A bill for an act

relating to commerce; regulating insurance fees, coverages, contracts, filings, and forms; regulating financial planners, real estate appraisers, domestic mutual insurance companies, and collection agencies; making technical and clarifying changes; amending Minnesota Statutes 2006, sections 60A.71, subdivision 7; 62A.149, subdivision 1; 62A.152, subdivision 2; 62E.10, subdivision 2; 62M.02, subdivision 21; 62Q.47; 62Q.64; 62S.01, by adding subdivisions; 62S.13, subdivision 4; 62S.15; 62S.18, subdivision 2; 62S.20, subdivision 6, by adding subdivisions; 62S.26, subdivision 2; 62S.266, subdivisions 4, 10; 62S.29, by adding subdivisions; 65A.37; 66A.02, subdivision 4; 66A.07, by adding a subdivision; 72A.51, subdivision 2; 82B.23, subdivision 1; 256B.0571, subdivision 8; Minnesota Statutes 2007 Supplement, sections 62A.30, subdivision 2; 72A.52, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62S; 332; repealing Minnesota Statutes 2006, section 62A.149, subdivision 2; Laws 2006, chapter 255, section 26.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2006, section 60A.71, subdivision 7, is amended to read:

Subd. 7. **Duration; fees.** (a) Each applicant for a reinsurance intermediary license shall pay to the commissioner a fee of $200 for an initial two-year license and a fee of $150 for each renewal. Applications shall be submitted on forms prescribed by the commissioner.

(b) Initial licenses issued under this chapter are valid for a period not to exceed 24 months and expire on October 31 of the renewal year assigned by the commissioner. Each renewal reinsurance intermediary license is valid for a period of 24 months. Licensees who submit renewal applications postmarked or delivered on or before October 15 of the renewal year may continue to transact business whether or not the renewal license has been received by November 1. Licensees who submit applications postmarked or delivered

after October 15 of the renewal year must not transact business after the expiration date of the license until the renewal license has been received.

(c) All fees are nonreturnable, except that an overpayment of any fee may be refunded upon proper application.

Sec. 2. Minnesota Statutes 2006, section 62A.149, subdivision 1, is amended to read:

Subdivision 1. **Application.** The provisions of this section apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and family members as a nongroup policy unless the individual elects in writing to refuse benefits under this subdivision in exchange for an appropriate reduction in premiums or subscriber charges under the policy or plan, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis or policies that provide accident only coverage.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide ~~for payment of benefits~~ coverage that complies with the requirements of section 62Q.47, paragraphs (b) and (c), for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage. ~~thereunder on the same basis as coverage for other benefits when treatment is rendered in~~

~~(1) a licensed hospital,~~

~~(2) a residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine,~~

~~(3) a nonresidential treatment program approved or licensed by the state of Minnesota.~~

Sec. 3. Minnesota Statutes 2006, section 62A.152, subdivision 2, is amended to read:

Subd. 2. **Minimum benefits.** ~~(a)~~ All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage ~~on the same basis as coverage for other benefits for at least 80 percent of the cost of the usual and customary charges of the first ten hours of treatment incurred over a 12-month benefit period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient~~

~~in a hospital, and at least 75 percent of the cost of the usual and customary charges for any additional hours of treatment during the same 12-month benefit period for serious or persistent mental or nervous disorders, if the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of human services or other authorized state agency, or (3) a mental health professional, as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5). Prior authorization from an accident and health insurance company, or a nonprofit health service corporation, shall be required for an extension of coverage beyond ten hours of treatment. This prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may be limited to a maximum of 30 visit hours during any 12-month benefit period.~~

~~(b) For purposes of this section, covered treatment for a minor includes treatment for the family if family therapy is recommended by a provider listed in paragraph (a). For purposes of determining benefits under this section, "hours of treatment" means treatment rendered on an individual or single-family basis. If treatment is rendered on a group basis, the hours of covered group treatment must be provided at a ratio of no less than two group treatment sessions to one individual treatment hour.~~ that complies with the requirements of section 62Q.47, paragraphs (b) and (c).

Sec. 4. Minnesota Statutes 2007 Supplement, section 62A.30, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 that provides coverage to a Minnesota resident must provide coverage for routine screening procedures for cancer and related office visits, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer as defined in subdivision 3, pap smears, and colorectal screening tests for men and women, when ordered or provided by a physician in accordance with the standard practice of medicine.

