

**DEPARTMENT OF FINANCIAL SERVICES
STATE OF NEW YORK
THIRD AMENDMENT TO 11 NYCRR 39
INSURANCE REGULATION 144**

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

I, Benjamin M. Lawskey, Superintendent of Financial Services, pursuant to the authority granted by Sections 202, 301, and 302 of the Financial Services Law, Sections 301, 1117, 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 Third Amendment to Part 39 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Insurance Regulation 144) to take effect on June 1, 2012, to read as follows:

(NEW MATTER UNDERSCORED, DELETED MATTER IN BRACKETS)

Section 39.3(b)(8) is amended to read as follows:

(8) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection [no less than] of three and one-half percent compounded or five percent compounded on an annual calendar or policy year basis. The insurer shall permit the covered person to choose either the three and one-half percent compounded or the five percent compounded lifetime inflation option. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.

Section 39.4(b)(8) is amended to read as follows:

(8) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection [no less than] of three and one-half percent compounded or five percent compounded on an annual calendar or policy year basis. The insurer shall permit the covered person to choose either the three and one-half percent compounded or the five percent compounded lifetime inflation option. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.

Section 39.5(b)(11) is amended to read as follows:

(11) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection [no less than] of three and one-half percent compounded or five percent compounded on an annual calendar or policy year basis. The insurer shall permit the covered person to choose either the three and one-half percent compounded or the five percent compounded lifetime inflation option. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.

Section 39.6(b)(11) is amended to read as follows:

(11) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection [no less than] of three and one-half percent compounded or five percent compounded on an annual calendar or policy year basis. The insurer shall permit the covered person to choose either the three and one-half percent

compounded or the five percent compounded lifetime inflation option. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.

New sections 39.7 and 39.8 are added to read as follows:

Section 39.7 Minimum benefit standards for qualified policies/certificates for the 2/4/50 plan design.

(a) Basic program minimum coverage requirements. All program participating insurers issuing this plan design shall offer a basic policy/certificate providing minimum coverage under this section and may also offer coverage exceeding the minimum daily benefit amounts under this section. The insurer selling a policy/certificate providing minimum coverage under this section also 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 2/4/50 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 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 24 months for each covered person. A covered person must be permitted to substitute home and community-based care benefits or residential care facility benefits for nursing home care benefits on the basis of two home and community-based care or residential care facility service 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 \$253 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 2013. Policies/certificates sold on or after January 1, 2013 shall provide benefits at the increased minimum standard in the year sold. Minimum daily benefits for the years listed below shall be as follows:

(i) January 1, 2012 - \$253 (nursing home), \$127 (residential care facility and home and community-based care - 50 percent);

(ii) January 1, 2013 - \$265 (nursing home), \$133 (residential care facility and home and community-based care - 50 percent).

(2) Residential care facility services. Coverage of residential care facility services shall include but is not limited to nursing care, maintenance or personal care, therapy services, and room and board accommodations for not less than a lifetime maximum total of 48 months for each covered person. 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 residence or adult care facility.

(i) The minimum residential care facility coverage to be offered shall 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 residential care facility coverage amount shall continue to be the minimum residential care facility benefit standard regardless of the amount of nursing home coverage actually purchased.

Residential care facility coverage which exceeds the minimum benefit standards shall not affect the requirement for a lifetime maximum total of 48 months of residential care facility benefits.

(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 residential care facility benefits for nursing home care benefits on the basis of two residential care facility days for one nursing home day. Complete substitution of residential care facility benefits for nursing home care benefits shall result in a lifetime maximum total of 48 months of residential care facility benefits.

(3) Home and community-based care. Home and community based care coverage shall be provided for not less than a lifetime maximum total of 48 months for each covered person 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 NYCRR. 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) 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 also must be permitted to substitute home and community-based care benefits for nursing home care benefits on the basis of two home and community-based care days for one nursing home day. Complete substitution of home and community-based care benefits for nursing home care benefits shall result in a lifetime maximum total of 48 months of home and community-based care benefits.

(iii) The minimum home and community-based care coverage to be offered shall 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 and community-based care coverage amount shall continue to be the minimum home and community-based care benefit standard regardless of the amount of nursing home coverage actually purchased.

(iv) 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.

(4) The required lifetime maximum totals for nursing home care, residential care facility benefits and home and community-based care benefits may be expressed in monetary terms. The required lifetime maximum total of 48 months of residential care facility benefits and the required lifetime maximum total of 48 months of home and community-based care benefits is one combined lifetime maximum total of 48 months for both benefits for each covered person.

