CHAPTER 62S

QUALIFIED LONG-TERM CARE INSURANCE POLICIES

62S.01 DEFINITIONS.

[For text of subds 1 to 13, see M.S.2000]

Subd. 13a. **Exceptional increase.** (a) "Exceptional increase" means only those premium rate increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or rules applicable to long-term care coverage in this state, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in section 62S.265, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

[For text of subds 14 to 17, see M.S.2000]

Subd. 17a. **Incidental.** "Incidental," as used in section 62S.265, subdivision 10, means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue.

[For text of subds 18 to 23, see M.S.2000]

Subd. 23a. **Qualified actuary.** "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

[For text of subds 24 and 25, see M.S.2000]

Subd. 25a. **Similar policy forms.** "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 62S.01, subdivision 15, clause (1), are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

[For text of subds 26 and 27, see M.S.2000]

History: *1Sp2001 c 9 art 8 s 4-7*

62S.021 LONG-TERM CARE INSURANCE; INITIAL FILING.

Subdivision 1. **Applicability.** This section applies to any long-term care policy issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

Subd. 2. **Required submission to commissioner.** An insurer shall provide the following information to the commissioner 30 days prior to making a long-term care insurance form available for sale:

(1) a copy of the disclosure documents required in section 62S.081; and

(2) an actuarial certification consisting of at least the following:

(i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration; and

(iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(A) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(C) a statement that the net valuation premium for renewal years does not increase, except for attained age rating where permitted;

(D) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if such a statement cannot be made, a complete description of the situations in which this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under item (i) based on a standard age distribution; and

(E) either a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Subd. 3. **Actuarial demonstration.** The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. If the commissioner asks for additional information under this subdivision, the 30-day time limit in subdivision 2 does not include the time during which the insurer is preparing the requested information.

History: *1Sp2001 c 9 art 8 s 8*

62S.081 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS.

Subdivision 1. **Application.** This section applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002.

(b) For certificates issued on or after July 1, 2001, under a policy of group long-term care insurance as defined in section 62S.01, subdivision 15, that was in force on July 1, 2001, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. **Required disclosures.** Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subdivision to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time; in

this case, an insurer shall provide all of the information listed in this subdivision to the applicant no later than at the time of delivery of the policy or certificate:

(1) a statement that the policy may be subject to rate increases in the future;

(2) an explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) a general explanation of applying premium rate or rate schedule adjustments that must include:

(i) a description of when premium rate or rate schedule adjustments will be effective, for example the next anniversary date or the next billing date; and

(ii) the right to a revised premium rate or rate schedule as provided in clause (3) if the premium rate or rate schedule is changed; and

(5)(i) information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) the policy forms for which premium rates have been increased;

(B) the calendar years when the form was available for purchase; and

(C) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

(ii) the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

(iii) an insurer has the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;

(iv) if an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of July 1, 2001, or the end of a 24-month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company must include the disclosure of that rate increase according to item (i); and

(v) if the acquiring insurer in item (iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in item (iv), the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase referenced in item (iv).

Subd. 3. **Acknowledgment.** An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivision 2. If, due to the method of application, the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

Subd. 4. **Forms.** An insurer shall use the forms in Appendices B and F of the Long-term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners to comply with the requirements of subdivisions 1 and 2.

Subd. 5. **Notice of increase.** An insurer shall provide notice of an upcoming premium rate schedule increase, after the increase has been approved by the commissioner, to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice

must include the information required by subdivision 2 when the rate increase is implemented.

History: *1Sp2001 c 9 art 8 s 9*

62S.26 LOSS RATIO.

(a) 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.

(b) This section does not apply to policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265, and that comply with those sections.

History: *1Sp2001 c 9 art 8 s 10*

62S.265 PREMIUM RATE SCHEDULE INCREASES.

Subdivision 1. **Applicability.** (a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

(b) For certificates issued on or after July 1, 2001, under a group long-term care insurance policy as defined in section 62S.01, subdivision 15, issued under this chapter, that was in force on July 1, 2001, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. **Notice.** An insurer shall file a requested premium rate schedule increase, including an exceptional increase, to the commissioner for prior approval at least 60 days prior to the notice to the policyholders and shall include:

(1) all information required by section 62S.081;

(2) certification by a qualified actuary that:

(i) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(ii) the premium rate filing complies with this section;

(3) an actuarial memorandum justifying the rate schedule change request that includes:

(i) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(A) annual values for the five years preceding and the three years following the valuation date must be provided separately;

(B) the projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(C) the projections must demonstrate compliance with subdivision 3; and

(D) for exceptional increases, the projected experience must be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and, if the commissioner determines that offsets to higher claim costs may exist, the insurer shall use appropriate net projected experience;

(ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary;

(iv) a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(v) if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates;

(4) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) sufficient information for review and approval of the premium rate schedule increase by the commissioner.

Subd. 3. **Requirements pertaining to rate increases.** All premium rate schedule increases must be determined according to the following requirements:

(1) exceptional increases must provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) the accumulated value of the initial earned premium times 58 percent;

(ii) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) the present value of future projected initial earned premiums times 58 percent; and

(iv) 85 percent of the present value of future projected premiums not in item (iii) on an earned basis;

(3) if a policy form has both exceptional and other increases, the values in clause (2), items (ii) and (iv), must also include 70 percent for exceptional rate increase amounts; and

(4) all present and accumulated values used to determine rate increases must use the maximum valuation interest rate for contract reserves permitted for valuation of whole life insurance policies issued in this state on the same date. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

Subd. 4. **Projections.** For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as described in subdivision 2, clause (3), item (i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 5. **Lifetime projections.** If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as described in subdivision 2, clause (3), item (i), must be filed for approval by the commissioner every five years following the end of the required period in subdivision 4. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 6. **Effect of actual experience.** (a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subdivision 3, the commissioner may require the insurer to implement any of the following:

(1) premium rate schedule adjustments; or

(2) other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration must be given to subdivision 2, clause (3), item (v), if applicable.

