Senate Counsel, Research, and Fiscal Analysis

G-17 State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
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Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 2477 - MinnesotaCare

Author: Senator Charles W. Wiger

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: March 14, 2006

S.F. No. 2477 eliminates premiums for members of the military who enroll in MinnesotaCare within 24 months following the member's tour of active duty. This exemption applies for 12 months so long as the individual or family remains eligible for the program during this period.

KC:ph

Senators Wiger, Vickerman and Murphy introduced–

S.F. No. 2477: Referred to the Committee on Health and Family Security.

A bill for an act

relating to MinnesotaCare; eliminating premiums for military personnel and their families; amending Minnesota Statutes 2004, section 256L.15, subdivision 1.

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

Section 1. Minnesota Statutes 2004, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare are exempt from this section and section 256L.06 upon eligibility approval made within 24 months following the end of the member's tour of active duty. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption shall apply for 12 months if the individual or family remains eligible upon six-month renewal.

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Senate
State of Minnesota

S.F. No. 2621 - Minimum Pass Rate for EMT Training Programs

Author: Senator Gary Kubly

Prepared by: David Giel, Senate Research (296-7178)

Date: March 13, 2006

Section 1 (144E.285, subdivision 1) requires all Emergency Medical Technician (EMT) training programs to maintain a minimum average yearly pass rate on the state EMT certification exam that is equal to the national average pass rate on the exam, as determined by the percentage of candidates who pass on the first try.

A program not meeting the standard shall be placed on probation with a performance improvement plan approved by the Emergency Medical Services Regulatory Board, which regulates these training programs. If a training program fails to meet the pass rate standard after two years in which an EMT initial course has been taught, the board may take further disciplinary action.

DG:rdr

Senators Kubly, Berglin, Lourey and Kiscaden introduced–

S.F. No. 2621: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; requiring programs to meet an average yearly pass rate for EMT certification; amending Minnesota Statutes 2004, section 144E.285, subdivision 1.

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

Section 1. Minnesota Statutes 2004, section 144E.285, subdivision 1, is amended to read:

Subdivision 1. **Approval required.** (a) All training programs for an EMT, EMT-I, or EMT-P must be approved by the board.

(b) To be approved by the board, a training program must:

(1) submit an application prescribed by the board that includes:

(i) type and length of course to be offered;

(ii) names, addresses, and qualifications of the program medical director, program training coordinator, and instructors;

(iii) names and addresses of clinical sites, including a contact person and telephone number;

(iv) admission criteria for students; and

(v) materials and equipment to be used;

(2) for each course, implement the most current version of the United States Department of Transportation curriculum or its equivalent as determined by the board applicable to EMT, EMT-I, or EMT-P training;

(3) have a program medical director and a program coordinator;

(4) utilize instructors who meet the requirements of section 144E.283 for teaching at least 50 percent of the course content. The remaining 50 percent of the course may be taught by guest lecturers approved by the training program coordinator or medical director;

(5) have at least one instructor for every ten students at the practical skill stations;

(6) maintain a written agreement with a licensed hospital or licensed ambulance service designating a clinical training site;

(7) retain documentation of program approval by the board, course outline, and student information;

(8) notify the board of the starting date of a course prior to the beginning of a course; ~~and~~

(9) submit the appropriate fee as required under section 144E.29~~.~~; and

(10) maintain a minimum average yearly pass rate on the state EMT certification exam that is equal to the national average pass rate on the certification exam. The pass rate will be determined by the percent of candidates who pass the exam on the first attempt. A training program not meeting this yearly standard shall be placed on probation and shall be on a performance improvement plan approved by the board until meeting the pass rate standard. While on probation, the training program may continue providing classes if meeting the terms of the performance improvement plan as determined by the board. If a training program having probation status fails to meet the pass rate standard after two years in which an EMT initial course has been taught, the board may take disciplinary action under subdivision 5.

Senators Koering, Berglin, Foley and Lourey introduced–

S.F. No. 2534: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; requiring the Brainerd Regional Treatment Center laundry services to be maintained or expanded; allowing Brainerd Regional Treatment Center employees and service units to bid on certain service contracts.

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

Section 1. **LAUNDRY SERVICES AT BRAINERD REGIONAL TREATMENT CENTER.**

The commissioner of human services shall maintain or expand laundry services that are provided by the laundry unit at the Brainerd Regional Treatment Center until January 2010.

