CHAPTER 62S
QUALIFIED LONG-TERM CARE INSURANCE POLICIES

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; or

(2) 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. 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.

Subd. 14. **Loss of functional capacity.** "Loss of 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. 16a. **Hands-on assistance.** "Hands-on assistance" means minimal, moderate, or maximal physical assistance without which the individual would not be able to perform the activity of daily living.

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. 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.

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 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. 22a. **Personal care.** "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

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

Subd. 23b. **Providers of services.** All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," and "home care agency" are defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it must also state what requirements a provider must meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies, or registers the provider of services under another name.

Subd. 24. **Qualified long-term care insurance policy.** "Qualified long-term care insurance policy" means a policy that meets the requirements of Section 7702B 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. 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.

Subd. 25b. **Skilled nursing care, personal care, home care, specialized care, assisted living care, and other services.** "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care," and other services are defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

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.

History: *1997 c 71 art 1 s 1; 1998 c 328 s 4; 1999 c 177 s 59; 1Sp2001 c 9 art 8 s 4-7; 2002 c 379 art 1 s 113; 2008 c 344 s 18-21; 2009 c 86 art 1 s 10*

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 and the filing

provisions of section 62A.02. 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.

History: *1997 c 71 art 1 s 2; 2000 c 483 s 17*

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; 2002 c 379 art 1 s 113*

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.

History: *1997 c 71 art 1 s 3*

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.

History: *1997 c 71 art 1 s 4*

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 more than 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.

Subd. 4. **Extension of limitation periods.** The commissioner may extend the limitation periods set forth in subdivisions 1 and 2 as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

History: *1997 c 71 art 1 s 5; 1999 c 177 s 60; 2006 c 255 s 36; 2006 c 282 art 17 s 2*

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.

History: *1997 c 71 art 1 s 6*

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.

History: *1997 c 71 art 1 s 7*

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

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 CONTINUED IN FORCE OR DISCONTINUED.

(a) (For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:)

(1) (Policies and certificates that are guaranteed renewable shall contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, (certificate) to continue this policy as long as you pay your premiums on time. (Company name) cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) (Policies and certificates that are noncancelable shall contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. (Company name) cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, (company name) may increase your premium at that time for those additional benefits.

(b) (For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.)

(c) (Describe waiver of premium provisions or state that there are not such provisions.)

(5) TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

(In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.)

(6) 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.)

(7) 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.

(8) 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.)

(9) 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.)

(d) (Eligibility for payment of benefits.)

(Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.)

(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.)

(10) 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 (8).)

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

(11) 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.

(12) 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.)

(13) 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.

(14) ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

(15) CONTACT THE STATE DEPARTMENT OF COMMERCE OR SENIOR LINKAGE LINE IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

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).

History: *1997 c 71 art 1 s 8; 2006 c 255 s 37; 2006 c 282 art 17 s 3*

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 (Personal Worksheet) and F (Potential Rate Increase Disclosure Form) 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; 2002 c 379 art 1 s 113; 2006 c 255 s 38; 2006 c 282 art 17 s 4*

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.

History: *1997 c 71 art 1 s 9*

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;

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

(4) a statement that any long-term care inflation protection option required by section 62S.23 is not available under this policy.

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.

History: *1997 c 71 art 1 s 10; 2006 c 255 s 39; 2006 c 282 art 17 s 5*

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.

History: *1997 c 71 art 1 s 11*

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.

History: *1997 c 71 art 1 s 12*

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 and using the insurer's underwriting guidelines.

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.

Subd. 6. **Death of insured.** In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by section 61A.03, subdivision 1, paragraph (c). In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

History: *1997 c 71 art 1 s 13; 2006 c 255 s 40; 2006 c 282 art 17 s 6; 2008 c 344 s 22*

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. The term "level premium" may only be used when the insurer does not have the right to change the premium.

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

History: *1997 c 71 art 1 s 14; 2006 c 255 s 41; 2006 c 282 art 17 s 7*

62S.15 AUTHORIZED LIMITATIONS AND EXCLUSIONS.

(a) 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 non-fare-paying aviation;

(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;

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy; and

(7) in the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(b) This subdivision does not prohibit exclusions and limitations by type of provider or territorial limitations. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(1) when the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

(2) when the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

History: *1997 c 71 art 1 s 15; 2006 c 255 s 42; 2006 c 282 art 17 s 8; 2008 c 344 s 23*

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.

