State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2389

03/17/2025 Authored by Finke
The bill was read for the first time and referred to the Committee on Commerce Finance and Policy
03/24/2025 Adoption of Report: Amended and re-referred to the Committee on Judiciary Finance and Civil Law

A bill for an act

relating to insurance; authorizing certain data calls; providing for and regulating limited long-term care insurance; modifying various provisions governing automobile insurance; classifying certain data; providing penalties; making technical changes; amending Minnesota Statutes 2024, sections 45.027, subdivisions 1, 2, by adding a subdivision; 65B.02, subdivision 7; 65B.05; 65B.06, subdivisions 1, 2, 3; 65B.10, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 62A; repealing Minnesota Statutes 2024, section 65B.10, subdivision 3.

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

Section 1. Minnesota Statutes 2024, section 45.027, subdivision 1, is amended to read:

Subdivision 1. **General powers.** (a) In connection with the duties and responsibilities entrusted to the commissioner, and Laws 1993, chapter 361, section 2, the commissioner of commerce may:

(1) make public or private investigations within or without this state as the commissioner considers necessary to determine whether any person has violated or is about to violate any law, rule, or order related to the duties and responsibilities entrusted to the commissioner;

(2) require or permit any person to file a statement in writing, under oath or otherwise as the commissioner determines, as to all the facts and circumstances concerning the matter being investigated;

(3) hold hearings, upon reasonable notice, in respect to any matter arising out of the duties and responsibilities entrusted to the commissioner;

(4) conduct investigations and hold hearings for the purpose of compiling information related to the duties and responsibilities entrusted to the commissioner;

(5) examine the books, accounts, records, and files of every licensee, and of every person who is engaged in any activity regulated; the commissioner or a designated representative shall have free access during normal business hours to the offices and places of business of the person, and to all books, accounts, papers, records, files, safes, and vaults maintained in the place of business;

(6) publish information which is contained in any order issued by the commissioner;

(7) require any person subject to duties and responsibilities entrusted to the commissioner, to report all sales or transactions that are regulated. The reports must be made within ten days after the commissioner has ordered the report. The report is accessible only to the respondent and other governmental agencies unless otherwise ordered by a court of competent jurisdiction; ~~and~~

(8) assess a natural person or entity subject to the jurisdiction of the commissioner the necessary expenses of the investigation performed by the department when an investigation is made by order of the commissioner. The cost of the investigation shall be determined by the commissioner and is based on the salary cost of investigators or assistants and at an average rate per day or fraction thereof so as to provide for the total cost of the investigation. All money collected must be deposited into the general fund. A natural person or entity licensed under chapter 60K, 82, or 82B shall not be charged costs of an investigation if the investigation results in no finding of a violation. This clause does not apply to a natural person or entity already subject to the assessment provisions of sections 60A.03 and 60A.031~~.~~; and

(9) issue data calls.

(b) For purposes of this section, "data call" means a written request from the commissioner to two or more natural persons or entities subject to the commissioner's jurisdiction to provide data or other information within a reasonable time period commensurate with the volume and nature of the data required to be collected in the data call for a specific, targeted regulatory oversight purpose. A data call is not market analysis, as defined under section 60A.031, subdivision 4, paragraph (f), and is not subject to section 60A.033.

Sec. 2. Minnesota Statutes 2024, section 45.027, is amended by adding a subdivision to read:

Subd. 1b. **Data calls.** (a) Information provided in response to a data call issued by the commissioner: (1) must be treated as nonpublic data, as defined under section 13.02,

subdivision 9; and (2) is not subject to subpoena. If the commissioner performs a data call, the commissioner may make the results available for public inspection in an aggregated format and in such a manner as to not disclose the identity of a specific natural person or entity, including the name of any natural person or entity who responded to the data call. Prior to making the aggregated results of a data call available for public inspection, the commissioner must provide all natural persons and entities that responded to the data call 15 days' notice of the information to be publicly released. Nothing in this subdivision requires the commissioner to publicly release aggregated results from a data call. The results of a data call that requests data for the National Association of Insurance Commissioners' Market Conduct Annual Statement is subject to confidential treatment as provided under section 60A.031, subdivision 4, paragraph (f).