Sec. 2. **BRAINERD REGIONAL TREATMENT CENTER SERVICES.**

The commissioner of human services shall allow the Brainerd Regional Treatment Center employees and service units to bid on state contracting opportunities, specifically the contracts to provide services for the new community-based inpatient psychiatric hospitals.

Senator Berglin introduced–

S.F. No. 2726: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; extending the essential community provider designation to a mental health provider located in Hennepin County; amending Minnesota Statutes 2004, section 62Q.19, subdivision 2.

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

Section 1. Minnesota Statutes 2004, section 62Q.19, subdivision 2, is amended to read:

Subd. 2. **Application.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Except as provided in paragraphs (d) and (e), applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

(d) The commissioner shall accept an application for designation as an essential community provider until June 30, ~~2004~~ 2006, from one applicant that is a nonprofit community ~~services agency certified as a medical assistance provider that provides mental~~

~~health, behavioral health, chemical dependency, employment, and health wellness services to the underserved Spanish-speaking Latino families and individuals with locations in Minneapolis and St. Paul~~ mental health agency located in Hennepin County that partners with the Minneapolis public school system to provide mental health services to school-age children and their families and provides mental health services to immigrant communities.

EFFECTIVE DATE. This section is effective the day following final enactment.

- Reach out
- Make connections
- Create and affirm possibility
- Go beyond self-imposed limits
- Accept others as they are
- Make meaning, make sense of your world
- Balance your life
- Build better relationships
- Strengthen families
- Nurture youth
- Feed your heart, mind, body, and soul
- Inspire hope, action, and wholeness within yourself and within the world
- Work together for community wellness

Give to yourself,
Give to others,
Nurture
community

For more information
or to arrange for services,
contact:

The Mental Health Collective

3548 Bryant Avenue South
Minneapolis, MN 55408

Phone: 612-822-8227
e-mail: mhealth@cpinternet.com

The Mental Health Collective

Partnering within Our Community
to Improve Emotional Health
and Well-being

3548 Bryant Avenue South
Minneapolis, MN 55408

Phone: 612-822-8227
e-mail: mhealth@cpinternet.com

Who we are

We are a non-profit, community-based organization that takes a holistic approach to individual, family, and community wellness. We recognize the dynamic relationship between individuals and communities:

> *Individuals and families make a difference in the neighborhoods, communities, and organizations in which they live and participate; in turn, the health of neighborhoods, communities, and organizations directly affects residents and members.*

Since the start of the Mental Health Collective in 1999, we have endeavored to be creative and practical, to be involved in community life, to be responsive to community needs, and to learn from t with whom we work. We have:

- Applied our skills as mental health professionals through outreach, collaboration, and partnership with others to meet community needs;
- Delivered low-cost counseling, intervention, and support services; and
- Provided consultation and training to students and professionals in the mental health field.

We rely on volunteers to help us be cost-effective and to expand our ability to build a healthier community.

What we offer

Community Outreach

- Partnership with other community agencies and organizations to address and solve community problems.
- Support for student learning with a variety of services to schools in Minneapolis, including classroom support, skill-building groups, family support, and counseling to students to reduce learning barriers.
- An attendance improvement program for families of students who are at risk for not meeting attendance requirements to ensure that these students are at school, ready to learn.

Counseling Services

- Individual, couples, and family counseling on site at our office and at other community locations.
- Counseling services for immigrant survivors of torture.
- Specific issue groups for adults.