History: *1997 c 71 art 1 s 16*

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.

History: *1997 c 71 art 1 s 17*

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.** (a) 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.

(b) The purchase of additional coverage must not be considered a premium rate increase, but for purposes of the calculation required under section 62S.291, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

(c) A reduction in benefits must not be considered a premium change, but for purpose of the calculation required under section 62S.291, the initial annual premium must be based on the reduced benefits.

History: *1997 c 71 art 1 s 18; 2008 c 344 s 24*

62S.181 ELECTRONIC ENROLLMENT FOR GROUP POLICIES.

Subdivision 1. **Employers or labor unions.** In the case of a group defined in section 62S.01, subdivision 15, clause (1), any requirement that a signature of an insured be obtained by an agent or insurer is satisfied if:

(1) the consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information must be provided to the enrollee;

(2) the telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention, and prompt retrieval of records; and

(3) the telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and "privileged information" as defined by section 72A.491, subdivision 19, is maintained.

Subd. 2. **Availability of insurer records.** The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

History: *2008 c 344 s 25*

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.

History: *1997 c 71 art 1 s 19*

62S.20 REQUIRED DISCLOSURE PROVISIONS.

Subdivision 1. **Renewability.** (a) 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 that the coverage is guaranteed renewable or noncancelable. 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.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

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. 5a. **Disclosure of tax consequences.** With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the same time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page of the policy or rider and any other related documents. This subdivision does not apply to qualified long-term care insurance contracts.

Subd. 5b. **Benefit triggers.** Activities of daily living and cognitive impairment must be used to measure an insured's need for long-term care and must be described in the policy or certificate in a separate paragraph and must be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers must also be explained in this section. If these triggers differ for different benefits, explanation of the trigger must 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 shall be specified.

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 under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

History: *1997 c 71 art 1 s 20; 2006 c 255 s 43; 2006 c 282 art 17 s 9; 2008 c 344 s 26-28*

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.

History: *1997 c 71 art 1 s 21*

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;

(9) excluding coverage for adult day care services; or

(10) excluding coverage based upon location or type of residence in which the home health care services would be provided.

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.

History: *1997 c 71 art 1 s 22; 1Sp2003 c 14 art 2 s 5*

62S.23 REQUIREMENT TO OFFER INFLATION PROTECTION.

Subdivision 1. **Inflation protection feature.** (a) 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.

(b) A long-term care partnership policy must provide the inflation protection described in this subdivision. If the policy is sold to an individual who:

(1) has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection;

(2) has attained age 61, but has not attained age 76 as of such date, the policy must provide some level of inflation protection; and

(3) has attained the age of 76 as of such date, the policy may, but is not required to, provide some level of inflation protection.

Inflation protection for a long-term care partnership policy may not be less than one percent per year or a rate based on changes in the Consumer Price Index. The commissioner, however, may approve other types of inflation protection that comply with this section and further the goals of the partnership program.

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.

History: *1997 c 71 art 1 s 23; 2007 c 104 s 17; 2008 c 344 s 29; 2015 c 59 s 2*

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 accident and sickness or 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 (including health care service contract or health maintenance organization contract)?;

(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?;

(3) are you covered by Medicaid?; and

(4) do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

Subd. 1a. **Other health insurance policies sold by agent.** Agents shall list all other health insurance policies they have sold to the applicant that are still in force or were sold in the past five years and are no longer in force.

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

(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 accident and sickness or 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 accident and sickness or 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

I have reviewed your current medical health 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 accident and sickness or 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 ACCIDENT

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or 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 accident and sickness or 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) (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.

Subd. 7. **Life insurance policies.** Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of sections 61A.53 to 61A.60. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

Subd. 8. **Exchange for long-term care partnership policy; addition of policy rider.** (a) With respect to the long-term care partnership program referenced in section 256B.0571, issuers of long-term care policies may voluntarily exchange a current long-term care insurance policy for a long-term care partnership policy that meets the requirements of Public Law 109-171, section 6021, after the effective date of the state plan amendment implementing the partnership program in this state. The exchange may be in the form of: (1) an amendment or rider; or (2) a disclosure statement indicating that the coverage is now partnership qualified.