(b) The commissioner may grant access to data submitted by insurers in response to a data call issued by the commissioner with other state, federal, and international regulatory agencies; with the National Association of Insurance Commissioners and its affiliates and subsidiaries; and with state, federal, and international law enforcement authorities, provided that the recipient agrees in writing to maintain the data as nonpublic data and has the legal authority to maintain the data as nonpublic data.

Sec. 3. Minnesota Statutes 2024, section 45.027, subdivision 2, is amended to read:

Subd. 2. **Power to compel production of evidence.** For the purpose of any investigation, hearing, proceeding, or inquiry related to the duties and responsibilities entrusted to the commissioner, the commissioner or a designated representative may issue data calls, administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of books, papers, correspondence, memoranda, agreements, or other documents or records that the commissioner considers relevant or material to the inquiry.

A subpoena issued pursuant to this subdivision must state that the person to whom the subpoena is directed may not disclose the fact that the subpoena was issued or the fact that the requested records have been given to law enforcement personnel except:

(1) insofar as the disclosure is necessary to find and disclose the records; or

(2) pursuant to court order.

Sec. 4. **[62A.481] LIMITED LONG-TERM CARE INSURANCE.**

Subdivision 1. **Short title.** This section may be known and cited as the "Limited Long-Term Care Insurance Act."

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Applicant" means:

(1) in the case of an individual limited long-term care insurance policy, the individual who seeks to contract for benefits; or

(2) in the case of a group limited long-term care insurance policy, the proposed group policy holder.

(c) "Elimination period" means the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer.

(d) "Group limited long-term care insurance policy" means a limited long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(1) one or more employers or labor organizations, a trust or the trustees of a fund established by one or more employers, labor organizations, or a combination of employers and labor organizations for: (i) employees, former employees, or a combination of employees or former employees; or (ii) members, former members, or a combination of members or former members of the labor organizations;

(2) a professional, trade, or occupational association for the association's members, former members, retired members, or a combination of members, former members, or retired members, if the association:

(i) is composed of individuals, all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance;

(3) an association, a trust, or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within Minnesota, an association, or the insurer of an association, must file evidence with the commissioner that the association has at the outset: (i) a minimum of 100 individuals; (ii) been organized and maintained in good faith for purposes other than obtaining insurance; (iii) been in active existence for at least one year; and (iv) a constitution and bylaws that provide:

(A) the association holds regular meetings not less than annually to further purposes of the members;

(B) except for credit unions, the association collects dues or solicits contributions from members; and

(C) the members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, an association is deemed to satisfy the organizational requirements unless the commissioner makes a finding that an association does not satisfy the organizational requirements; or

(4) a group other than a group described in clauses (1) to (3), subject to the commissioner finding that:

(i) issuing the policy is not contrary to the public interest;

(ii) issuing the policy results in acquisition or administrative economies; and

(iii) the policy's benefits are reasonable in relation to the premiums charged.

(e) "Limited long-term care insurance policy" means a policy, contract, subscriber agreement, certificate, rider, or endorsement:

(1) delivered or issued for delivery in this state by: an insurance company licensed under chapter 60A; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; or a fraternal benefit society operating under chapter 64B;

(2) advertised, marketed, offered, or designed to provide coverage for less than 12 consecutive months for each insured individual on an expense-incurred, indemnity, prepaid, or other basis; and

(3) for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than a hospital's acute care unit.

Limited long-term care insurance policy includes a group limited long-term care insurance policy. Limited long-term care insurance includes a policy that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. A limited long-term care insurance policy does not include an insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical

expense coverage, disability income or related asset-protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(f) "Waiting period" means the time an insured individual must wait before some or all of the insured individual's coverage becomes effective.

Subd. 3. **Group limited long-term care insurance; extra-territorial jurisdiction.** Group limited long-term care insurance coverage must not be offered to a Minnesota resident under a group policy issued in another state to a group described in subdivision 2, paragraph (d), clause (4), unless the commissioner makes a determination that the statutory limited long-term care insurance requirements of this section have been met.

Subd. 4. **Limited long-term care insurance; disclosure and performance standards.** (a) A limited long-term care insurance policy must not:

(1) cancel, not renew, or otherwise terminate on the basis of the insured individual's or certificate holder's age, gender, or deterioration of mental or physical health;

(2) contain a provision that establishes a new waiting period in the event existing coverage is converted to or replaced by a new or other form of coverage by the same issuer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) provide coverage for only skilled nursing care or provide significantly more coverage for skilled nursing care in a facility than coverage provided for lower levels of care.