Training

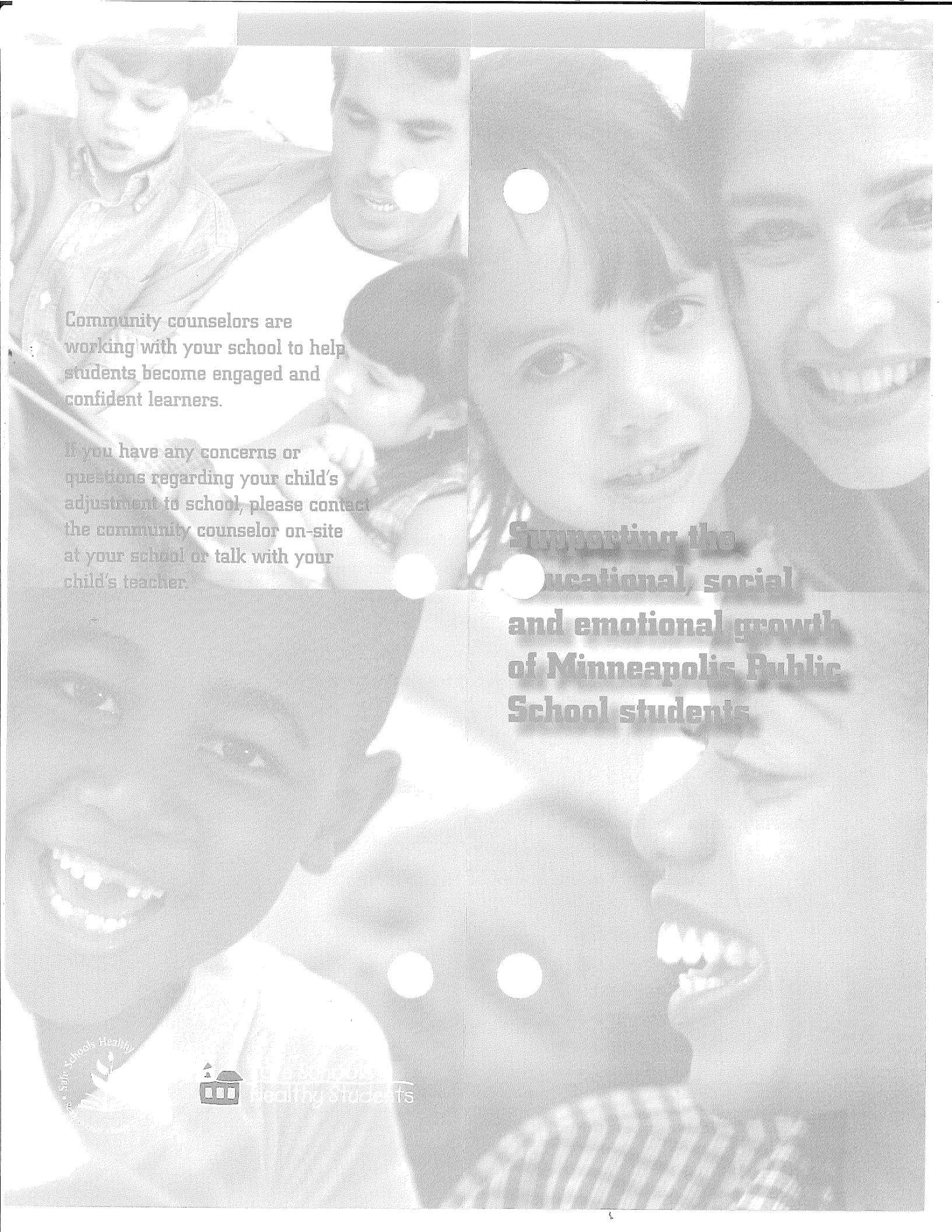
- Training for master's and doctoral students in psychology and marriage and family therapy.
- Consultation, supervision, and training to mental health professionals and other community leaders and members.

Our values

As an organization and as individuals, we believe the following:

- The relationship between individuals and their community is a dynamic one.
- Community mental health services can and should address the many, interdependent issues affecting the overall health of the community.
- Human relationships have the power to affirm life, improve health, and build community.
- Individuals benefit by becoming agents of their own and others' care and well-being, by placing equal value on getting and giving, and by seeing a larger purpose outside themselves.
- Individuals benefit through connection and productive involvement in their communities; in so doing, they contribute to community wellness in addition to their own learning, healing, and growth.

When we work with you, it is a collaborative process. You can expect us to listen; to be flexible; to value what you have to offer; to treat you with respect and courtesy; to help you to help yourself; to help you to heal, when needed; and to nurture your responsibility to yourself, to others, and to the community.



Community counselors are working with your school to help students become engaged and confident learners.

If you have any concerns or questions regarding your child's adjustment to school, please contact the community counselor on-site at your school or talk with your child's teacher.

Supporting the educational, social and emotional growth of Minneapolis Public School students

Healthy Students

- *Do you have concerns about your child's relationships or behavior at school?*
- *Does your child feel uncomfortable or disinterested in learning at school?*
- *Is your family facing difficulties that are affecting your child?*

WE ARE HERE TO HELP WITH COMMUNITY COUNSELORS AVAILABLE ON-SITE

Children do better in school when they feel safe and curious about the world around them. Sometimes, children need help learning how to expr mselves a justing emotionally to their environment. After stressful or difficult events, children and families need support.