Sec. 5. Minnesota Statutes 2006, section 62E.10, subdivision 2, is amended to read:

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of eleven members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; five public directors selected by the commissioner, at least two of whom

must be ~~plan~~ enrollees who are covered under an individual plan subject to assessment under section 62E.11 or group plan offered by an employer subject to assessment under section 62E.11, two of whom must be representatives of employers whose accident and health insurance premiums are part of the association's assessment base, and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven county metropolitan area. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, health maintenance contract payment, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 6. Minnesota Statutes 2006, section 62M.02, subdivision 21, is amended to read:

Subd. 21. **Utilization review organization.** "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a prepaid limited health service organization issued a certificate of authority and operating under sections 62A.451 to 62A.4528; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state. Utilization review organization does not include a clinic or health care system acting pursuant to a written delegation agreement with an

otherwise regulated utilization review organization that contracts with the clinic or health care system. The regulated utilization review organization is accountable for the delegated utilization review activities of the clinic or health care system.

Sec. 7. Minnesota Statutes 2006, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

Sec. 8. Minnesota Statutes 2006, section 62Q.64, is amended to read:

62Q.64 DISCLOSURE OF EXECUTIVE COMPENSATION.

(a) Each health plan company doing business in this state whose annual Minnesota premiums exceed $10,000,000 based on the most recent assessment base of the Minnesota Comprehensive Health Association shall annually file with ~~the Consumer Advisory Board created in section 62J.75~~ either the commissioner of commerce or the commissioner of health, as appropriate:

(1) a copy of the health plan company's form 990 filed with the federal Internal Revenue Service; or

(2) if the health plan company did not file a form 990 with the federal Internal Revenue Service, a list of the amount and recipients of the health plan company's five highest salaries, including all types of compensation, in excess of $50,000.

(b) A filing under this section is public data under section 13.03.

Sec. 9. Minnesota Statutes 2006, section 62S.01, is amended by adding a subdivision to read:

Subd. 16a. **Hands-on assistance.** "Hands-on assistance" means minimal, moderate, or maximal physical assistance without which the individual would not be able to perform the activity of daily living.

Sec. 10. Minnesota Statutes 2006, section 62S.01, is amended by adding a subdivision to read:

Subd. 22a. **Personal care.** "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

Sec. 11. Minnesota Statutes 2006, section 62S.01, is amended by adding a subdivision to read:

Subd. 23b. **Providers of services.** All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," and "home care agency" are defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it must also state what requirements a provider must meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies, or registers the provider of services under another name.

Sec. 12. Minnesota Statutes 2006, section 62S.01, is amended by adding a subdivision to read:

Subd. 25b. **Skilled nursing care, personal care, home care, specialized care, assisted living care, and other services.** "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care," and other services are defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

Sec. 13. Minnesota Statutes 2006, section 62S.13, subdivision 4, is amended to read:

Subd. 4. **Field issue prohibition.** A long-term care insurance policy or certificate may not be field issued based on medical or health status. For purposes of this section,

"field issued" means a policy or certificate issued by an agent or a third-party administrator under the underwriting authority granted to the agent or third-party administrator by an insurer and using the insurer's underwriting guidelines.

Sec. 14. Minnesota Statutes 2006, section 62S.15, is amended to read:

62S.15 AUTHORIZED LIMITATIONS AND EXCLUSIONS.

(a) No policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) preexisting conditions or diseases;

(2) mental or nervous disorders; except that the exclusion or limitation of benefits on the basis of Alzheimer's disease is prohibited;

(3) alcoholism and drug addiction;

(4) illness, treatment, or medical condition arising out of war or act of war; participation in a felony, riot, or insurrection; service in the armed forces or auxiliary units; suicide, attempted suicide, or intentionally self-inflicted injury; or non-fare-paying aviation;

(5) treatment provided in a government facility unless otherwise required by law, services for which benefits are available under Medicare or other government program except Medicaid, state or federal workers' compensation, employer's liability or occupational disease law, motor vehicle no-fault law; services provided by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; ~~and~~

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy~~.~~; and

(7) in the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(b) This subdivision does not prohibit exclusions and limitations by type of provider or territorial limitations. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(1) when the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider

satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

(2) when the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

Sec. 15. Minnesota Statutes 2006, section 62S.18, subdivision 2, is amended to read:

Subd. 2. **Premiums.** (a) The premiums charged to an insured for long-term care insurance replaced under subdivision 1 shall not increase due to either the increasing age of the insured at ages beyond 65 or the duration the insured has been covered under this policy.