(b) A group limited long-term care insurance policy is prohibited from: (1) using a definition for preexisting condition that is more restrictive than or excludes a condition for which medical advice or treatment was recommended by or received from a health care services provider within the six months preceding the date an insured individual's coverage is effective; and (2) excluding coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months of the date an insured individual's coverage is effective. The commissioner may extend the limitation periods established in clauses (1) and (2) with respect to specific age group categories in specific policy forms upon a finding that the extension is in the public interest. The definition of preexisting condition required under clause (1) does not prohibit the policy issuer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the applicant's answers on the application, from underwriting in accordance with established underwriting standards. Unless otherwise provided in the policy, an issuer is not required to cover a preexisting condition, regardless of whether the preexisting condition is disclosed on the application, until the waiting period under clause (2) expires.

A limited long-term care insurance policy is prohibited from excluding or using waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period established in clause (2).

(c) A limited long-term care insurance policy must not be delivered or issued for delivery in this state if the policy conditions eligibility: (1) for any benefits, on a prior hospitalization requirement; (2) for benefits provided in an institutional care setting, on the receipt of a higher level of institutional care; or (3) for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits, on a prior institutionalization requirement. A limited long-term care insurance policy is prohibited from conditioning eligibility for noninstitutional benefits on the prior or continuing receipt of skilled care services.

(d) An applicant has the right to:

(1) return the policy to the issuer within 30 days of its receipt; and

(2) have the premium refunded if, after examination, the applicant is not satisfied with the policy for any reason.

(e) A limited long-term care insurance policy must have the below notice prominently printed on its first page. This requirement does not apply to a group limited long-term care insurance policy.

"You have 30 days from the date you receive this policy, certificate, or rider to review and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide to not keep the policy, certificate, or rider, simply return it to the company at the company's administrative office, or you may return it to the agent that you bought it from. You must return the policy, certificate, or rider within 30 days of the date you first received it. The company must refund the full amount of any premium paid within 30 days of the date the company receives the returned policy, certificate, or rider. The premium refund is sent directly to the person who paid it. A returned policy, certificate, or rider is void, as if it never was issued."

(f) A coverage outline must be delivered to a prospective applicant for a limited long-term care insurance policy at the time an initial solicitation is made, using a means that prominently directs the recipient's attention to the coverage outline and the coverage outline's purpose. The commissioner must prescribe: (1) a standard format, including style, arrangement, and overall appearance; and (2) the content that must be contained on a coverage outline. With respect to an insurance producer solicitation, the insurance producer must deliver the coverage

outline before presenting an application or enrollment form. With respect to a direct response solicitation, the coverage outline must be provided in conjunction with an application or enrollment form. Delivery of a coverage outline is not required for a group limited long-term care insurance policy if the information described in paragraph (g) is contained in other materials relating to enrollment. A copy of the other materials must be made available to the commissioner upon request.

(g) The coverage outline provided under paragraph (f) must include:

(1) a description of the principal benefits and coverage provided in the policy;

(2) a description of the eligibility triggers for benefits and how the eligibility triggers are met;

(3) a statement identifying the principal exclusions, reductions, and limitations contained in the policy;

(4) a statement describing the terms under which the policy may be continued in force or discontinued, including any reservation in the policy of a right to change premium. A continuation or conversion provision for a group limited long-term care insurance policy specifically described;

(5) a statement indicating that coverage outline is a summary only and not an insurance contract, and that the policy or group master policy contains the governing contractual provisions;

(6) a description of the terms under which the policy may be returned and premium refunded;

(7) a brief description of the relationship between cost of care and benefits; and

(8) a statement that discloses to the policyholder or group policyholder that the policy is not long-term care insurance.

(h) A group limited long-term care policy must include:

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement identifying the principal exclusions, reductions, and limitations contained in the policy; and

(3) a statement indicating that the group master policy determines governing contractual provisions.

(i) If an application for a limited long-term care insurance policy is approved, the issuer must deliver the policy to the applicant no later than 30 days after the date the application is approved.

(j) If a claim under a limited long-term care insurance policy is denied, the issuer must, within 60 days of the date the policyholder or their representative submits a written request:

(1) provide a written explanation detailing the reasons for the denial; and

(2) make available all information directly related to the denial.