Community counselors are available on-site at your school to help. We provide counseling and supportive services that are confidential and safe in a comfortable and relaxed atmosphere.

Community counselors are based at your school full-time and are able to provide a full range of services on-site.

Counseling and supportive services include:

- Screening (with parental permission)
- Consultation with parents
- Assessment
- Individual Counseling
- Family Counseling
- Group Counseling
- Consultation with teachers
- Staff development trainings

"Children do well if they can. If they can't, we adults need to figure out why, so we can help." – Ross Greene

The Mental Health Collective 3548 Bryant Avenue South, Minneapolis, MN 55408
Phone: 612-822-8227
Contact: LarryKivens(larrykivens@mentalhealthcollective.org)

Background:

- Founded in 1999, our vision is to improve the emotional health and well-being of our diverse community.
- We are located in South Minneapolis, but receive referrals from the larger Twin Cities metropolitan area.
- Our mission is to solve problems through community partnership; to provide affordable, accessible, and culturally sensitive mental health services; to locate services in community locations including public schools and neighborhood centers; and to mentor mental health professionals and others in community outreach and collaboration.
- Our agency has a grant-funded contract (Safe Schools, Healthy Students) with the Minneapolis School District to provide preventive and direct mental health services on site at three Minneapolis public schools (Andersen Open, Andersen Elementary, and Sullivan); we also provide on-site services at Whittier, Burroughs, Anishinabe Academy, and South High School, and we have a staff person on-site at the South Area Family Resource Center who handles referrals from all South Area Minneapolis public schools.
- We serve a diverse population, including many low-income, immigrant, and high-risk/special needs children and families.
- Our services are available through medical insurance or a sliding fee scale, and we do not restrict access to services due to financial limitations.

Purpose for Designation as an Essential Community Provider:

- To increase access for children and families at our school-based clinics.
- To expand our ability to provide early intervention with high-risk children, thereby reducing the long-term cost of services.
- To support mental health providers who are trained to serve diverse populations, *e.g.*, immigrant Africans, Latinos, Native Americans.
- Under the supervision of licensed staff, to enable our graduate student trainees to provide services to children and families with medical insurance as well as to those on a sliding fee scale.

The Mental Health Collective

Annual Report 2004

Partnering within Our Community to Improve Emotional Health and Well-being

Grants Support School-Based Clinic Expansion

A grant from the Community Investment Fund of the Greater Twin Cities United Way provided seed money [illegible] the Mental Health Collective to staff school-based [illegible]ital health services at Sullivan and Whittier schools in South Minneapolis and to expand our services at Andersen schools, also in South Minneapolis. The agency received additional funding for school programs from the Beim Family Foundation.

With this funding to assist student success in school and in life, we were able to provide outreach services, including classroom support, skill-building groups, consultation with school faculty, and individual and family counseling, during the school year at our clinic sites and at South and Southwest High Schools, Northeast Middle School, Anishinabe Academy, and Burroughs Community School. To sustain student progress over the summer, our services included clinic visits, home visits, and a six-week activity group for students ages 9-12 that met on Friday mornings.

"When we returned to Sullivan School in the fall of 2004, it was wonderful. Students and staff recognized us and we could pick up where we had started with students the year before. We were a part of the school learning community."

— Betsy McCullough, School Therapist

Agency Vision and Mission Statement

The Mental Health Collective is a nonprofit, community-based organization, established in 1999 to improve the emotional health and well-being of our community and its diverse inhabitants. We offer affordable, accessible, and culturally sensitive mental health services at our clinic in South Minneapolis, at school-based clinics located in Minneapolis schools, and through outreach to other schools and locations in the community; we provide supervision and training to students and professionals in the mental health field; and we engage in collaborative problem-solving with community partners to address issues that impact on individual, family, and community wellness.

3548 Bryant Avenue South, Minneapolis, MN 55408
Phone: 612-822-8227 • Fax: 612-825-4204 • e-mail: mhealth@mentalhealthcollective.org

Letter from the Board Chair:

It is a privilege to be part of the Mental Health Collective and to serve as the Board Chair. The year 2004 brought enormous growth and change for the agency.

Our previous years of establishing a presence in local schools, providing a sliding fee scale and insurance reimbursed services to individuals and families, partnering with other non-profit organizations, and offering practicum and internship opportunities for students from a variety of backgrounds set a strong foundation for our programs. These efforts continued in 2004, as did the work of our board of directors, who, hand in hand with co-directors and staff, spent many hours proactively addressing the needs of a growing organization.

