2/100 minimum plan design and the basic 1.5/3/50 minimum plan design under sections 39.4 and 39.6 of this Part to the prospective insured at the same time.
- (b) Minimum benefit standards for the 4/4/100 plan design. To be approved as a qualified policy/certificate under this section a policy/certificate shall provide coverage on an expense incurred, indemnity, prepaid, or other basis and shall provide at least all the benefits in this section and:
- (1) The policy/certificate shall provide at least a lifetime maximum total of 48 months coverage for each covered person. The policy/certificate may express the requirement for at least a lifetime maximum total of 48 months coverage for each covered person in monetary terms. The monetary expression shall be at least a lifetime maximum total of 1,460 days of coverage for each covered person multiplied by a daily benefit amount of at least \$171 per day for policies/certificates sold in 2004. The minimum daily benefit shall be increased each year on the first day of January beginning in 2005. Policies/certificates sold after January 1, 2005 shall provide benefits at the increased minimum standard in the year sold. Minimum daily benefits for the next 10 years shall be as follows:
- (i) January 1, 2004 - \$171;
 - (ii) January 1, 2005 - \$180;
 - (iii) January 1, 2006 - \$189;
 - (iv) January 1, 2007 - \$198;
 - (v) January 1, 2008 - \$208;
 - (vi) January 1, 2009 - \$218;
 - (vii) January 1, 2010 - \$229;
 - (viii) January 1, 2011 - \$241;
 - (ix) January 1, 2012 - \$253;
 - (x) January 1, 2013 - \$265.

- (2) Nursing home care. Coverage of nursing home care shall consist of payment for skilled nursing care, intermediate care, and custodial care in nursing homes. Payment for nursing home care services may be limited to services rendered in a nursing home licensed by the jurisdiction in which it is located. The minimum nursing home care coverage benefit shall be provided in an amount equal to the minimum daily benefit amount as stated in this section.
- (3) Residential care facility services. Coverage of residential care facility services shall include but are not limited to nursing care, maintenance or personal care, therapy services, and room and board accommodations. Services must be rendered by an entity that is legally operating as a residential care facility as required under the laws of the jurisdiction in which it is located. Examples of a residential care facility include an assisted living facility or adult care facility. The minimum residential care facility services benefit shall be provided in an amount equal to the minimum daily benefit amount as stated in this section.
- (4) Home and community-based care. Home and community-based care coverage shall be provided when services are rendered in the insured's place of residence, in a group setting such as an adult day care center, or where human assistance is required by the insured to aid in necessary travel, such as to a physician's office.
 - (i) Home and community-based care benefits shall be provided for at least the following services: skilled nursing care, home health care, personal care (including homemaker services), assisted living (other than in a facility) and adult day care, provided that such services are rendered by entities licensed and/or certified by the Department of Health or agencies exempt from licensure or certification in accordance with articles 28 and/or 36 of the Public Health Law and regulations promulgated thereunder or Section 505.14 of Part 505 of Title 18 of the New York Codes, Rules and Regulations. Payment for home and community-based care services received outside of New York State may be limited to services rendered by an entity licensed to provide such services in the jurisdiction where the services were rendered. It is also required that the insured has incurred expense for the cost of a covered service.
 - (ii) The minimum home and community-based care coverage benefit shall be provided in an amount equal to the minimum daily benefit amount as stated in this section.
 - (iii) Home and community-based care coverage which exceeds the minimum benefit standards shall not affect the requirement for a lifetime maximum total of 48 months of home and community-based care benefits. However, at the discretion of the insurer, it shall be permissible to combine benefit days to pay an amount in excess of the daily benefit amount set forth in the policy/certificate. In no case where benefit days have been combined shall the equivalent of more than 31 days of home and community-based care benefits be provided in any one-month period.
- (5) Nursing Home Care Bed Reservation (holds nursing home bed when the insured must leave the nursing home for a time period). The minimum nursing home bed reservation coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 20 days annually.
- (6) Residential Care Facility Bed Reservation (holds residential care facility bed when the insured must leave the residential care facility for a time period). The minimum residential care facility bed reservation coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 20 days annually.
- (7) Respite care. The minimum respite care coverage benefit, meaning nursing home, residential care facility, and/or home and community-based care services provided in lieu of informal

caregiver services, shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 14 days annually. Covered days of respite care need not be consecutive and shall be provided at the daily benefit amount regardless of where the respite care services are actually rendered and regardless of the actual cost of such services. Payment for respite care services may be conditioned upon the following:

- (i) a covered person's eligibility to receive policy/certificate benefits for a period not to exceed six consecutive months without regard to receipt of formal nursing home, residential care facility and/or home and community-based care services and without regard to satisfaction of policy/certificate waiting periods;
 - (ii) expenses for respite services qualifying under the policy/certificate are incurred;
 - (iii) once the requirement of subparagraph (i) of this paragraph has been met an insurer may not impose another such requirement unless the covered person is no longer eligible to receive policy/certificate benefits; or the policy/certificate is lapsed or cancelled; or benefits under the policy/certificate are exhausted.
- (8) Hospice care. The minimum hospice care coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate regardless of where the hospice care services are actually rendered and regardless of the actual cost of such services.
- (9) Alternate care. Where an otherwise covered person is unable to obtain access to nursing home care, residential care facility services, or home and community-based care services, and the covered person is in a hospital setting awaiting the availability of such services, and has been determined by the attending physician to be in alternate care status, such covered person shall, for the purpose of benefit eligibility including the satisfaction of any elimination period, be deemed to be receiving the nursing home, residential care facility, or home and community-based care services for which such covered person is awaiting placement. Benefit payments while the covered person is in alternate care status shall be the daily benefit amount in effect under the policy/certificate.
- (10) Care Management: The care management coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 2 days per year.
- (11) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection no less than five percent compounded on an annual calendar or policy year basis. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.
- (12) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of Insurance for all persons covered by a specific policy/certificate form.
- (13) Replacement. If a long term care insurance policy/certificate qualified under this Part replaces another qualified long term care insurance policy/certificate under this Part, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, and probationary periods in the new long term care policy/certificate to the extent such time has elapsed under the original policy/certificate. The insurer may, however, exercise any legal rights available with regard to alleged fraud or material misrepresentation in obtaining the replacement policy/certificate.

- (14) Policy/certificate modification provision in the event of a national long term care program. Qualified policies/certificates shall include a provision for modification of such policies/certificates in the event of enactment of a national long term care program using public funds which program duplicates coverage provided under qualified policies/certificates. The modification provision must state that the policy/certificate will be amended to the extent possible to provide benefits appropriately interrelated with the national program. In the event of modification or, if necessary, termination the insurer must submit a plan to the superintendent providing for any premium adjustment or refund required as a result of modification or termination.
- (15) Elimination periods. Elimination periods no greater than 100 days are permitted in qualified policies/certificates. Only a single elimination period for all covered services will be permitted. The commencement of a new elimination period is permitted only when a period of care is separated from another period of care by more than six months.
- (16) A long term care policy/certificate providing coverage under this section on an indemnity, prepaid, or any basis other than expense incurred may be sold in this State. However, the insurer selling such a policy or certificate must offer a policy/certificate providing coverage on an expense incurred basis at the same time to the prospective insured.
- (c) Additional and optional benefits. One or more of the following long term care services may be offered in a qualified policy/certificate up to a required aggregate lifetime maximum per covered person equal to but not exceeding the minimum daily benefit amount as stated in this section multiplied by 50 and:
- (1) The long term care services shall be:
 - (i) Additional nursing home care and residential care facility bed reservation benefits
 - (ii) Additional respite care benefits
 - (iii) Additional care management benefit
 - (iv) Home modification benefit
 - (v) Informal caregiver training benefit
 - (vi) Emergency response system benefit
 - (vii) Therapeutic device benefit
 - (viii) Supportive/durable medical equipment benefit
 - (ix) Specialized transportation benefit, such as specialized transportation to and from adult day care.
 - (2) Additional and optional benefits provided shall be deducted from the policy/certificate lifetime maximum coverage of at least 48 months per covered person subject to the limit stated in this subdivision.
- (d) Tax qualification. Qualified policies/certificates providing coverage under this section shall meet the standards required under federal and New York State laws and regulations for favorable tax qualification status.

§ 39.6 Minimum benefit standards for qualified policies/certificates for the 2/2/100 plan design.

- (a) Basic program minimum coverage requirements. All program participating insurers issuing this plan design must offer a basic policy/certificate providing minimum coverage under this section. . Additional products which exceed the basic policy/certificate minimum coverage will be permitted, but less than a 3/3/100 (3 years of nursing home coverage and 3 years of home and community-based care coverage) plan design shall be offered under this section. The insurer selling a policy/certificate

providing minimum coverage under this section must offer a policy/certificate providing the basic 1.5/3/50 minimum plan design under section 39.4 of this Part to the prospective insured at the same time.

