CHAPTER 71—S.F.No. 465

An act relating to insurance; regulating the sale of certain qualified long–term care insurance policies; amending Minnesota Statutes 1996, sections 61A.072, subdivisions 1 and 4; 62A.011, subdivision 3; 62A.31, subdivision 6; 62A.48, by adding a subdivision; 62A.50, by adding a subdivision; and 62L.02, subdivision 15; proposing coding for new law as Minnesota Statutes, chapter 62S.

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

ARTICLE 1

QUALIFIED LONG–TERM CARE INSURANCE POLICY

Section 1. **[62S.01] DEFINITIONS.**

Subdivision 1. **APPLICATION.** The definitions in this section apply to this chapter.

Subd. 2. **ACTIVITIES OF DAILY LIVING.** "Activities of daily living" means eating, toileting, transferring, bathing, dressing, and continence.

Subd. 3. **ACUTE CONDITION.** "Acute condition" means that the individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

Subd. 4. **ADULT DAY CARE.** "Adult day care" means a program for six or more individuals of social and health–related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

Subd. 5. **APPLICANT.** "Applicant" means:

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

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

Subd. 6. **BATHING.** "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Subd. 7. **CERTIFICATE.** "Certificate" means a certificate issued under a group long–term care insurance policy delivered or issued for delivery in this state.

Subd. 8. **CHRONICALLY ILL INDIVIDUAL.** "Chronically ill individual" means an individual who has been certified by a licensed health care practitioner, within the preceding 12–month period, as either:

(1) 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;

(2) having a disability similar to the level of disability described in clause (1); or

(3) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Subd. 9. **COGNITIVE IMPAIRMENT.** "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as a person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Subd. 10. **COMMISSIONER.** "Commissioner" means the commissioner of commerce.

Subd. 11. **CONTINENCE.** "Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

Subd. 12. **DRESSING.** "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Subd. 13. **EATING.** "Eating" means feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.

Subd. 14. **FUNCTIONAL CAPACITY.** "Functional capacity" means requiring the substantial assistance of another person to perform the prescribed activities of daily living.

Subd. 15. **GROUP LONG-TERM CARE INSURANCE.** "Group long-term care insurance" means a long-term care insurance policy delivered or issued for delivery in this state and issued to:

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

(2) a professional, trade, or occupational association for its members or former or retired members, or combination, 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 or a trust or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations. Before advertising, marketing, or offering the policy within this state, the association or the insurer of the association must file evidence with the commissioner that the association has at the outset a minimum of 100 persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance; has been in active existence for at least one year; and has a constitution and bylaws that provide that:

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

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

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

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

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

(i) the issuance of the group policy is not contrary to the best interest of the public;

(ii) the issuance of the group policy would result in economies of acquisition or administration; and

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

Subd. 16. **GUARANTEED RENEWABLE.** "Guaranteed renewable" means the insured has the right to continue the long–term care insurance in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

Subd. 17. **HOME HEALTH CARE SERVICES.** "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. The services may include homemaker services, assistance with activities of daily living, and respite care services.

Subd. 18. **LONG–TERM CARE INSURANCE.** "Long–term care insurance" means a qualified long–term care insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Long–term care insurance includes:

(1) group and individual annuities and life insurance policies or riders that provide directly or that supplement long–term care insurance; and

(2) a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long–term care insurance 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. With regard to life insurance, long–term care insurance does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical

intervention, or permanent institutional confinement, and that provide the option of a lump–sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long–term care.

Subd. 19. **MAINTENANCE OR PERSONAL CARE SERVICES.** "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. 20. **MEDICARE.** "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended, or Title I, Part I, of Public Law Number 89–97, as Enacted by the Eighty–Ninth Congress of the United States of America, as amended.

Subd. 21. **MENTAL OR NERVOUS DISORDER.** "Mental or nervous disorder" means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Subd. 22. **NONCANCELABLE.** "Noncancelable" may be used only when the insured has the right to continue the long–term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

Subd. 23. **POLICY.** "Policy" means a policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization; or a similar organization.

Subd. 24. **QUALIFIED LONG–TERM CARE INSURANCE POLICY.** "Qualified long–term care insurance policy" means a policy that meets the requirements of Section 7702(B) of the Internal Revenue Code, as amended, and this chapter.

Subd. 25. **QUALIFIED LONG–TERM CARE SERVICES.** "Qualified long–term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance or personal care services, which are:

(1) required by a chronically ill individual; and

(2) provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Subd. 26. **TOILETING.** "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Subd. 27. **TRANSFERRING.** "Transferring" means moving into or out of a bed, chair, or wheelchair.