(b) With respect to the long-term care partnership program referenced in section 256B.0571, to allow an existing long-term care insurance policy to qualify as a partnership policy by addition of: (1) a policy rider or amendment; or (2) a disclosure statement, the issuer of the policy is authorized to add the rider, amendment, or disclosure statement to the policy after the effective date of the state plan amendment implementing the partnership program in this state.

(c) The commissioner, in cooperation with the commissioner of human services, shall pursue any federal law changes or waivers necessary to allow the implementation of paragraphs (a) and (b).

Subd. 9. **Certain pre-July 1, 2006, policies.** (a) Notwithstanding section 256B.0571, subdivision 6, a long-term care insurance policy issued before July 1, 2006, that otherwise meets all requirements for partnership policy status shall be qualified as a partnership policy, provided that benefits have not yet been paid out on the policy.

(b) An insured may make written inquiry to the issuer of the long-term care insurance policy as to whether the policy meets the requirements for partnership policy status. The issuer of the policy must reply to the inquiry within 30 days, and if the policy does so qualify, must add a rider, amendment, or disclosure statement to the policy as documentation of the partnership policy status.

History: *1997 c 71 art 1 s 24; 2006 c 255 s 44-49; 2006 c 282 art 17 s 10-15; 2010 c 310 art 4 s 1; 2010 c 384 s 25; 2015 c 59 s 3*

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 for any reason 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. For purposes of this subdivision, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

Subd. 7. **Reports.** Reports under this section shall be done on a statewide basis and filed with the commissioner. They shall include, at a minimum, the information in the format contained in Appendix E (Claim Denial Reporting Form) and in Appendix G (Replacement and Lapse Reporting Form) of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners.

History: *1997 c 71 art 1 s 25; 2006 c 255 s 50,51; 2006 c 282 art 17 s 16,17*

62S.251 RESERVE STANDARDS.

Subdivision 1. **Benefits provided through acceleration of benefits under life policies.** When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, policy reserves for the benefits must be determined in accordance with section 61A.25. Claim reserves must also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this section must be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event must the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subdivision, due regard must be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) definition of insured events;

(2) covered long-term care facilities;

(3) existence of home convalescence care coverage;

(4) definition of facilities;

(5) existence or absence of barriers to eligibility;

(6) premium waiver provision;

(7) renewability;

(8) ability to raise premiums;

(9) marketing method;

(10) underwriting procedures;

(11) claims adjustment procedures;

(12) waiting period;

(13) maximum benefit;

(14) availability of eligible facilities;

(15) margins in claim costs;

(16) optional nature of benefit;

(17) delay in eligibility for benefit;

(18) inflation protection provisions; and

(19) guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

Subd. 2. **Benefits provided otherwise.** When long-term care benefits are provided other than as in subdivision 1, reserves must be determined in accordance with sections 60A.76 to 60A.768.

History: *2008 c 344 s 30*

62S.26 LOSS RATIO.

Subdivision 1. **Minimum 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.

Subd. 2. **Life insurance policies.** Subdivision 1 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, 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 life insurance benefits meets the nonforfeiture requirements of section 61A.24;

(3) the policy meets the disclosure requirements of sections 62S.09, 62S.10, and 62S.11;

(4) any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; 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 percentage 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 shall 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 shall 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 life insurance policy, both for active lives and those in long-term care claim status.

Subd. 3. **Nonapplication.** 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: *1997 c 71 art 1 s 26; 1Sp2001 c 9 art 8 s 10; 2002 c 379 art 1 s 113; 2006 c 255 s 52; 2006 c 282 art 17 s 18; 2008 c 344 s 31*

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; 2002 c 379 art 1 s 113*

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.** (a) 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.

(b) When a group long-term care insurance policy is issued, the offer required in paragraph (a) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in section 62S.01, subdivision 15, clause (4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

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) A contingent benefit on lapse must also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium

set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in paragraph (f), clause (2), is 40 percent or more. 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
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by paragraph (c) and where both are triggered, the benefit provided must be at the option of the insured.

(e) 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).

(f) On or before the effective date of a substantial premium increase as defined in paragraph (d), 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 where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in paragraph (d); and

(3) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (d) shall be deemed to be the election of the offer to convert in clause (2) if the ratio is 40 percent or more.

