**62A.48 LONG-TERM CARE POLICIES.**

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover prescribed long-term care in nursing facilities or the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. A long-term care policy may cover both prescribed long-term care in nursing facilities and the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy, other than one that covers only nursing facility services, must include: a minimum lifetime benefit limit of at least $25,000 for services. A long-term care policy that covers only nursing facility services must include a minimum lifetime benefit limit of not less than one year of nursing facility services. Nursing facility and home care coverages under a long-term care policy must not be subject to separate lifetime maximums for policies that cover both nursing facility and home health care. Prior hospitalization may not be required under a long-term care policy.

The policy must cover 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. Coverage under the policy may include a waiting period of up to 180 days before benefits are paid, but there must be no more than one waiting period per benefit period; for purposes of this sentence, "days" can mean calendar or benefit days. If benefit days are used, an appropriate premium reduction and disclosure must be made. If benefit days are used in connection with coverage for home care services, the waiting period for home care services must not be longer than 90 benefit days. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and

have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

No individual long-term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

The insurer may file a policy form that utilizes a plan of care prepared as provided under section 62A.46, subdivision 5, clause (1) or (2).

Subd. 2. **Per diem coverage.** If benefits are provided on a per diem basis, the minimum daily benefit for care in a nursing facility must be the lesser of $40 or actual charges under a long-term care policy and the minimum benefit per visit for home care under a long-term care policy must be the lesser of $25 or actual charges. The home care services benefit must cover at least seven paid visits per week.

Subd. 3. **Expense-incurred coverage.** If benefits are provided on an expense-incurred basis, a benefit of not less than 80 percent of covered charges for prescribed long-term care must be provided.

Subd. 4. **Loss ratio.** The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis. This subdivision does not apply to policies issued on or after January 1, 2002, that comply with sections 62S.021 and 62S.081.

Subd. 5. **Solicitations by mail or media advertisement.** For purposes of this section, long-term care policies issued as a result of solicitations of individuals through mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

Subd. 6. **Coordination of benefits.** A long-term care policy may be secondary coverage for services provided under sections 62A.46 to 62A.56. Nothing in sections 62A.46 to 62A.56 shall require the secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

There shall be no coordination of benefits between a long-term care policy and a policy designed primarily to provide coverage payable on a per diem, fixed indemnity or non-expense-incurred basis, or a policy that provides only accident coverage.

Subd. 7. **Existing policies.** Nothing in sections 62A.46 to 62A.56 prohibits the renewal of the following long-term care policies:

(1) policies sold outside the state of Minnesota to persons who at the time of sale were not residents of the state of Minnesota;

(2) policies sold before August 1, 1986; and

(3) policies sold before July 1, 1988, by associations exempted from sections 62A.3099 to 62A.44 under section 62A.31, subdivision 6.

Subd. 8. **Cancellation for nonpayment of premium.** No individual long-term care policy shall be canceled for nonpayment of premium unless the insurer, at least 30 days before the effective date of the cancellation, has given notice to the insured and to those persons designated pursuant to section 62A.48, subdivision 1, at the address provided by the insured for purposes of receiving notice of cancellation.

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.

Subd. 10. **Regulation of premiums and premium increases.** Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with sections 62S.021, 62S.081, 62S.265, and 62S.266 to the same extent as policies issued under chapter 62S.

Subd. 11. **Nonforfeiture benefits.** Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with section 62S.02, subdivision 2, to the same extent as policies issued under chapter 62S.

Subd. 12. **Regulatory flexibility.** The commissioner may upon written request issue an order to modify or suspend a specific provision or provisions of sections 62A.46 to 62A.56 with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) the modification or suspension is in the best interest of the insureds;

(2) the purpose to be achieved could not be effectively or efficiently achieved without the modifications or suspension; and

(3)(i) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(ii) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(iii) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

**History:** *1986 c 397 s 4; 1987 c 337 s 59-62; 1988 c 689 art 2 s 8; 1989 c 209 art 2 s 1; 1989 c 330 s 19; 1990 c 551 s 5-7; 1993 c 330 s 12; 1994 c 625 art 8 s 4; 1995 c 258 s 33,34; 1996 c 389 s 1; 1996 c 446 art 1 s 37; 1997 c 71 art 2 s 5; 1Sp2001 c 9 art 8 s 1-3; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 3; 2005 c 17 art 1 s 14*