Sec. 2. **[62S.02] QUALIFIED LONG–TERM CARE INSURANCE POLICY.**

Subdivision 1. **REQUIREMENTS.** A qualified long–term care insurance policy may not be offered, issued, delivered, or renewed in this state unless the policy satisfies the requirements of this chapter. A qualified long–term care insurance policy must cover qualified long–term care services.

Subd. 2. **NONFORFEITURE REQUIREMENT.** An insurer shall offer a nonforfeiture provision available in the event of default in the payment of any premiums. The amount of the benefit may be adjusted after being initially granted, if necessary, to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts. The nonforfeiture provision must provide at least one of the following:

(1) reduced paid–up insurance;

(2) extended term insurance; or

(3) shortened benefit period.

Subd. 3. **REFUND RESTRICTIONS.** A qualified long–term care insurance policy shall not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. The aggregate premium paid under the policy may be refunded in the event of death of the insured or a complete surrender or cancellation of the policy.

Subd. 4. **NONREIMBURSABLE EXPENSES.** A qualified long–term care insurance policy shall not pay or reimburse expenses incurred for services or items if the expenses are reimbursable under Medicare or would be reimbursable if a deductible or coinsurance amount was not applied. This subdivision does not apply to expenses which are reimbursable under Medicare only as a secondary payor and does not prohibit the offering of a qualified long–term care insurance policy on the basis that the policy coordinates its benefits with those provided under Medicare. Notwithstanding this subdivision, payments may be made under a long–term care insurance policy on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

Subd. 5. **ACTIVITIES OF DAILY LIVING.** A qualified long–term care insurance policy shall take into account at least five of the activities of daily living in making the determination of whether an individual is chronically ill. Assessments of activities of daily living and cognitive impairment must be performed by a licensed or certified professional, such as a physician, nurse, or social worker.

Subd. 6. **APPEALS PROCESS.** A qualified long–term care insurance policy must include a clear description of the process for appealing and resolving benefit determinations.

Sec. 3. **[62S.03] EXTRATERRITORIAL JURISDICTION.**

Group long–term care insurance coverage may not be offered to a resident of this state under a group policy issued in another state to a group described in section 62S.01, subdivision 15, clause (4), unless this state or another state having statutory and regulatory long–term care insurance requirements substantially similar to those adopted in this state has made a determination that the requirements have been met.

Sec. 4. **[62S.04] PROHIBITIONS.**

A long–term care insurance policy may not:

(1) be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

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

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

Sec. 5. **[62S.05] PREEXISTING CONDITION.**

Subdivision 1. **AUTHORIZED DEFINITION.** A long-term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in section 62S.01, subdivision 15, clause (1), may not use a definition of preexisting condition that is more restrictive than the definition in this subdivision. "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months before the effective date of coverage of an insured person.

Subd. 2. **PROHIBITED EXCLUSION.** A long-term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in section 62S.01, subdivision 15, clause (1), may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

Subd. 3. **UNDERWRITING STANDARDS.** The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting according to that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision 2 expires. A long-term care insurance policy or certificate may not exclude or use waivers 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 described in subdivision 2.

Sec. 6. **[62S.06] PRIOR HOSPITALIZATION OR INSTITUTIONALIZATION.**

Subdivision 1. **PROHIBITED CONDITIONS.** A long-term care insurance policy may not be delivered or issued for delivery in this state if the policy conditions eligibility for any benefits:

(1) on a prior hospitalization requirement;

(2) provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement.

Subd. 2. **BENEFIT LABELING.** A long-term care insurance policy containing postconfinement, postacute care, or recuperative benefits must clearly label in a separate

paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" the limitations or conditions, including any required number of days of confinement.

Subd. 3. **BENEFIT CONDITIONS.** (a) A long–term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

(b) A long–term care insurance policy or rider that provides benefits only following institutionalization may not condition the benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

Sec. 7. **[62S.07] RIGHT TO RETURN; REFUND.**

Subdivision 1. **RIGHT TO RETURN.** A long–term care insurance applicant may return the policy or certificate within 30 days of its delivery and is entitled to a refund of the premium if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long–term care insurance policies and certificates must include a notice prominently printed on the first page or attached to the first page stating in substance that the applicant may return the policy or certificate within 30 days of its delivery and have the premium refunded if for any reason, after examination of the policy or certificate, other than a certificate issued under a policy issued to a group as defined in section 62S.01, subdivision 15, clause (1), the applicant is not satisfied.

Subd. 2. **REFUND.** If an application for a qualified long–term care insurance policy is denied, the issuer shall refund to the applicant any premium and fees submitted by the applicant within 30 days of the denial.

Sec. 8. **[62S.08] COVERAGE OUTLINE.**

Subdivision 1. **DELIVERY.** An outline of coverage must be delivered to a prospective applicant for long–term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose. In the case of agent solicitations, an agent must deliver the outline of coverage before the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with an application or enrollment form.