(b) The purchase of additional coverage must not be considered a premium rate increase, but for purposes of the calculation required under section 62S.291, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

(c) A reduction in benefits must not be considered a premium change, but for purpose of the calculation required under section 62S.291, the initial annual premium must be based on the reduced benefits.

Sec. 16. **[62S.181] ELECTRONIC ENROLLMENT FOR GROUP POLICIES.**

Subdivision 1. **Employers or labor unions.** In the case of a group defined in section 62S.01, subdivision 15, clause (1), any requirement that a signature of an insured be obtained by an agent or insurer is satisfied if:

(1) the consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information must be provided to the enrollee;

(2) the telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention, and prompt retrieval of records; and

(3) the telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and "privileged information" as defined by section 72A.491, subdivision 19, is maintained.

Subd. 2. **Availability of insurer records.** The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Sec. 17. Minnesota Statutes 2006, section 62S.20, is amended by adding a subdivision to read:

Subd. 5a. **Disclosure of tax consequences.** With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the same time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page of the policy or rider and any other related documents. This subdivision does not apply to qualified long-term care insurance contracts.

Sec. 18. Minnesota Statutes 2006, section 62S.20, is amended by adding a subdivision to read:

Subd. 5b. **Benefit triggers.** Activities of daily living and cognitive impairment must be used to measure an insured's need for long-term care and must be described in the policy or certificate in a separate paragraph and must be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers must also be explained in this section. If these triggers differ for different benefits, explanation of the trigger must accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

Sec. 19. Minnesota Statutes 2006, section 62S.20, subdivision 6, is amended to read:

Subd. 6. **Qualified long-term care insurance policy.** A qualified long-term care insurance policy must include a disclosure statement in the policy that the policy is intended to be a qualified long-term care insurance policy under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

Sec. 20. **[62S.251] RESERVE STANDARDS.**

Subdivision 1. **Benefits provided through acceleration of benefits under life policies.** When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, policy reserves for the benefits must be determined in accordance with section 61A.25. Claim reserves must also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this section must be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates.

Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event must the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subdivision, due regard must be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) definition of insured events;

(2) covered long-term care facilities;

(3) existence of home convalescence care coverage;

(4) definition of facilities;

(5) existence or absence of barriers to eligibility;

(6) premium waiver provision;

(7) renewability;

(8) ability to raise premiums;

(9) marketing method;

(10) underwriting procedures;

(11) claims adjustment procedures;

(12) waiting period;

(13) maximum benefit;

(14) availability of eligible facilities;

(15) margins in claim costs;

(16) optional nature of benefit;

(17) delay in eligibility for benefit;

(18) inflation protection provisions; and

(19) guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

Subd. 2. **Benefits provided otherwise.** When long-term care benefits are provided other than as in subdivision 1, reserves must be determined in accordance with sections 60A.76 to 60A.768.

Sec. 21. Minnesota Statutes 2006, section 62S.26, subdivision 2, is amended to read:

Subd. 2. **Life insurance policies.** Subdivision 1 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) the portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of section 61A.24;

(3) the policy meets the disclosure requirements of sections 62S.09, 62S.10, and 62S.11; ~~and~~

(4) any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and

~~(4)~~ (5) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on which the long-term care rates were determined;

(ii) a description of the basis for the reserves;

(iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Sec. 22. Minnesota Statutes 2006, section 62S.266, subdivision 4, is amended to read:

Subd. 4. **Contingent benefit upon lapse.** (a) After rejection of the offer required under subdivision 2, for individual and group policies without nonforfeiture benefits issued after July 1, 2001, the insurer shall provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse must be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium based on the insured's issue age provided in this paragraph, and the policy or certificate lapses within 120 days of the due date of the premium increase. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and Under	200
30-34	190
35-39	170
40-44	150
45-49	130
50-54	110
55-59	90
60	70
61	66
62	62
63	58
64	54
65	50
66	48
67	46
68	44
69	42
70	40
71	38
72	36
73	34
74	32
75	30
76	28

77	26
78	24
79	22
80	20
81	19
82	18
83	17
84	16
85	15
86	14
87	13
88	12
89	11
90 and over	10

(d) A contingent benefit on lapse must also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in paragraph (e), clause (2), is 40 percent or more. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by paragraph (c) and where both are triggered, the benefit provided must be at the option of the insured.