- (b) Minimum benefit standards for the 2/2/100 plan design. To be approved as a qualified policy/certificate under this [Part] section a policy/certificate shall provide coverage on an expense incurred basis and shall provide at least all the benefits in this section and:
- (1) The policy/certificate shall provide at least a lifetime maximum total of 24 months coverage for each covered person. The policy/certificate may express the requirement for at least a lifetime maximum total of 24 months coverage for each covered person in monetary terms. The monetary expression shall be at least a lifetime maximum total of 730 days of coverage for each covered person multiplied by a daily benefit amount of at least \$171 per day for policies/certificates sold in 2004. The minimum daily benefit shall be increased each year on the first day of January beginning in 2005. Policies/certificates sold after January 1, 2005 shall provide benefits at the increased minimum standard in the year sold. Minimum daily benefits for the next 10 years shall be as follows:
 - (i) January 1, 2004 - \$171;
 - (ii) January 1, 2005 - \$180;
 - (iii) January 1, 2006 - \$189;
 - (iv) January 1, 2007 - \$198;
 - (v) January 1, 2008 - \$208;
 - (vi) January 1, 2009 - \$218;
 - (vii) January 1, 2010 - \$229;
 - (viii) January 1, 2011 - \$241;
 - (ix) January 1, 2012 - \$253;
 - (x) January 1, 2013 - \$265.
 - (2) Nursing home care. Coverage of nursing home care shall consist of payment for skilled nursing care, intermediate care, and custodial care in nursing homes. Payment for nursing home care services may be limited to services rendered in a nursing home licensed by the jurisdiction in which it is located. The minimum nursing home care coverage benefit shall be provided in an amount equal to the minimum daily benefit amount as stated in this section.
 - (3) Residential care facility services. Coverage of residential care facility services shall include but are not limited to nursing care, maintenance or personal care, therapy services, and room and board accommodations. Services must be rendered by an entity that is legally operating as a residential care facility as required under the laws of the jurisdiction in which it is located. Examples of a residential care facility include an assisted living facility or adult care facility. The minimum residential care facility services benefit shall be provided in an amount equal to the minimum daily benefit amount as stated in this section.
 - (4) Home and community-based care. Home and community-based care coverage shall be provided when services are rendered in the insured's place of residence, in a group setting such as an adult day care center, or where human assistance is required by the insured to aid in necessary travel, such as to a physician's office.
 - (i) Home and community-based care benefits shall be provided for at least the following services: skilled nursing care, home health care, personal care (including homemaker services), assisted living (other than in a facility) and adult day care, provided that such services are rendered by entities licensed and/or certified by the Department of Health or agencies exempt from licensure or certification in accordance with articles

- 28 and/or 36 of the Public Health Law and regulations promulgated thereunder or Section 505.14 of Part 505 of Title 18 of the New York Codes, Rules and Regulations. Payment for home and community-based care services received outside of New York State may be limited to services rendered by an entity licensed to provide such services in the jurisdiction where the services were rendered. It is also required that the insured has incurred expense for the cost of a covered service.
- (ii) The minimum home and community-based care coverage benefit shall be provided in an amount equal to the minimum daily benefit amount as stated in this section.
 - (iii) Home and community-based care coverage which exceeds the minimum benefit standards shall not affect the requirement for a lifetime maximum total of 24 months of home and community-based care benefits.
- (5) Nursing Home Care Bed Reservation (holds nursing home bed when the insured must leave the nursing home for a time period). The minimum nursing home bed reservation coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 20 days annually.
- (6) Residential Care Facility Bed Reservation (holds residential care facility bed when the insured must leave the residential care facility for a time period). The minimum residential care facility bed reservation coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 20 days annually.
- (7) Respite care. The minimum respite care coverage benefit, meaning nursing home, residential care facility, and/or home and community-based care services provided in lieu of informal caregiver services, shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 14 days annually. Covered days of respite care need not be consecutive and shall be provided at the daily benefit amount regardless of where the respite care services are actually rendered and regardless of the actual cost of such services. Payment for respite care services may be conditioned upon the following:
- (i) a covered person's eligibility to receive policy/certificate benefits for a period not to exceed six consecutive months without regard to receipt of formal nursing home, residential care facility and/or home and community-based care services and without regard to satisfaction of policy/certificate waiting periods;
 - (ii) expenses for respite services qualifying under the policy/certificate are incurred;
 - (iii) once the requirement of subparagraph (i) of this paragraph has been met an insurer may not impose another such requirement unless the covered person is no longer eligible to receive policy/certificate benefits; or the policy/certificate is lapsed or cancelled; or benefits under the policy/certificate are exhausted.
- (8) Hospice care. The minimum hospice care coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate regardless of where the hospice care services are actually rendered and regardless of the actual cost of such services.
- (9) Alternate care. Where an otherwise covered person is unable to obtain access to nursing home care, residential care facility services, or home and community-based care services, and the covered person is in a hospital setting awaiting the availability of such services, and has been determined by the attending physician to be in alternate care status, such covered person shall, for the purpose of benefit eligibility including the satisfaction of any elimination period, be deemed to be receiving the nursing home, residential care facility, or home and community-based care services for which such covered person is awaiting placement. Benefit payments while the covered person is in alternate care status shall be the daily benefit amount in effect under the policy/certificate.