Subd. 2. **REQUIREMENTS.** The outline of coverage must be a freestanding document, using no smaller than ten–point type, and may not contain material of an advertising nature. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to the capitalization or underscoring.

Subd. 3. **MANDATORY FORMAT.** The following standard format outline of coverage must be used, unless otherwise specifically indicated:

COMPANY NAME
ADDRESS – CITY AND STATE
TELEPHONE NUMBER
LONG–TERM CARE INSURANCE
OUTLINE OF COVERAGE

Policy Number or Group Master Policy and Certificate Number

(Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

CAUTION: The issuance of this long–term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).

(1) This policy is (an individual policy of insurance) (a group policy) which was issued in the (indicate jurisdiction in which group policy was issued).

(2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.

(3) THIS PLAN IS INTENDED TO BE A QUALIFIED LONG–TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702(B)(b) OF THE INTERNAL REVENUE CODE OF 1986.

(4) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) (Provide a brief description of the right to return — "free look" provision of the policy.)

(b) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.)

(5) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) neither (insert company name) nor its agents represent Medicare, the federal government, or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government, or any state government.

(6) LONG–TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long–term care expenses, subject to policy (limitations), (waiting periods), and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

(7) BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should 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 must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long–term care, then these qualifying criteria or screens must be explained.)

(8) LIMITATIONS AND EXCLUSIONS:

Describe:

(a) preexisting conditions;

(b) noneligible facilities/provider;

(c) noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) exclusions/exceptions; and

(e) limitations.

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (6).)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG–TERM CARE NEEDS.

(9) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long–term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. As applicable, indicate the following:

(a) that the benefit level will not increase over time;

(b) any automatic benefit adjustment provisions;

(c) whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) if there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and

(e) whether there will be any additional premium charge imposed and how that is to be calculated.

(10) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. (State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically, describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

(11) PREMIUM.

(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

(12) ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

Subd. 4. **OUTLINE OF COVERAGE.** The outline of coverage must include the inflation protection information required under section 62S.23, subdivision 3, and the notice to buyer requirements specified under section 62S.29, subdivision 1, clause (3).

Sec. 9. **[62S.09] CERTIFICATE REQUIREMENTS.**

Subdivision 1. **CONTENT.** A certificate issued under a group long-term care insurance policy delivered or issued for delivery in this state must include:

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

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

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

Subd. 2. **DELIVERY.** The issuer of a qualified long-term care insurance policy shall deliver to the applicant, policyholder, or certificate holder the contract or certificate no later than 30 days after the date of approval.

Sec. 10. **[62S.10] POLICY SUMMARY.**

Subdivision 1. **DELIVERY.** At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer must deliver the policy summary upon the applicant's request, but regardless of request, must make the delivery no later than at the time of policy delivery.

Subd. 2. **CONTENTS.** The summary must include the following information:

(1) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person; and

(3) any exclusions, reductions, and limitations on benefits of long-term care.

Subd. 3. **ADDITIONAL INFORMATION REQUIRED.** If applicable to the policy type, the summary must include the following information:

(1) a disclosure of the effects of exercising other rights under the policy;

(2) a disclosure of guarantees related to long-term care costs of insurance charges; and

(3) current and projected maximum lifetime benefits.

Sec. 11. **[62S.11] MONTHLY REPORT.**

Subdivision 1. **REQUIRED REPORT.** Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report must be provided to the policyholder.

Subd. 2. **CONTENTS.** The report must include the following information:

(1) long-term care benefits paid out during the month;

(2) an explanation of changes in the policy, such as death benefits or cash values, due to long-term care benefits being paid out; and

(3) the amount of long-term care benefits existing or remaining.

Sec. 12. **[62S.12] CLAIM DENIAL.**

If a claim under a qualified long-term care insurance contract is denied, the issuer shall provide a written explanation of the reasons for the denial and make available all information directly related to the denial within 60 days of the date of a written request by the policyholder or certificate holder, or a representative of the policyholder or certificate holder.

Sec. 13. **[62S.13] INCONTESTABILITY PERIOD.**

Subdivision 1. **RESCISSION BEFORE SIX MONTHS.** For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to acceptance for coverage.

Subd. 2. **RESCISSION AFTER SIX MONTHS.** For a policy or certificate that has been in force for at least six months, but less than two years, an insurer may rescind a long–term care insurance policy or certificate or deny an otherwise valid long–term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.

Subd. 3. **CONTESTED POLICY AFTER TWO YEARS.** After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone. The policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

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.

Subd. 5. **BENEFIT PAYMENTS NOT RECOVERABLE.** If an insurer has paid benefits under the long–term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

Sec. 14. **[62S.14] RENEWABILITY.**

Subdivision 1. **GUARANTEED RENEWABLE.** A qualified long–term care insurance policy must be guaranteed renewable.