Subd. 7. **Contingent benefit upon lapse.** If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or a demonstration that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subdivision 8, paragraph (b); and

(2) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subdivision 3 had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subdivision 3, clause (2), items (i) and (iii).

Subd. 8. **Projected lapse rates.** (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) the rate increase is not the first rate increase requested for the specific policy form or forms;

(2) the rate increase is not an exceptional increase; and

(3) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer must:

(1) be subject to the approval of the commissioner;

(2) be based upon actuarially sound principles, but not be based upon attained age; and

(3) provide that maximum benefits under any new policy accepted by an insured are reduced by comparable benefits already paid under the existing policy.

(c) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase must be limited to the lesser of the maximum rate increase determined based on the combined experience and the maximum rate increase determined based only upon the experience of the insureds originally issued the form plus ten percent.

Subd. 9. **Persistent practice of inadequate initial rates.** If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subdivision 8, prohibit the insurer from either of the following:

(1) filing and marketing comparable coverage for a period of up to five years; or

(2) offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

Subd. 10. **Incidental long-term care benefits.** Subdivisions 1 to 9 do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in section 62S.01, subdivision 17a, if the policy complies with all of the following provisions:

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

(2) the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) for life insurance, section 61A.25;

(ii) for individual deferred annuities, section 61A.245; and

(iii) for variable annuities, section 61A.21;

(3) the policy meets the disclosure requirements of sections 62S.10 and 62S.11 if the policy is governed by chapter 62S and of section 62A.50 if the policy is governed by sections 62A.46 to 62A.56;

(4) the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(i) policy illustrations to the extent required by state law applicable to life insurance;

(ii) disclosure requirements in state law applicable to annuities; and

(iii) disclosure requirements applicable to variable annuities; and

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

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

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

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

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

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

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

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

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

Subd. 11. **Large group policies.** Subdivisions 6 and 9 do not apply to group long-term care insurance policies as defined in section 62S.01, subdivision 15, where:

(1) the policies insure 250 or more persons, and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) the policyholder, and not the certificate holder, pays a material portion of the premium, which is not less than 20 percent of the total premium for the group in the calendar year prior to the year in which a rate increase is filed.

History: *1Sp2001 c 9 art 8 s 11*

62S.266 NONFORFEITURE BENEFIT REQUIREMENT.

Subdivision 1. **Applicability.** This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Subd. 2. **Requirement.** An insurer must offer each prospective policyholder a nonforfeiture benefit in compliance with the following requirements:

(1) a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subdivision 5; and

(2) the offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

Subd. 3. **Effect of rejection of offer.** If the offer required to be made under subdivision 2 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

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

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

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

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and Under	200
30–34	190
35–39	170
40–44	150
45–49	130
50–54	110
55–59	90
60	70
61	66

62	62
63	58
64	54
65	50
66	48
67	46
68	44
69	42
70	40
71	38
72	36
73	34
74	32
75	30
76	28
77	26
78	24
79	22
80	20
81	19
82	18
83	17
84	16
85	15
86	14
87	13
88	12
89	11
90 and over	10

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

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

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

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

Subd. 5. **Nonforfeiture benefits; requirements.** (a) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, must be as described in this subdivision.

(b) For purposes of this subdivision, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(c) For purposes of this subdivision, the nonforfeiture benefit must be of a shortened benefit period providing paid-up, long-term care insurance coverage after lapse. The same benefits, amounts, and frequency in effect at the time of lapse, but not increased thereafter, will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in paragraph (d).

(d) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, so long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration.

However, the minimum nonforfeiture credit must not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of this subdivision.

(e) The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(f) Notwithstanding paragraph (e), for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(1) the end of the tenth year following the policy or certificate issue date; or

(2) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(g) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

Subd. 6. **Benefit limit.** All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

Subd. 7. **Minimum benefits; individual and group policies.** There must be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

Subd. 8. **Application; effective dates.** This section becomes effective January 1, 2002, and applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy issued in this state on or after January 1, 2002.

(b) For certificates issued on or after January 1, 2002, under a group long-term care insurance policy that was in force on January 1, 2002, the provisions of this section do not apply.

Subd. 9. **Effect on loss ratio.** Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of section 62A.48, subdivision 4, or 62S.26, treating the policy as a whole, except for policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265 and that comply with those sections.

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

Subd. 11. **Level premium contracts.** A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts must be offered that meets the following requirements:

(1) the nonforfeiture provision must be appropriately captioned;

(2) the nonforfeiture provision must provide a benefit available in the event of a default in the payment of any premiums and must state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) the nonforfeiture provision must provide at least one of the following:

(i) reduced paid-up insurance;

(ii) extended term insurance;

(iii) shortened benefit period; or

(iv) other similar offerings approved by the commissioner.

History: *1Sp2001 c 9 art 8 s 12*

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.46, subdivision 4.

History: *2001 c 117 art 2 s 12*

NOTE: The amendment to this section by Laws 2001, chapter 117, article 2, section 12, is effective July 1, 2002. Laws 2001, chapter 117, article 2, section 19.