State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 3798

April 26, 2010
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The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight

A bill for an act

relating to insurance; prohibiting increases in long-term care insurance premiums on existing policies without advance notice to policyholders and approval of the commissioner; amending Minnesota Statutes 2008, sections 60A.08, subdivision 3; 62A.48, subdivision 1; 62S.01, subdivision 13a; 62S.081, subdivision 5; 62S.265, subdivision 2.

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

Section 1. Minnesota Statutes 2008, section 60A.08, subdivision 3, is amended to read:

Subd. 3. **Renewal; new policy.** Any insurance policy terminating by its provisions at a specified expiration date or limited as to term by any statute and not otherwise renewable may be renewed or extended at the option of the insurer, at the premium rate then required therefor, for a specific additional period or periods by a certificate, and without requiring the issuance of a new policy. The insurer must also post the current policy form on its Web site, or must inform the policyholder annually in writing that a copy of the current policy form is available on request. Renewal of a long-term care insurance policy at a higher premium rate schedule is subject to section 62A.48, subdivision 1, or 62S.081, subdivision 5, whichever applies.

EFFECTIVE DATE. This section is effective January 1, 2011, and applies to premium increase requests submitted on or after that date.

Sec. 2. Minnesota Statutes 2008, section 62A.48, subdivision 1, is amended to read:

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by

a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover prescribed long-term care in nursing facilities or the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. A long-term care policy may cover both prescribed long-term care in nursing facilities and the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy, other than one that covers only nursing facility services, must include: a minimum lifetime benefit limit of at least $25,000 for services. A long-term care policy that covers only nursing facility services must include a minimum lifetime benefit limit of not less than one year of nursing facility services. Nursing facility and home care coverages under a long-term care policy must not be subject to separate lifetime maximums for policies that cover both nursing facility and home health care. Prior hospitalization may not be required under a long-term care policy.

The policy must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under the policy may include a waiting period of up to 180 days before benefits are paid, but there must be no more than one waiting period per benefit period; for purposes of this sentence, "days" can mean calendar or benefit days. If benefit days are used, an appropriate premium reduction and disclosure must be made. If benefit days are used in connection with coverage for home care services, the waiting period for home care services must not be longer than 90 benefit days. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date, with the advance approval of the commissioner and written notice of the application for approval provided to policyholders who would be adversely affected by the premium increase, sent to policyholders on the day following the insurer's submission of the application, together with information prepared by the commissioner on how a policyholder may have meaningful and timely input to the commissioner's decision on such requests for approval. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return

a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

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

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

EFFECTIVE DATE. This section is effective January 1, 2011, and applies to premium increase requests submitted on or after that date.

Sec. 3. Minnesota Statutes 2008, section 62S.01, subdivision 13a, is amended to read:

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 insurer must make the report of the review available to affected policyholders upon request and must inform affected policyholders of their right to make the request. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs and shall consider input from affected policyholders.

EFFECTIVE DATE. This section is effective January 1, 2011, and applies to premium increase requests submitted on or after that date.

Sec. 4. Minnesota Statutes 2008, section 62S.081, subdivision 5, is amended to read:

Subd. 5. **Notice of increase.** An insurer shall provide notice of an upcoming request for a premium rate schedule increase, ~~after~~ at the time the request for approval of the increase ~~has been approved by~~ is submitted to the commissioner, to all policyholders or certificate holders, if applicable, and at least 45 days notice 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 requested and when it is implemented. The notice of the insurer's request for an increase must include information prepared by the commissioner on how the policyholders and certificate holders may have meaningful and timely input to the commissioner's decision on this type of request.

EFFECTIVE DATE. This section is effective January 1, 2011, and applies to premium increase requests submitted on or after that date.

Sec. 5. Minnesota Statutes 2008, section 62S.265, subdivision 2, is amended to read:

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 of approved increase to the policyholders required under section 62S.081, subdivision 5, and no earlier than the advance notice to policyholders and certificate holders of the request for the rate increase required under that same subdivision. Both the request to the commissioner and the advance notice of the request for the rate increase to policyholders and certificate holders 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.

EFFECTIVE DATE. This section is effective January 1, 2011, and applies to premium increase requests submitted on or after that date.