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MINNESOTA REQUIREMENTS, LONG TERM CARE INSURANCE – QUALIFIED PLANS

Insurance Product Filing Unit
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I. Minnesota Specific Requirements to be Included in All Long-Term Care Insurance Policies

The following are the requirements that the department analysts will be applying to long-term care insurance qualified plan filings submitted to the department.

A. Long Term Care Materials Required to be filed with Department

Minn. Stat. Chapter §62S.29, subd. 3 The insurer shall file with the commissioner the following material:

- (1) the policy and certificate;
- (2) a corresponding outline; and
- (3) all advertisements requested by the commissioner.

B. Language Required

Minn. Stat. §62S.21, subd. 3 (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).

C. Key Definitions

Minn. Stat. §62S.01

Subd. 2 Activities of daily living. “Activities of daily living” means eating, toileting, transferring, bathing, dressing, and continence.

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. 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. 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. 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. 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.

D. Qualified Long-Term Care Services

Minn. Stat. §62S.02, subd. 1 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 chapter 62S and the filing provisions of section 62A.02. A qualified long-term care insurance policy must cover qualified long-term care services.

Minn. Stat. §62S.01, 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.

E. Activities of Daily Living

Minn. Stat. §62S.02, subd. 5 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.

F. Appeals Process

Minn. Stat. §62S.02, subd. 6 A qualified long-term care insurance policy must include a clear description of the process for appealing and resolving benefit determinations.

G. Required Submission to Commissioner

Minn. Stat. 62S.021, subd. 2

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;
- (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.

H. Benefit Labeling

Minn. Stat. §62S.06, subd. 2

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.

I. Renewability

Minn. Stat. §62S.14

Subd. 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.

J. Unintentional Lapse, Notice Before Lapse or Termination

Minn. Stat. §62S.19, subd. 1 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.

K. Unintentional Lapse, Reinstatement

Minn. Stat. §62S.19, subd. 4 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.

L. Required Disclosure Provisions

Minn. Stat. §62S.20

Subd. 1(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. 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. 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 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.

M. Requirement to Offer Inflation Protection, Inflation Protection Feature

Minn. Stat. §62S.23, subd. 1

- (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 age 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 three 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.

N. Nonforfeiture Benefit Requirement

Minn. Stat. § 62S.266

Subd. 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.

O. Contingent Nonforfeiture Benefit Upon Lapse Requirement

Minn. Stat. § 62S.266

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

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

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 (e), 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.

II. Minnesota Specific Items Prohibited From Inclusion in Long Term Care Insurance Policies

A. Prohibitions

Minn. Stat. § 62S.04 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.

B. Prior Hospitalization or Institutionalization

Minn. Stat. § 62S.06

Subd. 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. 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.

C. Authorized Limitations and Exclusions

Minn. Stat. § 62S.15

- (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

- (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.

D. Minimum Standards for Home Health and Community Care Benefits

Minn. Stat. § 62S.22

Subd. 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.

III. Requirements Specific to Individual Long Term Care Insurance Policies

A. Preexisting Condition

Minn. Stat. § 62S.05

Subd. 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.

B. Renewability

Minn. Stat. § 62S.14

Subd. 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.

C. Required Disclosure Provisions, Renewability

Minn. Stat. § 62S.20, subd. 1.

(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.

V. Requirements Specific to Group Long Term Care Insurance Policies

A. Certificate Requirements, Content

Minn. Stat. § 62S.09, subd. 1 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.

B. Continuation or Conversion

Minn. Stat. § 62S.17

Subd. 1. Requirement. Group long-term care insurance shall provide covered individuals with a basis for continuation or conversion of coverage.

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.

C. Nonforfeiture Benefit Requirement

Minn. Stat. § 62S.266, subd. 2

(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 is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(b) When a group long-term policy is issued, the offer required in paragraph (a) shall be made to the group policy holder. 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.

V. Outlines of Coverage

A. Coverage Outline

Minn. Stat. § 62S.08

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

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

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

Policy number or Group Master Policy and Certificate Number

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

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

- (1) This policy is (an individual policy of insurance) (a group policy) which was issued in the (indicate jurisdiction in which group policy was issued).
- (2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.
- (3) THIS PLAN IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702(B)(b) OF THE INTERNAL REVENUE CODE OF 1986.
- (4) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.
 - (a)(For long-term care health insurance policies or certificates describe 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

(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 A 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).

B. Required Disclosure Provisions, Payment of Benefits

Minn. Stat. § 62S.20, subd. 3 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.

C. Requirement to Offer Inflation Protection, Required Information

Minn. Stat. § 62S.23, subd. 3 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.

VII. Advertising

Minn. Stat. § 62S.28, subd. 1 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.

State of Minnesota Department of Commerce Bulletin 2009-1 contains specific filing instructions:

http://www.state.mn.us/mn/externalDocs/Commerce/Bulletin_20091_013009114854_Bulletin2009-1.pdf