(k) A disclosure, statement, or written information and explanation required in this section, whether in print or electronic form, must accommodate the communication needs of individuals with disabilities and persons with limited English proficiency, as required by law.

Subd. 5. **Incontestability period.** (a) An issuer may (1) rescind a limited long-term care insurance policy, or (2) deny an otherwise valid limited long-term care insurance claim, for a policy that has been in force for less than six months upon a showing of misrepresentation that is material to the coverage acceptance.

(b) An issuer may (1) rescind a limited long-term care insurance policy, or (2) deny an otherwise valid limited long-term care insurance claim, for a policy that has been in force for at least six months but less than two years upon a showing of misrepresentation that is both material to the coverage acceptance and that pertains to the condition for which benefits are sought.

(c) A limited long-term care policy that has been in force for two years is not contestable upon the grounds of misrepresentation alone. A limited long-term care policy that has been in force for two years may be contested only upon a showing that the insured individual knowingly and intentionally misrepresented relevant facts relating to the insured individual's health.

(d) A limited long-term care insurance policy may be field issued if compensation to the field issuer is not based on the number of policies issued. For purposes of this paragraph, "field issued" means a policy issued by an insurance producer or a third-party administrator (1) pursuant to the underwriting authority granted to the producer or third-party administrator by an issuer, and (2) using the issuer's underwriting guidelines.

(e) If an issuer paid benefits under the limited long-term care insurance policy, the benefit payments are not recoverable by the issuer if the policy is rescinded.

Subd. 6. **Nonforfeiture benefits.** (a) A limited long-term care insurance policy may offer the option to purchase a policy that includes a nonforfeiture benefit. A nonforfeiture benefit may be offered in the form of a rider that is attached to the policy. If the insured individual does not purchase the nonforfeiture benefit, the issuer must provide a contingent benefit upon lapse that must be available for a specified period of time after a substantial increase in premium rates.

(b) When a group limited long-term care insurance policy is issued, a nonforfeiture benefit offer must be made to the group policyholder. If the group limited long-term care insurance policy is issued to an entity other than a continuing care retirement community or other similar entity, a nonforfeiture benefit offer must be made to each proposed insured individual.

Subd. 7. **Penalties.** In addition to any other penalties provided by the laws of Minnesota, a policy issuer or insurance producer that violates any requirement of this section is subject to an administrative fine of up to three times the amount of commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 5. Minnesota Statutes 2024, section 65B.02, subdivision 7, is amended to read:

Subd. 7. **Participation ratio.** "Participation ratio" means the ratio of the member's Minnesota premiums, or other measure of business written approved by the commissioner, in relation to the comparable statewide totals for all members.

(1) For private passenger nonfleet automobile insurance coverages the participation ratio shall be based on voluntary car years written in this state for the calendar year ending December 31 of the second prior year, as reported by the statistical agent of each member as private passenger nonfleet exposures.

(2) For insurance coverages on all other automobiles, including insurance for fleets, commercial vehicles, public vehicles and garages, the ratio shall be based on the total Minnesota gross, direct automobile insurance premiums written, including both policy and membership fees less return premiums and premiums on policies not taken, without including reinsurance assumed and without deducting reinsurance ceded, and less the amount of such premiums reported as received for insurance on private passenger nonfleet vehicles, for the calendar year ending December 31 of the second prior year.

(3) For the purpose of determining each member's responsibility for expenses and assessments to operate the facility, the ratio shall be based on each member's total Minnesota

car years and gross, direct premiums written, including both policy and membership fees less return premiums and premiums on policies not taken, without including reinsurance assumed and without deducting reinsurance ceded, for the calendar year ending December 31 of the second prior year, provided, however, that the preliminary determination of each member's responsibility for expenses and assessments may use the calendar year ending December 31 of the third prior year.

Sec. 6. Minnesota Statutes 2024, section 65B.05, is amended to read:

65B.05 POWER OF FACILITY, GOVERNING COMMITTEE.

(a) The facility is authorized to: (1) issue or cause to be issued insurance policies in the name of the Minnesota automobile insurance plan to applicants for the types of insurance available under the plan, subject to limits specified in the plan of operation; (2) underwrite the insurance and adjust and pay losses with respect to the plan; and (3) retain, hire, or appoint an individual or company to perform a function under clause (1) or (2).