Subd. 2. **TERMS.** The terms "guaranteed renewable" and "noncancelable" may not be used in an individual long–term care insurance policy without further explanatory language that complies with the disclosure requirements of section 62S.20.

Subd. 3. **AUTHORIZED RENEWAL PROVISIONS.** A policy issued to an individual may not contain renewal provisions other than guaranteed renewable or noncancelable.

Sec. 15. **[62S.15] AUTHORIZED LIMITATIONS AND EXCLUSIONS.**

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 nonfare–paying aviation; and

(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.

This subdivision does not prohibit exclusions and limitations by type of provider or territorial limitations.

Sec. 16. **[62S.16] EXTENSION OF BENEFITS.**

Termination of long–term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long–term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long–term care insurance was in force may be limited to the duration of the benefit period or to payment of the maximum benefits and may be subject to a policy waiting period, and all other applicable provisions of the policy.

Sec. 17. **[62S.17] CONTINUATION OR CONVERSION.**

Subdivision 1. **REQUIREMENT.** Group long–term care insurance shall provide covered individuals with a basis for continuation or conversion of coverage.

Subd. 2. **BASIS FOR CONTINUATION OF COVERAGE.** A basis for continuation of coverage policy provision must maintain coverage under the existing group policy when the coverage would otherwise terminate and is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits and shall take into consideration the differences between managed care and nonmanaged care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.

Subd. 3. **BASIS FOR CONVERSION OF COVERAGE.** A basis for conversion of coverage policy provision must provide that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy and any group policy which it replaced, for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy the insured is covered, without evidence of insurability.

Subd. 4. **CONVERTED INDIVIDUAL POLICY.** A converted individual policy of long–term care insurance must provide benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.

Subd. 5. **CONVERTED POLICY APPLICATION.** Written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy must be issued effective on the day following the termination of coverage under the group policy, and is renewable annually.

Subd. 6. **CONVERTED POLICY PREMIUM CALCULATION.** Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

Subd. 7. **EXCEPTIONS.** Continuation of coverage or issuance of a converted policy is mandatory, except under the following conditions:

(1) termination of group coverage resulting from an individual's failure to make a required payment of premium or contribution when due; or

(2) replacement group coverage:

(i) is in place not later than 31 days after termination and is effective on the day following the termination of coverage;

(ii) provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(iii) premium is calculated in a manner consistent with the requirements of subdivision 6.

Subd. 8. **REDUCTION IN BENEFITS.** Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long–term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. This provision may only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

Subd. 9. **BENEFIT LIMIT.** A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in effect.

Subd. 10. **ELIGIBILITY.** Notwithstanding any other provision of this section, an insured individual whose eligibility for group long–term care coverage is based upon the insured individual's relationship to another person, is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

Subd. 11. **MANAGED CARE PLAN.** For the purposes of this section, a "managed care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

Sec. 18. **[62S.18] DISCONTINUANCE AND REPLACEMENT.**

Subdivision 1. **REQUIRED COVERAGE.** If a group long–term care policy is replaced by another group long–term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced and shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long–term care services.

Subd. 2. **PREMIUMS.** 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.

Sec. 19. **[62S.19] UNINTENTIONAL LAPSE.**

Subdivision 1. **NOTICE BEFORE LAPSE OR TERMINATION.** No individual long–term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver must state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long–term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

The insurer shall notify the insured of the right to change this written designation at least once every two years.

Subd. 2. **PAYMENT PLAN PROVISIONS.** When the policyholder or certificate holder pays the premium for a long–term care insurance policy or certificate through a payroll or pension deduction plan, the requirements specified under subdivision 1 are effective 60 days after the policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for the policies or certificates must clearly indicate the payment plan selected by the applicant.

Subd. 3. **NOTICE REQUIREMENTS.** No individual long–term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at

least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under subdivision 1, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice must be given by first class United States mail, postage prepaid, and notice may not be given until 30 days after a premium is due and unpaid. Notice is considered to have been given as of five days after the date of mailing.

Subd. 4. **REINSTATEMENT.** In addition to the requirement in subdivision 1, a long–term care insurance policy or certificate must include a provision which provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option must be available to the insured if requested within five months after termination and must allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

Sec. 20. **[62S.20] REQUIRED DISCLOSURE PROVISIONS.**

Subdivision 1. **RENEWABILITY.** Individual long–term care insurance policies must contain a renewability provision that is appropriately captioned, appears on the first page of the policy, and clearly states the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This subdivision does not apply to policies which are part of or combined with life insurance policies which do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder.

Subd. 2. **RIDERS AND ENDORSEMENTS.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long–term care insurance policy, all riders or endorsements added to an individual long–term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require signed acceptance by the individual insured. After the date of policy issue, a rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to, in writing, signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be specified in the policy, rider, or endorsement.

