§ 3229. Minimum benefit standards for certain long term care plans. (a) The minimum standards for an insurance plan, which may qualify under the partnership for long term care program pursuant to section three hundred sixty-seven-f of the social services law, shall be established by regulations of the superintendent, in consultation with the commissioner of health and the director of the state office for the aging, as approved by the director of the budget, which shall require at a minimum (1) a residential health care facility benefit in an amount to be determined by the regulations of the superintendent; (2) a home care benefit with personal care, nursing care, adult day health care and respite care services, which shall provide total benefits in an amount determined by regulations of the superintendent; (3) a duration of benefits not less than twelve months; and (4) arrangements through the insurance plan for managed care including preauthorized assessment and referral programs, utilization controls and use of approved providers.

(b) In establishing minimum benefit standards for insurance plans pursuant to this section, the superintendent shall seek to ensure the cost effectiveness of the partnership for long term care program established pursuant to section three hundred sixty-seven-f of the social services law, and may establish minimum permissible payments under such insurance plans. The superintendent shall not approve an insurance plan which includes an exclusion for pre-existing conditions that exceeds six months, or which does not comply with paragraph six of subsection (b) of section one thousand one hundred seventeen of this chapter.