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) or (d), 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; 2002 c 379 art 1 s 113; 2006 c 255 s 53; 2006 c 282 art 17 s 19; 2008 c 344 s 32,33; 2010 c 384 s 26*

62S.267 STANDARDS FOR BENEFIT TRIGGERS.

Subdivision 1. **Benefit payment determinations.** A long-term care insurance policy must condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits must not be more restrictive than requiring either a deficiency in the ability to perform not more than two of the activities of daily living or the presence of cognitive impairment.

Activities of daily living include at least the following as defined in section 62S.01 and in the policy: bathing, continence, dressing, eating, toileting, and transferring.

Insurers may use activities of daily living to trigger covered benefits in addition to those contained in this subdivision as long as they are defined in the policy.

Subd. 2. **Additional provisions for determining benefit payments.** An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate if the provisions do not restrict, and are not in lieu of, the requirements contained in subdivision 1.

Subd. 3. **Deficiency determination.** For purposes of this section, the determination of a deficiency must not be more restrictive than requiring the hands-on assistance of another person to perform the prescribed activities of daily living, or if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

Subd. 4. **Assessments.** Assessments of activities if daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

Subd. 5. **Appeal process.** Long-term care insurance policies must include a clear description of the process for appealing and resolving benefit determinations.

History: *2008 c 344 s 34*

62S.268 ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "Qualified long-term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as 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, or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury.

(d) "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. 2. **Services.** A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Subd. 3. **Payment of benefits.** A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

Subd. 4. **Certifications.** (a) Certifications regarding activities of daily living and cognitive impairment required pursuant to subdivision 3 shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

(b) Certifications required pursuant to subdivision 3 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except

that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

Subd. 5. **Dispute resolution.** Qualified long-term care insurance contracts must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

History: *2008 c 344 s 35*

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.

History: *1997 c 71 art 1 s 27*

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.

History: *1997 c 71 art 1 s 28*

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 and agent training requirements to assure that any marketing activities, including any 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) provide copies of the disclosure forms required in section 62S.081, subdivision 4, to the applicant;

(5) 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;

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

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

(8) use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to section 62S.14; and

(9) provide an explanation of contingent benefit upon lapse provided for in section 62S.266.

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. 2a. **Associations to educate members.** With respect to the obligations set forth in this section, the primary responsibility of an association, as defined in section 62S.01, subdivision 15, clause (2), when endorsing or selling long-term care insurance is to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

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. 6a. **Additional association duties.** An association shall also at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change; actively monitor the marketing efforts of the insurer and its agents; and review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. This subdivision does not apply to qualified long-term care insurance contracts.

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.

Subd. 9. **Unfair trade practices.** Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of sections 72A.17 to 72A.32.

History: *1997 c 71 art 1 s 29; 2006 c 255 s 54; 2006 c 282 art 17 s 20; 2008 c 344 s 36-38; 2010 c 384 s 27*

62S.291 AVAILABILITY OF NEW SERVICES OR PROVIDERS.

Subdivision 1. **Requirement.** An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice must be provided within 12 months of the date that the new policy series is made available for sale in this state.

Subd. 2. **Exception.** (a) Notwithstanding subdivision 1, notification is not required for any policy issued before August 1, 2008, or to any policyholder or certificate holder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

(b) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subdivision, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased a new pro-

prietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

Subd. 3. **Compliance.** An insurer shall make the new coverage available in one of the following ways:

(1) by adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) by exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits must be based on premiums paid or reserves held for the prior policy or certificate;

(3) by exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) by an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the commissioner.

Subd. 4. **Policies considered exchanges.** Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges are not subject to sections 62S.24 and 62S.30, and the reporting requirements of section 62S.25, subdivisions 1 to 6.

Subd. 5. **Notification to certain groups.** Where the policy is offered through an employer, labor organization, professional, trade, or occupational organization, the required notification in subdivision 1 must be made to the offering entity. However, if the policy is issued to a group defined in section 62S.01, subdivision 15, clause (4), the notification must be made to each certificate holder.

Subd. 6. **Effect on coverage offers and requests for coverage.** Nothing in this section prohibits an insurer from offering any policy, rider, certificate, or coverage change to any policyholder or certificate holder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

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

History: *2008 c 344 s 39*

62S.292 RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.

Subdivision 1. **Required policy or certificate provision.** Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(1) reducing the maximum benefit; or

(2) reducing the daily, weekly, or monthly benefit amount.