Subd. 3. **PAYMENT OF BENEFITS.** A long–term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or similar words must include a definition and an explanation of the terms in its accompanying outline of coverage.

Subd. 4. **LIMITATIONS.** If a long–term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the policy or certificate and must be labeled as "preexisting condition limitations."

Subd. 5. **OTHER LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS.** A long–term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in section 62S.06 shall provide a

description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "limitations or conditions on eligibility for benefits."

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.

Sec. 21. **[62S.21] PROHIBITION AGAINST POSTCLAIMS UNDERWRITING.**

Subdivision 1. **HEALTH CONDITION.** All applications for long–term care insurance policies or certificates, except those which are guaranteed issue must contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

Subd. 2. **MEDICATION INFORMATION REQUIRED.** If an application for long–term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

Subd. 3. **LANGUAGE REQUIRED.** (a) The following language must be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long–term care insurance policy or certificate:

CAUTION: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy.

(b) The following language, or language substantially similar to the following, must be set out conspicuously on the long–term care insurance policy or certificate at the time of delivery:

CAUTION: The issuance of this long–term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).

Subd. 4. **NECESSARY INFORMATION.** Before issuing a long–term care policy or certificate to an applicant aged 80 or older, the insurer shall obtain one of the following:

(1) a report of a physical examination;

(2) an assessment of functional capacity;

(3) an attending physician's statement; or

(4) copies of medical records.

Subd. 5. **EXCEPTION.** Subdivisions 3 and 4 do not apply to policies or certificates which are guaranteed issue.

Subd. 6. **COPY REQUIREMENT.** A copy of the completed application or enrollment form, whichever is applicable, must be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

Subd. 7. **RECORDS.** An insurer or other entity selling or issuing long–term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the commissioner.

Sec. 22. **[62S.22] MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS.**

Subdivision 1. **PROHIBITED LIMITATIONS.** A long–term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

(1) requiring that the insured would need care in a skilled nursing facility if home health care services were not provided;

(2) requiring that the insured first or simultaneously receive nursing or therapeutic services in a home, community, or institutional setting before home health care services are covered;

(3) limiting eligible services to services provided by a registered nurse or licensed practical nurse;

(4) requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of licensure or certification;

(5) excluding coverage for personal care services provided by a home health aide;

(6) requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) requiring that the insured have an acute condition before home health care services are covered;

(8) limiting benefits to services provided by Medicare–certified agencies or providers; or

(9) excluding coverage for adult day care services.

Subd. 2. **REQUIRED COVERAGE AMOUNT.** A long–term care insurance policy or certificate, if it provides for home health or community care services, must provide total home health or community care coverage that is a dollar amount equivalent to at least one–half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.

Subd. 3. **APPLICATION OF HOME HEALTH CARE COVERAGE.** Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Sec. 23. **[62S.23] REQUIREMENT TO OFFER INFLATION PROTECTION.**

Subdivision 1. **INFLATION PROTECTION FEATURE.** No insurer may offer a long–term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long–term care services covered by the policy. In addition to other options that may be offered, insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

(2) guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

Subd. 2. **GROUP OFFER.** Except as otherwise provided in this subdivision, if the policy is issued to a group, the required offer in subdivision 1 must be made to the group policyholder. If the policy is issued to a group as defined in section 62S.01, subdivision 15, clause (4), other than to a continuing care retirement community, the offering must be made to each proposed certificate holder.

Subd. 3. **REQUIRED INFORMATION.** Insurers shall include the following information in or with the outline of coverage:

(1) a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a 20–year period; and

(2) any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

An insurer may use a reasonable, hypothetical, or a graphic demonstration for the purposes of this disclosure.

Subd. 4. **BENEFIT CONTINUED.** Inflation protection benefit increases under a policy which contains this benefit shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

Subd. 5. **AUTOMATIC BENEFIT INCREASES.** An offer of inflation protection which provides for automatic benefit increases must include an offer of a premium which the insurer expects to remain constant. The offer must disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

Subd. 6. **REJECTION.** Inflation protection as provided in subdivision 1, clause (1), must be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this section. The rejection may be either in the application or on a separate form.

The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protections. Specifically, I have reviewed plans ....., and I reject inflation protection.

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

Sec. 24. **[62S.24] REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.**

Subdivision 1. **REQUIRED QUESTIONS.** An application form must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the following questions may be used. If a replacement policy is issued to a group as defined under section 62S.01, subdivision 15, clause (1), the following questions may be modified only to the extent necessary to elicit information about long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement:

(1) do you have another long-term care insurance policy or certificate in force?;

(2) did you have another long-term care insurance policy or certificate in force during the last 12 months?;

(i) if so, with which company?; and

(ii) if that policy lapsed, when did it lapse?; and

(3) are you covered by Medicaid?