(e) On or before the effective date of a substantial premium increase as defined in paragraph (c), the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subdivision 5. This option may be elected at any time during the 120-day period referenced in paragraph (c); and

(3) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (c) is deemed to be the election of the offer to convert in clause (2).

(f) On or before the effective date of a substantial premium increase as defined in paragraph (d), the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in paragraph (d); and

(3) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (d) shall be deemed to be the election of the offer to convert in clause (2) if the ratio is 40 percent or more.

Sec. 23. Minnesota Statutes 2006, section 62S.266, subdivision 10, is amended to read:

Subd. 10. **Purchased blocks of business.** To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision 4, paragraph (c) or (d), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

Sec. 24. **[62S.267] STANDARDS FOR BENEFIT TRIGGERS.**

Subdivision 1. **Benefit payment determinations.** A long-term care insurance policy must condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits must not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

Activities of daily living include at least the following as defined in section 62S.01 and in the policy: bathing, continence, dressing, eating, toileting, and transferring.

Insurers may use activities of daily living to trigger covered benefits in addition to those contained in this subdivision as long as they are defined in the policy.

Subd. 2. **Additional provisions for determining benefit payments.** An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate if the provisions do not restrict, and are not in lieu of, the requirements contained in subdivision 1.

Subd. 3. **Deficiency determination.** For purposes of this section, the determination of a deficiency must not be more restrictive than requiring the hands-on assistance of another person to perform the prescribed activities of daily living, or of the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

Subd. 4. **Assessments.** Assessments of activities if daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

Subd. 5. **Appeal process.** Long-term care insurance policies must include a clear description of the process for appealing and resolving benefit determinations.

EFFECTIVE DATE. This section is effective and applies to a long-term care policy issued in this state on or after the effective date of this section. This section does not apply to certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in section 62S.01, subdivision 15, that was in force at the time this section became effective.

Sec. 25. **[62S.268] ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "Qualified long-term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a

loss of functional capacity, or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury.

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

Subd. 2. **Services.** A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Subd. 3. **Payment of benefits.** A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

Subd. 4. **Certifications.** (a) Certifications regarding activities of daily living and cognitive impairment required pursuant to subdivision 3 shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

(b) Certifications required pursuant to subdivision 3 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

Subd. 5. **Dispute resolution.** Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Sec. 26. Minnesota Statutes 2006, section 62S.29, is amended by adding a subdivision to read:

Subd. 2a. **Associations to educate members.** With respect to the obligations set forth in this section, the primary responsibility of an association, as defined in section 62S.01, subdivision 15, clause (2), when endorsing or selling long-term care insurance is to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

Sec. 27. Minnesota Statutes 2006, section 62S.29, is amended by adding a subdivision to read:

Subd. 6a. **Additional association duties.** An association shall also at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change; actively monitor the marketing efforts of the insurer and its agents; and review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. This subdivision does not apply to qualified long-term care insurance contracts.

Sec. 28. Minnesota Statutes 2006, section 62S.29, is amended by adding a subdivision to read:

Subd. 9. **Unfair trade practices.** Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of sections 72A.17 to 72A.32.

Sec. 29. **[62S.291] AVAILABILITY OF NEW SERVICES OR PROVIDERS.**

Subdivision 1. **Requirement.** An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice must be provided within 12 months of the date that the new policy series is made available for sale in this state.

Subd. 2. **Exception.** (a) Notwithstanding subdivision 1, notification is not required for any policy issued before the effective date of this section or to any policyholder or

certificate holder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(b) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subdivision, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

Subd. 3. **Compliance.** An insurer shall make the new coverage available in one of the following ways:

(1) by adding a rider to the existing policy and charging a separate premium for the new rider based in the insured's attained age;

(2) by exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits must be based on premiums paid or reserves held for the prior policy or certificate;

(3) by exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) by an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the commissioner.

Subd. 4. **Policies considered exchanges.** Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges are not subject to sections 62S.24 and 62S.30, and the reporting requirements of section 62S.25, subdivisions 1 to 6.

Subd. 5. **Notification to certain groups.** Where the policy is offered through an employer, labor organization, professional, trade, or occupational organization, the required notification in subdivision 1 must be made to the offering entity. However, if

the policy is issued to a group defined in section 62S.01, subdivision 15, clause (4), the notification shall be made to each certificate holder.