- (10) Care Management: The care management coverage benefit shall be provided in an amount equal to the daily benefit amount in effect under the policy/certificate for at least 2 days per year.
- (11) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection no less than five percent compounded on an annual calendar or policy year basis. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.
- (12) Level premium. Step rate premiums, policy/certificate options to increase benefits, or any premium payment feature where the premium rate rises automatically after issuance shall not be permitted. Premiums for qualifying policies/certificates shall be level for the duration of the policy/certificate except where a rate increase is granted by the Superintendent of Insurance for all persons covered by a specific policy/certificate form.
- (13) Replacement. If a long term care insurance policy/certificate qualified under this Part replaces another qualified long term care insurance policy/certificate under this Part, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, and probationary periods in the new long term care policy/certificate to the extent such time has elapsed under the original policy/certificate. The insurer may, however, exercise any legal rights available with regard to alleged fraud or material misrepresentation in obtaining the replacement policy/certificate.
- (14) Policy/certificate modification provision in the event of a national long term care program. Qualified policies/certificates shall include a provision for modification of such policies/certificates in the event of enactment of a national long term care program using public funds which program duplicates coverage provided under qualified policies/certificates. The modification provision must state that the policy/certificate will be amended to the extent possible to provide benefits appropriately interrelated with the national program. In the event of modification or, if necessary, termination the insurer must submit a plan to the superintendent providing for any premium adjustment or refund required as a result of modification or termination.
- (15) Elimination periods. Elimination periods no greater than 60 days are permitted in qualified policies/certificates. Only a single elimination period for all covered services will be permitted. The commencement of a new elimination period is permitted only when a period of care is separated from another period of care by more than six months.
- (c) Additional and optional benefits and feature. One or more of the following long term care services may be offered in a qualified policy/certificate:
- (1) Up to a required aggregate lifetime maximum per covered person equal to but not exceeding the minimum daily benefit amount as stated in this section multiplied by 25, and the long term care services shall be:
 - (i) Additional nursing home care and residential care facility bed reservation benefits
 - (ii) Additional respite care benefits
 - (iii) Additional care management benefit
 - (iv) Home modification benefit
 - (v) Informal caregiver training benefit
 - (vi) Emergency response system benefit
 - (vii) Therapeutic device benefit
 - (viii) Supportive/durable medical equipment benefit

- (ix) Specialized transportation benefit, such as specialized transportation to and from adult day care.
- (2) The long term care services stated in paragraph (1) of subdivision (c) of this section shall be deducted from the policy/certificate lifetime maximum coverage of at least 24 months per covered person subject to the limit stated in this subdivision.
- (3) At the discretion of the insurer, it shall be permissible to combine home and community-based care benefit days to pay an amount in excess of the daily benefit amount set forth in the policy/certificate. In no case where home and community-based care benefit days have been combined shall the equivalent of more than 31 days of home and community-based care benefits be provided in any one-month period. If the insurer offers this payment feature, each prospective insured must also be offered a minimum 2/2/100 plan without this payment feature.
- (d) Tax qualification. Qualified policies/certificates providing coverage under this section shall meet the standards required under federal and New York State laws and regulations for favorable tax qualification status for an expense incurred policy/certificate. A policy/certificate offering coverage on a per diem or other periodic basis (as permitted by the Internal Revenue Code) does not meet the standard set forth in subdivision (b) of this section for expense incurred coverage and is not permitted for this plan design.

I, Gregory V. Serio, Superintendent of Insurance, do hereby certify that the foregoing is the Second Amendment to 11 NYCRR 39 (Regulation No. 144), promulgated by me on December 31, 2004 pursuant to the authority granted by Sections 201, 301, 3201, 3217, 3221, 3229, 4235, 4237, and Article 43 of the Insurance Law and and Section 367-f of the Social Services Law, to take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on November 3, 2004. No other publication or prior notice is required by statute.

Gregory V. Serio
Superintendent of Insurance

December 31, 2004