Subd. 2. **ADDITIONAL APPLICATION REQUIREMENTS.** An application for a long-term care insurance policy or certificate must meet the requirements specified under section 62S.21.

Subd. 3. **SOLICITATIONS OTHER THAN DIRECT RESPONSE.** After determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods or its agent, shall furnish the applicant, before issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy signed by the applicant must be retained by the insurer. The required notice must be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG–TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing long–term care insurance and replace it with an individual long–term care insurance policy to be issued by (company name) insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all long–term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long–term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT

(BROKER OR OTHER REPRESENTATIVE):

(Use additional sheets, as necessary.)

I have reviewed your current insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

(a) Health conditions which you presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing long–term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

.....

(Signature of Agent, Broker, or Other Representative)

(Typed Name and Address of Agency or Broker)

The above "Notice to Applicant" was delivered to me on:

.....

(Date)

.....

(Applicant's Signature)

Subd. 4. **DIRECT RESPONSE SOLICITATIONS.** Insurers using direct response solicitation methods shall deliver a notice regarding replacement of long-term care coverage to the applicant upon issuance of the policy. The required notice must be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (company name) insurance company.

Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

(a) Health conditions which you presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replace-

ment of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) (To be included only if the application is attached to the policy.)

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

.....

(Company Name)

Subd. 5. **REPLACEMENT NOTIFICATION.** Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy must be identified by the insurer, name of the insured, and policy number or address including zip code. The notice must be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

Subd. 6. **WAIVER OF PREEXISTING CONDITION AND PROBATIONARY PERIODS.** If a long–term care insurance policy or certificate replaces another long–term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long–term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Sec. 25. **[62S.25] REPORTING REQUIREMENTS.**

Subdivision 1. **INSURER RECORDS.** Each insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long–term care insurance policies sold by the agent as a percent of the agent's total annual sales.

Subd. 2. **REQUIRED INFORMATION ON AGENTS.** Each insurer shall report annually by June 30 the ten percent of its agents with the greatest percentages of lapses and replacements as measured under subdivision 1.

Subd. 3. **INTENT.** Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long–term care insurance.

Subd. 4. **LAPSED POLICIES.** Each insurer shall report annually by June 30 the number of lapsed long–term care insurance policies as a percent of its total annual sales and as a percent of its total number of long–term care insurance policies in force as of the end of the preceding calendar year.

Subd. 5. **REPLACEMENT POLICIES.** Each insurer shall report annually by June 30 the number of replacement long–term care insurance policies sold as a percent of

its total annual sales and as a percent of its total number of long–term care insurance policies in force as of the preceding calendar year.

Subd. 6. **CLAIMS DENIED.** Each insurer shall report annually by June 30 the number of claims denied during the reporting period for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

Sec. 26. **[62S.26] LOSS RATIO.**

The minimum loss ratio must be at least 60 percent, calculated in a manner which provides for adequate reserving of the long–term care insurance risk. In evaluating the expected loss ratio, the commissioner shall give consideration to all relevant factors, including:

(1) statistical credibility of incurred claims experience and earned premiums;

(2) the period for which rates are computed to provide coverage;

(3) experienced and projected trends;

(4) concentration of experience within early policy duration;

(5) expected claim fluctuation;

(6) experience refunds, adjustments, or dividends;

(7) renewability features;

(8) all appropriate expense factors;

(9) interest;

(10) experimental nature of the coverage;

(11) policy reserves;

(12) mix of business by risk classification; and

(13) product features such as long elimination periods, high deductibles, and high maximum limits.

Sec. 27. **[62S.27] FILING REQUIREMENT.**

Before an insurer or similar organization offers group long–term care insurance to a resident of this state under section 62S.03, it must file with the commissioner evidence that the group policy or certificate has been approved by a state having statutory or regulatory long–term care insurance requirements substantially similar to those adopted in this state.

Sec. 28. **[62S.28] FILING REQUIREMENTS FOR ADVERTISING.**

Subdivision 1. **ADVERTISEMENT COPY.** An insurer or other entity providing long–term care insurance or benefits in this state shall provide a copy of any long–term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the commissioner for review or approval by the commissioner, to the extent it may be required under state law. All advertisements must be retained by the

insurer or other entity for at least three years from the date the advertisement was first used.

Subd. 2. **EXEMPTION.** The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

Sec. 29. **[62S.29] STANDARDS FOR MARKETING.**

Subdivision 1. **REQUIREMENTS.** An insurer or other entity marketing long–term care insurance coverage in this state, directly or through its producers, shall:

(1) establish marketing procedures to assure that a comparison of policies by its agents or other producers are fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued;

(3) display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, the following:

"Notice to buyer: This policy may not cover all of the costs associated with long–term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";

(4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long–term care insurance already has long–term care insurance and the types and amounts of the insurance;

(5) establish auditable procedures for verifying compliance with this subdivision; and

(6) if applicable, provide written notice to the prospective policyholder and certificate holder, at solicitation, that a senior insurance counseling program approved by the commissioner is available and the name, address, and telephone number of the program.