Subd. 6. **Effect on coverage offers and requests for coverage.** Nothing in this section prohibits an insurer from offering any policy, rider, certificate, or coverage change to any policyholder or certificate holder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

Subd. 7. **Life policies or riders.** This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Sec. 30. **[62S.292] RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.**

Subdivision 1. **Required policy or certificate provision.** Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(1) reducing the maximum benefit; or

(2) reducing the daily, weekly, or monthly benefit amount.

The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

Subd. 2. **Age determination.** The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

Subd. 3. **Limitation.** The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

Subd. 4. **Written reminder.** If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by section 7A(3) of this regulation.

Subd. 5. **Nonapplication.** This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

EFFECTIVE DATE. This section applies to any long-term care policy issued in this state on or after August 1, 2008.

Sec. 31. Minnesota Statutes 2006, section 65A.37, is amended to read:

65A.37 POLICY FORMS.

All policies must be on standard policy forms ~~published by Insurance Services Office,~~ issued for a term of one year~~,~~ and approved by the commissioner.

Sec. 32. Minnesota Statutes 2006, section 66A.02, subdivision 4, is amended to read:

Subd. 4. **Exceptions.** The following provisions of chapter 302A do not apply to domestic mutual insurance companies: sections 302A.011, subdivisions 2, 6, 6a, 7, 10, 20, 21, 25, 26, 27, 28, 29, 31, 32, and 37 to 59; 302A.105; 302A.137; 302A.161, subdivision 19; 302A.201, subdivision 2; 302A.401 to 302A.429; 302A.433, subdivisions 1, paragraphs (a), (b), (c), and (e), and 2; 302A.437, subdivision 2; 302A.443; 302A.445, subdivisions 3 to 6; 302A.449, subdivision 7; 302A.453 to 302A.457; 302A.461; 302A.463; 302A.471 to 302A.473; 302A.553; 302A.601 to 302A.651; 302A.671 to 302A.675; 302A.681 to 302A.691; and 302A.701 to 302A.791. Those clauses of section 302A.111 that refer to any of the sections previously referenced in this subdivision do not apply to domestic mutual insurance companies. The following sections of chapter 302A are modified in their application to domestic mutual insurance companies in the manner indicated:

(1) with regard to section 302A.133, the articles may be amended pursuant to section 302A.171 by the incorporators or by the board before the issuance of any policies by the company;

(2) with regard to section 302A.135, subdivision 2, a resolution proposing an amendment to the certificate of authority must be filed with the corporate secretary no less than 30 days before the meeting to consider the proposed amendment;

(3) with regard to section 302A.161, subdivision 19 of that section does not apply, except this must not be construed to limit the power of a mutual insurance company from issuing securities other than stock;

(4) with regard to section 302A.201, the references in subdivision 1 of that section to "subdivision 2" and "section 302A.457" do not apply;

(5) with regard to section 302A.203, the board shall consist of no less than five directors;

(6) with regard to section 302A.215, subdivisions 2 and 3 of that section only apply if the corporation's certificate of incorporation provides cumulative voting;

(7) with regard to section 302A.433, subdivision 1 of that section, special meetings of the members may be called for any purpose or purposes at any time by a person or persons authorized in the articles or bylaws to call special meetings, and with regard to subdivision

3 of that section, special meetings must be held on the date and at the time and place fixed by a person or persons authorized by the articles or bylaws to call a meeting; and

(8) with regard to section 302A.435, if the company complies substantially and in good faith with the notice requirements of section 302A.435, the company's failure to give any member or members the required notice does not impair the validity of any action taken at the members' meeting.

Sec. 33. Minnesota Statutes 2006, section 66A.07, is amended by adding a subdivision to read:

Subd. 5. **Quorum.** The number of members present in person or by proxy at a member meeting are a quorum for the transaction of business, unless a larger proportion or number is provided in the articles or bylaws. If a quorum is present when a duly called or held meeting is convened, the members present may continue to transact business until adjournment, even though the withdrawal of members originally present leaves less than the proportion or number otherwise required for a quorum.

EFFECTIVE DATE. This section is effective January 1, 2008.