In part through a capacity-building grant from the Bremer Foundation, in 2004 we enriched our capability to access the skills of consultants and volunteers; we recruited new members for our board of directors; and we developed a strategic plan for agency development. Our staff increased in size; policies and procedures were developed and implemented; contracts and grants were awarded to us; and we worked diligently to make sound business decisions for the organization during a time of rapid growth.

This year's annual report reflects many of the changes we experienced. It cannot, however, fully reflect the agency's impact on the lives of those our programs touched. Educators, parents, and children found our school-based programs to provide safe, healthy, productive ways to communicate with each other an to enrich our educational system and community. Native/Indigenous youth had new opportunities to be heard, respected, and valued as individuals. Future mental health providers learned first-hand about community involvement, cultures, and resources, while supporting independence and wellness for individuals and families.

As I look to 2005, I am excited for us to continue to support our mission, to help the Mental Health Collective grow and continue to provide quality services to the community, to manage our resources responsibly, and to enrich the lives of those we serve. We are proactively seeking additional resources to enlarge our volunteer base, to enrich and diversify our financial foundation, to identify other partner organizations, and to hire and retain quality staff. We are grateful for the trust our supporters have placed in us and we welcome the opportunity to share our story. Because of you, we have touched the lives of countless people. Thank you.

— Becky Real

Agency Programs Serve an Increasingly Diverse Community

Ann Gilligan, an LICSW and bilingual therapist, joined our staff in 2004 to provide clinical services to the Latino community. Graduate students Shanna Wilson, Javier Rodriguez-Gaitan, and Eugenia Apaza also provided services in 2004 to Spanish-speaking clients, thereby expanding our ability to work with the Hispanic community.

Through partnerships with the Center for Victims of Torture, African Aid, and the Minneapolis Public Schools, additional services were provided to immigrant community members from Iraq, Liberia, and East Africa. These services included individual counseling for survivors of war trauma in Africa, a support group for Iraqi children displaced by the turmoil in their country, a support group for Somali girls in middle school, and a transition group that focused on career exploration and development for students in the English as a Second Language (ELL) program at South High.

"I was particularly impressed by the positive attitudes, sense of humor, rich histories, and sense of values expressed by students we worked with. Their sense of appreciation for life and the vastness of opportunity available here in America make these individuals valuable assets to our community."

— Claudia Mendez, Pre-Doctoral Intern

Native/Indigenous Group Members Create a Name for Themselves

In his doctoral psychology practicum placement at our ·ency in 2002-2003, Brad Hauff responded to a .quest to provide clinical services to several Native/ Indigenous youth at a Minneapolis school. As a member of the Oglala Sioux Tribe with a specific interest in American Indian psychology and spirituality, Brad was interested in promoting educational success and healthy emotional development for Native/Indigenous students.

During the 2003-2004 and 2004-2005 school years, as part of his two-year pre-doctoral internship, Brad expanded his outreach to include middle school students at Anishinabe Academy, high school students at the All Nations program at South High, and summer students at Native Academy. The focus of his work with students has been on helping them to gain or regain a sense of community connection in hopes that this community support will help motivate these ıdents to succeed.

This past year, the students with whom Brad has been working proudly named their group the Native Youth Community. And with each school year, as many students return to the group and new students join, the Native Youth Community continues to grow into its name.

> ***"As a Native American and student in Argosy University's Psy.D. program, I appreciate this agency's efforts to reach out to what has been an underserved group of people in creative and nontraditional ways."***
>
> ***— Brad Hauff, Pre-Doctoral Intern***

^gency Receives State Collaborative .tar Program Recognition

In January of 2004, agency staff were informed that the Counseling Island, an on-site mental health clinic that we staff at the South Area Family Resource Center at Andersen School, was recognized by the Minnesota Department of Human Services as the 2003 Collaborative Star Program. The clinic provides students, families, school staff, and Resource Center staff with increased access to mental health providers, connects kids more quickly and easily to the resources they need and can use, and is intended to help these kids be more successful as students.

The collaborative effort betweeen the Mental Health Collective and the South Area Family Resource Center began during the 2002-2003 school year when our agency provided a half-time therapist to work in the Family Resource Center. The schedule was expanded for the 2003-2004 school year and reflected a 100 percent increase in the number of children seen for therapy at the site.