Subd. 2. **PROHIBITIONS.** In addition to the practices prohibited in chapter 72A, the following acts and practices are prohibited:

(1) knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer;

(2) employing a method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance;

(3) making use directly or indirectly of a method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company; and

(4) misrepresenting a material fact in selling or offering to sell a policy.

Subd. 3. **FILING OF MATERIAL.** The insurer shall file with the commissioner the following material:

(1) the policy and certificate;

(2) a corresponding outline of coverage; and

(3) all advertisements requested by the commissioner.

Subd. 4. **ASSOCIATION DISCLOSURE REQUIREMENTS.** An association shall disclose in a long-term care insurance solicitation:

(1) the specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees, and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members; and

(2) a brief description of the process under which the policies and the insurer issuing the policies were selected.

Subd. 5. **ADDITIONAL DISCLOSURE REQUIREMENTS.** If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose this fact to its members.

Subd. 6. **POLICY REVIEW AND APPROVAL.** The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

Subd. 7. **INFORMATION REQUIRED.** No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the commissioner the information required in this section.

Subd. 8. **INSURER CERTIFICATION.** The insurer shall not issue a long-term care policy or certificate to an association or continue to market a policy or certificate unless the insurer certifies annually that the association has complied with the requirements specified in this section.

Sec. 30. **[62S.30] APPROPRIATENESS OF RECOMMENDED PURCHASE.**

In recommending the purchase or replacement of a long-term care insurance policy or certificate, an agent shall comply with section 60K.14, subdivision 4.

Sec. 31. **[62S.31] REQUIREMENT TO DELIVER SHOPPER'S GUIDE.**

Subdivision 1. **SHOPPER'S GUIDE.** A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate:

(1) in the case of agent solicitations, an agent must deliver the shopper's guide before the presentation of an application or enrollment form; and

(2) in the case of direct response solicitations, the shopper's guide must be presented in conjunction with an application or enrollment form.

Subd. 2. **EXCEPTION.** Subdivision 1 does not apply to life insurance policies or riders containing accelerated long-term care benefits. The policy summary required under section 62S.10 must be furnished with a life insurance policy or rider containing accelerated long-term care benefits.

Sec. 32. **[62S.32] APPLICATION.**

Subdivision 1. **MEDICARE SUPPLEMENT INSURANCE POLICY.** Medicare supplement insurance policy laws do not apply to long–term care insurance.

Subd. 2. **QUALIFIED LONG–TERM CARE INSURANCE POLICY.** This chapter applies to long–term care insurance marketed as a qualified long–term care policy. This chapter does not apply to long–term care insurance governed by sections 62A.46 to 62A.56.

Sec. 33. **[62S.33] PENALTIES.**

In addition to any other penalties provided by the laws of this state, an insurer or agent found to have violated any requirement of this state relating to the regulation of long–term care insurance or the marketing of the insurance is subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Sec. 34. **EFFECTIVE DATE.**

Sections 1 to 33 are effective the day following final enactment.

ARTICLE 2

CROSS–REFERENCES

Section 1. Minnesota Statutes 1996, section 61A.072, subdivision 1, is amended to read:

Subdivision 1. **DISCLOSURE.** A life insurance contract or supplemental contract that contains a provision to permit the accelerated payment of benefits as authorized under section 60A.06, subdivision 1, clause (4), must contain the following disclosure: "This is a life insurance policy which pays accelerated death benefits at your option under conditions specified in the policy. This policy is not a long–term care policy meeting the requirements of sections 62A.46 to 62A.56 or chapter 62S."

Sec. 2. Minnesota Statutes 1996, section 61A.072, subdivision 4, is amended to read:

Subd. 4. **LONG–TERM CARE EXPENSES.** If the right to receive accelerated benefits is contingent upon the insured receiving long–term care services, the contract or supplemental contract shall include the following provisions:

(1) the minimum accelerated benefit shall be $1,200 per month if the insured is receiving nursing facility services and $750 per month if the insured is receiving home services with a minimum lifetime benefit limit of $50,000;

(2) coverage is effective immediately and benefits shall commence with the receipt of services as defined in section 62A.46, subdivision 3, 4, or 5, or 62S.01, subdivision 25, but may include a waiting period of not more than 90 days, provided that no more than

one waiting period may be required per benefit period as defined in section 62A.46, subdivision 11;

(3) premium shall be waived during any period in which benefits are being paid to the insured during confinement to a nursing home facility;

(4) coverage may not be canceled or renewal refused except on the grounds of nonpayment of premium;

(5) coverage must include preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage;

(6) coverage must include mental or nervous disorders which have a demonstrable organic cause such as Alzheimer's and related dementias;

(7) no prior hospitalization requirement shall be allowed unless a similar requirement is allowed by section 62A.48, subdivision 1, or 62S.06; and

(8) the contract shall include a cancellation provision that meets the requirements of section 62A.50, subdivision 2, or 62S.07.