(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 nursing home 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 minimum daily benefit amount for residential care facility services in effect under the policy/certificate for at least 20 days annually.

(7) Respite care. Respite care, meaning nursing home, residential care facility, and/or home and community-based 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 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, 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 nursing home daily benefit in effect under the policy/certificate in an inpatient setting and at the home and community-based care daily benefit in effect under the policy/certificate in all other settings.

(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 care, residential care facility services 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 nursing home daily benefit in effect under the policy/certificate.

(10) 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 two days per year.

(11) Inflation protection. Qualified policies/certificates shall provide lifetime inflation protection of three and one-half percent compounded or five percent compounded on an annual calendar or policy year basis. The insurer shall permit the covered person to choose either the three and one-half percent compounded or the five percent compounded lifetime inflation option. 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 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 shall 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 shall 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) 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.

Section 39.8 Disclosure explaining insurance regulatory issues and Medicaid asset protection issues when covered under New York State Partnership insurance or covered under Partnership insurance of other states after replacement.

(a) An insurer shall provide to an insured under a New York State Partnership program qualified policy /certificate a disclosure setting forth that:

(1) A New York State Partnership program qualified policy/certificate approved by the New York Superintendent of Financial Services is under the regulatory oversight of New York State.

(2) A policy/certificate of a Partnership program of another state that replaces a New York State Partnership program qualified policy/certificate shall be regulated by the other state.

(3) A New York State Partnership program insured who leaves New York State may not be eligible for Medicaid asset protection in another state after insurance purchase if that state is no longer a reciprocal state, and therefore, New York State Partnership program insureds leaving New York State should verify reciprocal participation after insurance purchase and until the insured is eligible and applying for Medicaid in another state.

(4) A New York State Partnership program insured who replaces a New York State Partnership program qualified policy/certificate with a policy/certificate under a Partnership program of another state may not be eligible for Medicaid asset protection from New York State after replacement occurs if New York State is no longer a reciprocal state when the insured is eligible and applies for Medicaid in New York State.

(5) A New York State Partnership program insured is ineligible for Medicaid asset protection in non-Partnership states and non-reciprocal states.

(6) A New York State Partnership program insured who replaces a New York State Partnership program qualified policy/certificate with long term care insurance from a non-Partnership state or non-reciprocal state is ineligible for Medicaid asset protection from New York State.

(7) A New York State Partnership program insured who purchases a policy/certificate marketed as protecting all assets upon becoming eligible for Medicaid in New York State shall only be eligible for Medicaid asset protection in a reciprocal state in an amount equal to the benefits paid by the New York State Partnership program qualified policy/certificate.

(8) A New York State Partnership program insured who replaces a New York State Partnership qualified policy/certificate with a policy/certificate under a Partnership program of another state shall only be eligible for asset protection in New York State in an amount equal to the benefits paid by the policy/certificate under a Partnership program of the other state.

(9) An insured who replaces a New York State Partnership program qualified policy/certificate with an individual long term care insurance policy not approved by New York State shall be ineligible for the New York State long term care insurance income tax credit for the premiums paid for the replacing individual policy of the other state.

(b) A disclosure statement, including the explanations of this section, shall accompany or be incorporated in a qualified policy/certificate under the program when the qualified policy/certificate is delivered to the insured or delivered to the applicant at the time application is made for the qualified policy/certificate. The insurer shall obtain an acknowledgement of receipt or certification of delivery of a disclosure statement that included the explanations of this section. For in-force qualified policies/certificates under the program on June 1, 2012, the insurer shall provide a disclosure statement, including the explanations of this section, to the in-force insureds. However, an acknowledgement of receipt or certification of delivery shall not be required for qualified policies/certificates in-force as of June 1, 2012.



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

I, Benjamin M. Lawsky, Superintendent of Financial Services, do hereby certify that the foregoing is the Third Amendment to Part 39 of Title 11 (Insurance Regulation 144), signed by me on April 26, 2012, pursuant to the authority granted by Sections 202, 301, and 302 of the Financial Services Law, Sections 301, 1117, 3201, 3217, 3221, 3229, 4235, 4237, and Article 43 of the Insurance Law, and Section 367-f of the Social Services Law, to take effect on June 1, 2012.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on February 29, 2012. No other publication or prior notice is required by statute.

A handwritten signature in black ink, appearing to read "Benjamin M. Lawsky".

Benjamin M. Lawsky
Superintendent of Financial Services

Date: April 26, 2012