These taxes shall be applied solely to pay costs of collection and to pay or secure the payment of any principal of, premium and interest on any bonds or any costs referred to in section 4, subdivision 3. The commissioner of revenue may enter into appropriate agreements with the city to provide for the collection of these taxes by the state on behalf of the city. The commissioner may charge the city a reasonable fee for its collection from the proceeds of any taxes. These taxes shall be subject to the same interest penalties and enforcement provisions as the taxes imposed under section 473.592.

Sec. 6. **POWERS GRANTED NOT LIMITED.**

Except as specifically provided in this act, the exercise of powers granted in this act shall not be limited by Minnesota Statutes, chapter 475, or any conflicting city charter provision.

Sec. 7. **EFFECTIVE DATE.**

This act is effective the day after compliance by the governing body of the city of Minneapolis with Minnesota Statutes, section 645.021, subdivision 3, but no tax permitted by sections 4 and 5 may become effective before January 1, 1987.

Approved March 21, 1986

CHAPTER 397—S.F.No. 1782

An act relating to insurance; accident and health; regulating long-term care policies; requiring coverage for home health care and care in skilled or intermediate nursing facilities; amending Minnesota Statutes 1984, sections 62A.041; 62A.31, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 62A.

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

Section 1. Minnesota Statutes 1984, section 62A.041, is amended to read:

62A.041 **MATERNITY BENEFITS; UNMARRIED WOMEN.**

Each group policy of accident and health insurance ~~issued or renewed after June 4, 1971,~~ and each group health maintenance contract ~~issued or renewed after August 1, 1984,~~ shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy ~~issued or renewed after July 1, 1976,~~ and each group contract ~~issued or renewed after August 1, 1984,~~ shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy ~~issued or renewed after July 1, 1976,~~ and each individual contract ~~issued or renewed after August 1, 1984,~~ shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

This section applies to policies and contracts issued, delivered, or renewed after August 1, 1985, that cover Minnesota residents.

Sec. 2. Minnesota Statutes 1984, section 62A.31, subdivision 1, is amended to read:

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract or other evidence of accident and health insurance issued or delivered in this state shall be sold or issued to an individual age 65 or older covered by medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2;

(b) The policy must cover pre-existing 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;

(c) The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured; and

(d) An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium.

Subd. 1a. **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 3 to 8, 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 by-laws 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, and (3) the members have voting privileges and representation on the governing board and committees.

Sec. 3. **[62A.46] DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** The definitions in this section apply to sections 3 to 8.

Subd. 2. **LONG-TERM CARE POLICY.** "Long-term care policy" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for medically prescribed long-term care, including nursing facility services and home care services, pursuant to the requirements of sections 3 to 8. A long-term care policy must contain a designation specifying whether the policy is a long-term care policy AA or A and a caption stating that the commissioner has established two categories of long-term care insurance and the minimum standards for each.

Sections 3, 4, and 6 to 8 do not apply to a long-term care policy issued to (a) 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 or (b) to a labor union or similar employee organization. The associations exempted from the requirements of sections 62A.31 to 62A.44 under 62A.31, subdivision 1, clause (c) shall not be subject to the provisions of sections 3 to 8 until July 1, 1988.

Subd. 3. **NURSING FACILITY.** "Nursing facility" means (1) a facility that is licensed as a nursing home under chapter 144A; (2) a facility that is both licensed as a boarding care home under sections 144.50 to 144.56 and certified as an intermediate care facility for purposes of the medical assistance program; and (3) in states other than Minnesota, a facility that meets licensing and certification standards comparable to those that apply to the facilities described in clauses (1) and (2).

Subd. 4. **HOME CARE SERVICES.** "Home care services" means one or more of the following medically prescribed services for the long-term care and treatment of an insured that are provided by a home health agency in a noninstitutional setting according to a written diagnosis and plan of care:

(1) nursing and related personal care services under the direction of a registered nurse, including the services of a home health aide;

(2) physical therapy;

(3) speech therapy;

(4) respiratory therapy;

(5) occupational therapy;

(6) nutritional services provided by a licensed dietician;

(7) homemaker services, meal preparation, and similar nonmedical services;

(8) medical social services; and

(9) other similar medical services and health-related support services.

Subd. 5. **MEDICALLY PRESCRIBED LONG-TERM CARE.** "Medically prescribed long-term care" means a service, type of care, or procedure that is specified in a plan of care prepared by a physician and a registered nurse and is appropriate and consistent with the physician's diagnosis and that could not be omitted without adversely affecting the patient's illness or condition.

Subd. 6. **QUALIFIED INSURER.** "Qualified insurer" means an entity licensed under chapter 62A or 62C.

Subd. 7. **PHYSICIAN.** "Physician" means a medical practitioner licensed under sections 147.02, 147.03, 147.031, and 147.037.

Subd. 8. **PLAN OF CARE.** "Plan of care" means a written document prepared and signed by a physician and registered nurse that specifies medically prescribed long-term care services or treatment that are consistent with the diagnosis and are in accordance with accepted medical and nursing standards of practice and that could not be omitted without adversely affecting the patient's illness or condition.