Sec. 3. Minnesota Statutes 1996, section 62A.011, subdivision 3, is amended to read:

Subd. 3. **HEALTH PLAN.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46 or 62S.01;

(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health mainte-

nance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended;

(11) workers' compensation insurance; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan.

Sec. 4. Minnesota Statutes 1996, section 62A.31, subdivision 6, is amended to read:

Subd. 6. **APPLICATION TO CERTAIN POLICIES.** The requirements of sections 62A.31 to 62A.44 shall not apply to disability income protection insurance policies, long-term care policies issued pursuant to sections 62A.46 to 62A.56 or chapter 62S, or group policies of accident and health insurance which do not purport to supplement Medicare issued to any of the following groups:

(a) A policy issued to an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage.

(b) A policy issued to a labor union or similar employee organization.

(c) A policy issued to an association, a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 100 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have a constitution and bylaws which provide that (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members, (2) except for credit unions, the association or associations collect dues or solicit contributions from members, (3) the members have voting privileges and representation on the governing board and committees, and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold a long-term care policy or Medicare supplement policy if the policy is available as an association benefit. This clause does not prohibit direct solicitations, offers, or sales made exclusively by mail.

An association may apply to the commissioner for a waiver of the 30-day waiting period as to that association. The commissioner may grant the waiver upon a finding of all of the following: (1) that the association is in full compliance with this section; (2) that sanctions have not been imposed against the association as a result of significant disciplinary action by the department of commerce; and (3) that at least 90 percent of the association's income comes from dues, contributions, or sources other than income from the sale of insurance.

Sec. 5. Minnesota Statutes 1996, section 62A.48, is amended by adding a subdivision to read:

Subd. 9. **QUALIFIED LONG-TERM CARE.** Sections 62A.46 to 62A.56 do not apply to policies marketed as qualified long-term care insurance policies under chapter 62S.

Sec. 6. Minnesota Statutes 1996, section 62A.50, is amended by adding a subdivision to read:

Subd. 4. **POLICIES OTHER THAN QUALIFIED LONG–TERM CARE INSURANCE POLICIES.** A policy that is not intended to be a qualified long–term care insurance policy as defined under section 62S.01, subdivision 24, must include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long–term care insurance policy. The disclosure must be prominently displayed and read as follows: This long–term care insurance policy (certificate) is not intended to be a qualified long–term care insurance contract as defined under section 7702 (B)(b) of the Internal Revenue Code of 1986. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing long–term care insurance.

Sec. 7. Minnesota Statutes 1996, section 62L.02, subdivision 15, is amended to read:

Subd. 15. **HEALTH BENEFIT PLAN.** "Health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or non–expense–incurred basis;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident–only coverage;

(9) a long–term care policy as defined in section 62A.46 or a qualified long–term care insurance policy as defined in section 62S.01;

(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended;

(11) workers' compensation insurance; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health benefit plan.

For the purpose of this chapter, a health benefit plan issued to eligible employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3, is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Sec. 8. **EFFECTIVE DATE.**

Sections 1 to 5 and 7 are effective the day following final enactment. Section 6 is effective for policies sold on or after August 1, 1997.

Presented to the governor April 28, 1997

Signed by the governor April 29, 1997, 2:27 p.m.

CHAPTER 72—H.F.No. 473

An act relating to metropolitan government; permitting the metropolitan council to provide a program for health and wellness services for council employees; amending Minnesota Statutes 1996, section 473.129, by adding a subdivision.

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

Section 1. Minnesota Statutes 1996, section 473.129, is amended by adding a subdivision to read:

Subd. 10. **EMPLOYEE HEALTH AND WELLNESS.** The council may provide a program for health and wellness services for council employees and provide necessary staff, funds, equipment, and facilities.

Sec. 2. **APPLICATION.**

Section 1 applies in the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Presented to the governor April 28, 1997

Signed by the governor April 29, 1997, 2:30 p.m.

CHAPTER 73—S.F.No. 1094

An act relating to real estate; regulating compensation paid by licensees to tenants for referrals; amending Minnesota Statutes 1996, section 82.19, subdivision 3.

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

Section 1. Minnesota Statutes 1996, section 82.19, subdivision 3, is amended to read:

Subd. 3. No real estate broker, salesperson, or closing agents shall offer, pay, or give, and no person shall accept, any compensation or other thing of value from any real estate broker, salesperson, or closing agents by way of commission–splitting, rebate, finder's