The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

Subd. 2. **Age determination.** The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

Subd. 3. **Limitation.** The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

Subd. 4. **Written reminder.** If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificate holder of the right to reduce coverage and premiums in the notice required by section 62S.19, subdivision 3.

Subd. 5. **Nonapplication.** This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

History: *2008 c 344 s 40; 2009 c 86 art 1 s 11*

62S.30 SUITABILITY.

Subdivision 1. **Standards.** Every insurer or other entity marketing long-term care insurance shall:

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

Subd. 2. **Procedures.** (a) To determine whether the applicant meets the standards developed by the insurer or other entity marketing long-term care insurance, the agent and insurer or other entity marketing long-term care insurance shall develop procedures that take the following into consideration:

(1) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet those goals or needs; and

(3) the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(b) The insurer or other entity marketing long-term care insurance, and the agent, where an agent is involved, shall make reasonable efforts to obtain the information set forth in paragraph (a). The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the insurer or other entity marketing long-term care insurance

shall contain, at a minimum, the information in the format contained in Appendix B of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners, in not less than 12-point type. The insurer or other entity marketing long-term care insurance may request the applicant to provide additional information to comply with its suitability standards. The insurer or other entity marketing long-term care insurance shall file a copy of its personal worksheet with the commissioner.

(c) A completed personal worksheet shall be returned to the insurer or other entity marketing long-term care insurance prior to consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses. The sale or dissemination by the insurer or other entity marketing long-term care insurance, or the agent, of information obtained through the personal worksheet, is prohibited.

(d) The insurer or other entity marketing long-term care insurance shall use the suitability standards it has developed under this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate. Agents shall use the suitability standards developed by the insurer or other entity marketing long-term care insurance in marketing long-term care insurance.

(e) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in not less than 12-point type.

(f) If the insurer or other entity marketing long-term care insurance determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer or other entity marketing long-term care insurance may reject the application. In the alternative, the insurer or other entity marketing long-term care insurance shall send the applicant a letter similar to Appendix D of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the insurer or other entity marketing long-term care insurance may use some other method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

Subd. 3. **Reports.** The insurer or other entity marketing long-term care insurance shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Subd. 4. **Application.** This section shall not apply to life insurance policies that accelerate benefits for long-term care.

History: *1997 c 71 art 1 s 30; 2001 c 117 art 2 s 12; 2006 c 255 s 55; 2006 c 282 art 17 s 21*

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.

History: *1997 c 71 art 1 s 31*

62S.312 CONSUMER PROTECTION STANDARDS FOR LONG-TERM CARE PARTNERSHIP POLICIES.

To qualify as a long-term care partnership policy under this chapter, long-term care insurance policies must meet the requirements for being tax qualified as defined in section 7702B(b) of the Internal Revenue Code and meet certain consumer protection requirements in Section 6021(a)(1)(B)(5)(A) of the Deficit Reduction Act of 2005, Public Law 109-171, which are taken from the National Association of Insurance Commissioners (NAIC) Model Act and Regulation of 2000. Insurance carriers must certify for each policy form to be included in the long-term care partnership that the form complies with the requirements of the NAIC Model Act and Regulation of 2000 as implemented in sections 62S.05 to 62S.11; 62S.13 to 62S.18; 62S.19; 62S.20, subdivisions 1 to 5; 62S.21; 62S.22; 62S.24; 62S.25; 62S.266; 62S.28; 62S.29; 62S.30; and 62S.31.

History: *2010 c 310 art 4 s 2*

62S.315 PRODUCER TRAINING.

The commissioner shall approve producer training requirements in accordance with the NAIC Long-Term Care Insurance Model Act provisions. The commissioner of the Department of Human Services shall provide technical assistance and information to the commissioner in accordance with Public Law 109-171, section 6021.

History: *2006 c 255 s 56; 2006 c 282 art 17 s 22; 2009 c 86 art 1 s 88*

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.

History: *1997 c 71 art 1 s 32*

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.

History: *1997 c 71 art 1 s 33*

62S.34 REGULATORY FLEXIBILITY.

The commissioner may, upon written request, issue an order to modify or suspend a specific provision or provisions of this chapter 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 modification 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: *1Sp2003 c 14 art 2 s 6*