Task Force Addresses Holistic Health Options

In response to requests from agency clients to identify alternatives to traditional psychiatric medications, a sub-group of staff and students at the Mental Health Collective formed a task force in 2004 to consider holistic options for the treatment of mental health issues. This task force is working with other community resources to identify alternative health care practitioners within the community who deal with mental health issues and to develop a resource list that can be made available to clients.

Two Groups Started for Seniors

To address the unique needs of community members who attend the Southwest Senior Center, the Mental Health Collective started two groups this past fall at the senior center. One group was a men's group that met twice a month, the other was a "reminiscing group" that provided an opportunity for members to share with each other and with group facilitators their careers, life work, life experiences, holiday memories, hobbies, and interests.

> ***"Reminiscing groups are intended for participants to share their life stories, forge a sense of community, gain support from one another, develop relationships with peers, promote self-esteem, and increase overall life satisfaction."***
>
> ***— Phoulavanh Chareun, Practicum Student***

2004

Board of Directors

Jan Mershon (chair)
Carolyn Ham (treasurer)
Jan Lubov (secretary)
Rebecca Real
Gretchen Wesche-Sherman
Charlie Wunsch

Co-Directors

Larry Kivens
Martha Olsen

Staff Therapists

Ann Gilligan
Connie Mayrand
Carla Mortensen
Lynn Overvoorde
Demmie Rosenberg

Trainees

Eugenia Apaza
Brad Bergan
Kathy Brush
Charlie Burt
Anne Chamberlain
Phoulavanh Chareun
Emily Duncan
Brad Hauff
Jessica Helle-Morissey
Betsy McCullough
Claudia Mendez
Michael Peterson
Sara Quam
Javier Rodriguez-Gaitan
Heather Svoboda
Laura Waldman
Shanna Wilson

Volunteers

Susan Carstens
Burton (Skip) Nolan
Glen Olsen
Barbara Steinhauser
Karma Walker

Individual Donors

Randy Baker and Kathleen Kimball-Baker
Charme Davidson, Ph.D.
Barbara Davis
Rachel Edwards and Charlie Schwab
Dana Fox
Carolyn Ham
Sonja Hansen Walker
Dan Hess
Tim and Suzanne Lauer
Jan Lubov
Don Masler
Bill and Jan Mershon
Craig Miller and Paul Moss
Carla and Joel Mortensen
Mary Kay and Paul Orman
Rebecca and Kevin Real
Dennis Schapiro
Mary Seabloom
Ellen and Jim Van Iwaarden
Gretchen Wesche-Sherman
Fran Zimmerman and Bernie Slutsky

Foundation and Corporate Donors

Beim Family Foundation
Dreyfuss Foundation
ING Matching Gifts Program
Otto Bremer Foundation
Greater Twin Cities United Way–Community Investment Fund

2004 Financial Report

Statement of Financial Position as of December 31, 2004

Assets	
Checking	32,390
Accounts Receivable	29,952
Fixed Assets	119,713
Total Assets	$182,055
Liabilities and Equity	
Mortgage Loan	123,600
Other Loans	2,400.00
Total Liabilities	$126,000
Net Assets	
Unrestricted	$31,956
Temporarily Restricted	$24,099
Total Liabilities and Net Assets	$182,055

Statement of Activities

January 1 – December 31, 2004

Revenues	
Cash Contributions	1,944
In-Kind Contributions	17,400
Grants	30,750
Fees	143,166
Other	4,050
Total Revenues	$197,310
Expenses	
Payroll	85,913
Contract Services	16,794
Occupancy	12,020
Professional Fees	10,062
Office	5,48(
Insurance	3,298
In-Kind	17,400
Other	3,079
Total Expenses	$154,052
Increase in Net Assets	$43,258

Senators Berglin and Higgins introduced–

S.F. No. 2793: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying essential community provider designation; amending Minnesota Statutes 2004, section 62Q.19, subdivision 2.

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

Section 1. Minnesota Statutes 2004, section 62Q.19, subdivision 2, is amended to read:

Subd. 2. **Application.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Except as provided in paragraphs (d) and (e), applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

(d) The commissioner shall accept an application for designation as an essential community provider until June 30, 2004, from one applicant that is a nonprofit community services agency certified as a medical assistance provider that provides mental health, behavioral health, chemical dependency, employment, and health wellness services to

the underserved Spanish-speaking Latino families and individuals with locations in Minneapolis and St. Paul.