Sec. 34. Minnesota Statutes 2006, section 72A.51, subdivision 2, is amended to read:

Subd. 2. **Return of policy or contract; notice.** Any individual person may cancel an individual policy of insurance against loss or damage by reason of the sickness of the assured or the assured's dependents, a nonprofit health service plan contract providing benefits for hospital, surgical and medical care, a health maintenance organization subscriber contract, or a policy of insurance authorized by section 60A.06, subdivision 1, clause (4), by returning the policy or contract and by giving written notice of cancellation any time before midnight of the tenth day following the date of purchase. Notice of cancellation ~~may be given personally, by mail, or by telegram. The policy or contract may be returned personally or by mail. If by mail, the notice or return of the policy or contract is effective upon being postmarked, properly addressed and postage prepaid.~~ must comply with the following:

(1) a minimum of ten days beginning on the date the policy is received by the owner;

(2) a minimum of 20 days beginning on the date the policy is received by the owner if the policy is a replacement policy subject to section 61A.57;

(3) a requirement for the return of the policy to the company or an agent of the company;

(4) a statement that the policy is considered void from the beginning and the parties shall be in the same position as if no policy had been issued;

(5) subject to subdivision 3, a refund of all premiums paid, including any fees or charges, if the policy is returned; and

(6) a statement that notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed, and postage prepaid.

Sec. 35. Minnesota Statutes 2007 Supplement, section 72A.52, subdivision 1, is amended to read:

Subdivision 1. **Contents.** In addition to all other legal requirements a policy or contract of insurance described in section 72A.51 shall show the name and address of the insurer and the seller of the policy or contract and shall state, clearly and conspicuously in boldface type of a minimum size of ten points, a right to cancel notice which shall include the following:

(1) a minimum of ten days beginning on the date the policy is received by the owner;

(2) a minimum of ~~30~~ 20 days beginning on the date the policy is received by the owner if the policy is a replacement policy;

(3) a requirement for the return of the policy to the company or an agent of the company;

(4) a statement that the policy is considered void from the beginning and the parties shall be in the same position as if no policy had been issued;

(5) a refund of all premiums paid, including any fees or charges, if the policy is returned; and

(6) a statement that notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed, and postage prepaid.

For variable annuity contracts issued pursuant to sections 61A.13 to 61A.21, this notice shall be suitably modified so as to notify the purchaser that the purchaser is entitled to a refund of the amount calculated in accordance with the provisions of section 72A.51, subdivision 3.

Sec. 36. Minnesota Statutes 2006, section 82B.23, subdivision 1, is amended to read:

Subdivision 1. **Requirement.** The commissioner shall certify and transmit to the appraisal subcommittee established pursuant to the Federal Institutions Reform, Recovery, and Enforcement Act of 1989, Public Law 100-73, the names of those licensees who have satisfied the requirements for certification and licensure established by the appraisal subcommittee and to collect and transmit any required fees.

Sec. 37. Minnesota Statutes 2006, section 256B.0571, subdivision 8, is amended to read:

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident at the time coverage first became effective under the partnership policy; and

(2) be a beneficiary of a partnership policy that (i) is issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota, or (ii) qualifies as a partnership policy under the provisions of subdivision 8a~~; and~~.

~~(3) have exhausted all of the benefits under the partnership policy as described in this section.~~ Benefits received under a long-term care insurance policy before July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.

Sec. 38. **[332.345] SEGREGATED ACCOUNTS.**

A payment collected by a collector or collection agency on behalf of a customer shall be held by the collector or collection agency in a separate trust account clearly designated for customer funds. The account must be in a bank or other depository institution authorized or chartered under the laws of any state or of the United States.

Sec. 39. **REPEALER.**

(a) Minnesota Statutes 2006, section 62A.149, subdivision 2, is repealed.

(b) Laws 2006, chapter 255, section 26, is repealed.

62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS.

Subd. 2. **Minimum coverage.** Coverage under subdivision 1, clauses (1) and (2), shall be for at least 20 percent of the total patient days allowed by the policy and in no event shall coverage be for less than 28 days in each 12-month benefit year. Coverage under subdivision 1, clause (3), shall be for at least 130 hours of treatment in a 12-month benefit year.

Laws 2006, chapter 255, section 26

Sec. 26. **[62J.83] REDUCED PAYMENT AMOUNTS PERMITTED.**

(a) Notwithstanding any provision of chapter 148 or any other provision of law to the contrary, a health care provider may provide care to a patient at a discounted payment amount, including care provided for free.

(b) This section does not apply in a situation in which the discounted payment amount is not permitted under federal law.