(b) The governing committee shall have the power to direct the operation of the facility in all pursuits consistent with the purposes and terms of sections 65B.01 to 65B.12, including but not limited to ~~the following~~:

(1) ~~To~~ sue and be sued in the name of the facility and ~~to~~ assess each member in accord with its participation ratio to pay any judgment against the facility as an entity, provided, however, that no judgment against the facility shall create any liabilities in one or more members disproportionate to their participation ratio or an individual representing members on the governing committee~~.~~;

(2) ~~To~~ delegate ministerial duties, ~~to~~ hire a manager, and ~~to~~ contract for goods and services from others~~.~~;

(3) ~~To~~ assess members on the basis of participation ratios to cover anticipated costs of operation and administration of the facility~~.~~; and

(4) ~~To~~ impose limitations on cancellation or nonrenewal by members of insureds covered pursuant to placement through the facility in addition to the limitations imposed by chapter 72A and sections 65B.1311 to 65B.21.

Sec. 7. Minnesota Statutes 2024, section 65B.06, subdivision 1, is amended to read:

Subdivision 1. **Distribution of private passenger, nonfleet auto risks.** With respect to private passenger, nonfleet automobiles, the facility shall provide for ~~the equitable distribution of qualified applicants to~~ members to share premium, losses, costs, and expenses

in accordance with the participation ratio ~~or among these insurance companies as selected under the provisions of the plan of operation~~.

Sec. 8. Minnesota Statutes 2024, section 65B.06, subdivision 2, is amended to read:

Subd. 2. **Private passenger; nonfleet auto coverage.** With respect to private passenger, nonfleet automobiles, the facility shall provide for the issuance of policies of automobile insurance ~~by members~~ with coverage as follows:

(1) bodily injury liability and property damage liability coverage in the minimum amounts specified in section 65B.49, subdivision 3;

(2) uninsured and underinsured motorist coverages as required by section 65B.49, subdivisions 3a and 4a;

(3) a reasonable selection of higher limits of liability coverage up to $50,000 because of bodily injury to or death of one person in any one accident and, subject to such limit for one person, up to $100,000 because of bodily injury to or death of two or more persons in any one accident, and up to $25,000 because of injury to or destruction of property of others in any one accident, or higher limits of liability coverage as recommended by the governing committee and approved by the commissioner;

(4) basic economic loss benefits, as required by section 65B.44, and other optional coverages as recommended by the governing committee and approved by the commissioner; and

(5) automobile physical damage coverage, including coverage of loss by collision, subject to deductible options.

Sec. 9. Minnesota Statutes 2024, section 65B.06, subdivision 3, is amended to read:

Subd. 3. **Other auto coverage.** With respect to all automobiles not included in subdivisions 1 and 2, the facility shall provide:

(1) the minimum limits of coverage required by section 65B.49, subdivisions 2, 3, 3a, and 4a, or higher limits of liability coverage as recommended by the governing committee and approved by the commissioner;

(2) for the equitable ~~distribution of qualified applicants~~ sharing of premium, losses, costs, and expenses for this coverage among the members in ~~accord~~ accordance with the applicable participation ratio~~, or among these insurance companies as selected under the provisions of the plan of operation~~; and

(3) for a school district or contractor transporting school children under contract with a school district, that amount of automobile liability insurance coverage, not to exceed $1,000,000, required by the school district by resolution or contract, or that portion of such $1,000,000 of coverage for which the school district or contractor applies and for which it is eligible under section 65B.10.

Sec. 10. Minnesota Statutes 2024, section 65B.10, subdivision 2, is amended to read:

Subd. 2. **Termination of eligibility.** Eligibility for placement through the facility will terminate if an insured is offered equivalent coverage in the voluntary market at a rate lower than the facility rate. ~~If the member that is required to provide coverage by the facility makes such an offer after giving 30 days' advance written notice to the agent of record before making the offer, the member shall have no further obligation to the agent of record.~~

Sec. 11. **REPEALER.**

Minnesota Statutes 2024, section 65B.10, subdivision 3, is repealed.

65B.10 ELIGIBILITY.

Subd. 3. **Review of insureds.** At least annually, every member shall review every private passenger nonfleet applicant which it insures through the facility and determine whether or not such applicant is acceptable for voluntary insurance at a rate lower than the facility rate. If such applicant is acceptable, the member shall make an offer to insure the applicant under voluntary coverage at such lower rate.