(e) The commissioner shall accept an application for designation as an essential community provider until June 30, 2006, from one applicant that is a nonprofit, county mental health services center certified as a medical assistance provider of behavioral health services and wrap-around eligibility support services to an underserved population with chemical dependency and serious mental illness.

Senate Counsel, Research,
and Fiscal Analysis

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FAX: (651) 296-7747

Jo Anne Zoff Sellner
Director

Senate
State of Minnesota

S.F. No. 2898 - Long-term Care Partnership Program (as Amended by the A-1 Amendment)

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (296-7178)

Date: March 13, 2006

S.F. No. 2898 modifies state law as required by recent federal legislation in order to allow implementation of a Long-Term Care Partnership Program under which persons who exhaust the benefits of a qualifying long-term care insurance policy are permitted, when applying for Medical Assistance (MA) payment of long-term care services, to protect from MA recovery an amount of assets equal to the policy benefits utilized.

Article 1
Qualified Long-Term Care Insurance Regulatory Changes

This article modifies Chapter 62S, which regulates long-term care insurance in Minnesota. All of the changes are mandated by federal law in order to permit the state to implement the long-term care partnership program. The most significant changes are to (1) increase consumer disclosures; (2) require new insurance agent training; and (3) make numerous technical regulatory changes to reflect the current National Association of Insurance Commissioners (NAIC) model law. This article is within the jurisdiction of the Commerce Committee.

Article 2
Long-Term Care Partnership Program

Section 1 (256B.0571) modifies the Partnership Program adopted last year in order to comply with recent federal law.

Subdivisions 1 to 7a delete several unneeded definitions; clarify that a Partnership Policy must be issued on or after July 1, 2006, and add a definition of "protected assets."

Subdivision 8 clarifies that in order to participate in the Partnership Program, a person must be a Minnesota resident at the time coverage first becomes effective under a partnership policy and that the policy must be issued no earlier than July 1, 2006. This subdivision deletes a reference to minimum policy benefits, which are removed later in this section, and requires a person to exhaust all policy benefits in order to receive asset protection under the MA program.

Subdivision 9 establishes procedures for allowing qualifying individuals, when applying for MA payment of long-term care services, to designate protected assets, including the determination of market value, valuation of life estates and joint tenancies, and the extent of and limits on the right to protect assets. Protection does not apply to recovery from trusts or annuities and similar legal instruments.

Subdivision 10 deletes policy requirements not allowed under federal law and establishes inflation protection required by federal law.

Subdivision 11 is stricken. It authorized "total asset protection policies," which are not permitted under federal law.

Subdivision 12 updates a reference to applicable federal law.

Subdivision 13 modifies the language placing limits on MA estate recovery. It states that protected assets are not subject to MA estate claims nor to the collection procedure for small claims under the uniform probate code. However, protected assets do not continue to be protected in the surviving spouse's estate if the surviving spouse also receives MA benefits. This subdivision requires personal representatives to use the value of available asset protection to protect the full value of each protected asset to the extent possible, rather than partially protecting a larger number of assets. The asset protection expires when the estate distributes an asset or if the estate is not probated within one year of death.

Subdivision 14 requires DHS to submit a state plan amendment to the federal government by September 30, 2006, so that the Partnership Program may take effect for policies issued on or after July 1, 2006.

Subdivision 15 exempts protected assets from the MA lien law to the extent the heir owns the property in the heir's own name. This protection does not apply once the heir disposes of the property or dies.

Subdivision 16 places the burden of proof on the individual or the individual's estate to document that an asset has been protected and remains protected.

DG:rdr

Senator Berglin introduced–

S.F. No. 2898: Referred to the Committee on Health and Family Security.

A bill for an act

relating to insurance; conforming regulation of qualified long-term care insurance to requirements for state participation in the federal long-term care partnership program; amending state long-term care partnership program requirements; amending Minnesota Statutes 2004, sections 62S.05, by adding a subdivision; 62S.08, subdivision 3; 62S.081, subdivision 4; 62S.10, subdivision 2; 62S.13, by adding a subdivision; 62S.14, subdivision 2; 62S.15; 62S.20, subdivision 1; 62S.24, subdivisions 1, 3, 4, by adding subdivisions; 62S.25, subdivision 6, by adding a subdivision; 62S.26; 62S.266, subdivision 2; 62S.29, subdivision 1; 62S.30; Minnesota Statutes 2005 Supplement, section 256B.0571; proposing coding for new law in Minnesota Statutes, chapter 62S.