Subd. 9. **INSURED.** "Insured" means a person covered under a long-term care policy.

Subd. 10. **HOME HEALTH AGENCY.** "Home health agency" means an entity that provides home care services and is (1) certified for participation in the medicare program; or (2) licensed as a home health agency where a state licensing statute exists, or is otherwise acceptable to the insurer if licensing is not required.

Sec. 4. **[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 3 to 8. A long-term care policy must cover medically prescribed long-term care in nursing facilities and at least the medically prescribed long-term home care services in section 3, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least $100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums, and a requirement of prior hospitalization for up to one day may be imposed only for long-term care in a nursing facility. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least $50,000 for services, nursing facility and home care coverages must not be subject to separate lifetime maximums, and a requirement of prior hospitalization for up to three days may be imposed for long-term care in a nursing facility or home care services.

Coverage under either policy designation may include a waiting period of up to 90 days before benefits are paid. 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. Policy options include 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 and a provision that the premium would be waived during any period in which benefits are being paid to the insured. 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.

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 $60 or actual charges under a long-term care policy AA or the lesser of $40 or actual charges under a long-term care policy A and the minimum daily benefit for home care must be the lesser of $25 or actual charges under a long-term care policy AA or the lesser of $25 or actual charges for nurse and therapy services and $20 for home health aide and nonmedical services under a long-term care policy A. If home care services are provided less frequently than daily, the minimum benefit is the lesser of actual charges or an amount determined by multiplying the number of days of the period during which services will be provided, or a reasonable interval of the service period, by $25 and dividing the resulting amount by the number of days during this period on which home care services were rendered. 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 medically 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.

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 shall be secondary coverage for services provided under sections 3 to 8. Nothing in sections 3 to 8 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.

Sec. 5. **[62A.50] DISCLOSURES AND REPRESENTATIONS.**

Subdivision 1. **SEAL OR EMBLEMS.** No graphic seal or emblem shall be displayed on any policy, or in connection with promotional materials on policy solicitations, that may reasonably be expected to convey to the purchaser that the policy form is approved, endorsed, or certified by a state or local unit of government or agency, the federal government, or a federal agency.

Subd. 2. **CANCELLATION NOTICE.** Long-term care policies issued on a nongroup basis must have a notice prominently printed on the first page of the policy stating that the policyholder may return the policy within 30 days of its delivery and have the premium refunded in full if the policyholder is not satisfied for any reason. A solicitation for a long-term care policy to be issued on a nongroup basis pursuant to a direct-response solicitation must state in substance that the policyholder may return the policy within 30 days of its delivery and have the premium refunded in full if the policyholder is not satisfied for any reason.

Subd. 3. **DISCLOSURES.** No long-term care policy shall be offered or delivered in this state, whether or not the policy is issued in this state, and no certificate of coverage under a group long-term care policy shall be offered or delivered in this state, unless a statement containing at least the following information is delivered to the applicant at the time the application is made:

(1) a description of the benefits and coverage provided by the policy and the differences between this policy, a supplemental medicare policy and the benefits to which an individual is entitled under parts A and B of medicare;

(2) a statement of the exceptions and limitations in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL NURSING CARE FACILITIES OR NURSING HOME OR HOME CARE EXPENSES AND DOES NOT COVER RESIDENTIAL CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(3) a statement of the renewal provisions including any reservation by the insurer of the right to change premiums;

(4) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

(5) an explanation of the policy's loss ratio including at least the following language: "This means that, on the average, policyholders may expect that $..... of every $100 in premium will be returned as benefits to policyholders over the life of the contract."; and

(6) a statement of the out-of-pocket expenses, including deductibles and copayments for which the insured is responsible, and an explanation of the specific out-of-pocket expenses that may be accumulated toward any out-of-pocket maximum as specified in the policy.

Sec. 6. **[62A.52] REVIEW OF PLAN OF CARE.**

The insurer may review an insured's plan of care at reasonable intervals, but not more frequently than once every 30 days.

Sec. 7. **[62A.54] PROHIBITED PRACTICES.**

Unless otherwise provided for in sections 2 to 8, the solicitation or sale of long-term care policies is subject to the requirements and penalties applicable to the sale of medicare supplement insurance policies as set forth in sections 62A.31 to 62A.44.

Sec. 8. **[62A.56] RULEMAKING.**

The commissioner may adopt rules pursuant to chapter 14 to carry out the purposes of sections 3 to 8. The rules may:

(1) establish additional disclosure requirements for long-term care policies designed to adequately inform the prospective insured of the need and extent of coverage offered;

(2) prescribe uniform policy forms in order to give the purchaser of long-term care policies a reasonable opportunity to compare the cost of insuring with various insurers; and

(3) establish other reasonable minimum standards as needed to further the purposes of sections 3 to 8.

Sec. 9. **EFFECTIVE DATE.**

Sections 2 to 8 are effective June 1, 1986.

Approved March 21, 1986

Changes or additions are indicated by underline, deletions by ~~strikeout~~.