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

ARTICLE 1

QUALIFIED LONG-TERM CARE INSURANCE REGULATORY CHANGES

Section 1. Minnesota Statutes 2004, section 62S.05, is amended by adding a subdivision to read:

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.

Sec. 2. Minnesota Statutes 2004, section 62S.08, subdivision 3, is amended to read:

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 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.)

~~(5)~~ (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.

~~(6)~~ (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.)

~~(7)~~ (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.)

~~(8)~~ (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 ~~(6)~~ (8).)

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

~~(9)~~ (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.

~~(10)~~ (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.)

~~(11)~~ (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.

~~(12)~~ (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.

Sec. 3. Minnesota Statutes 2004, section 62S.081, subdivision 4, is amended to read:

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.

Sec. 4. Minnesota Statutes 2004, section 62S.10, subdivision 2, is amended to read:

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; ~~and~~

(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.

Sec. 5. Minnesota Statutes 2004, section 62S.13, is amended by adding a subdivision to read:

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.

Sec. 6. Minnesota Statutes 2004, section 62S.14, subdivision 2, is amended to read:

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.

Sec. 7. Minnesota Statutes 2004, section 62S.15, is amended to read:

62S.15 AUTHORIZED LIMITATIONS AND EXCLUSIONS.

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; ~~and~~

(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; and

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

This subdivision does not prohibit exclusions and limitations by type of provider or territorial limitations.

Sec. 8. Minnesota Statutes 2004, section 62S.20, subdivision 1, is amended to read:

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 ~~the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~ 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.

Sec. 9. Minnesota Statutes 2004, section 62S.24, subdivision 1, is amended to read:

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?; ~~and~~

(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)?

Sec. 10. Minnesota Statutes 2004, section 62S.24, is amended by adding a subdivision to read:

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.

Sec. 11. Minnesota Statutes 2004, section 62S.24, subdivision 3, is amended to read:

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 INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(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
(BROKER OR OTHER REPRESENTATIVE):
(Use additional sheets, as necessary.)

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 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)

Sec. 12. Minnesota Statutes 2004, section 62S.24, subdivision 4, is amended to read:

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 AND SICKNESS OR
LONG-TERM CARE INSURANCE

(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 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 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)

Sec. 13. Minnesota Statutes 2004, section 62S.24, is amended by adding a subdivision to read:

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.

Sec. 14. Minnesota Statutes 2004, section 62S.25, subdivision 6, is amended to read:

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.

Sec. 15. Minnesota Statutes 2004, section 62S.25, is amended by adding a subdivision to read:

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.

Sec. 16. Minnesota Statutes 2004, section 62S.26, is amended to read:

62S.26 LOSS RATIO.

Subdivision 1. **Minimum loss ratio.** ~~(a)~~ 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; and

(4) an actuarial memorandum is filed with the insurance department 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.** ~~(b)~~ 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.

Sec. 17. Minnesota Statutes 2004, section 62S.266, subdivision 2, is amended to read:

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 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.

Sec. 18. Minnesota Statutes 2004, section 62S.29, subdivision 1, is amended to read:

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 ~~a~~ 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;

~~(5)~~ (6) establish auditable procedures for verifying compliance with this subdivision; ~~and~~

~~(6)~~ (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 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.

Sec. 19. Minnesota Statutes 2004, section 62S.30, is amended to read:

62S.30 ~~APPROPRIATENESS OF RECOMMENDED PURCHASE~~ SUITABILITY.

~~In recommending the purchase or replacement of a long-term care insurance policy or certificate, an agent shall comply with section 60K.46, subdivision 4.~~

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 where an agent is involved, the agent, 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.

Sec. 20. **[62S.315] PROVIDER TRAINING REQUIREMENTS.**

(a) Every insurer and other entity providing long-term care insurance in this state shall require that each producer authorized to solicit individual consumers for the sale of long-term care insurance shall complete the following training requirements that, for resident licensees, may be part of, and not in addition to, the continuing education requirements of section 60K.56:

(1) for producers issued a license after August 1, 2006, eight hours of training in the 24-month period prior to first soliciting individual consumers for the sale of long-term care insurance and eight hours of training in every 24-month period following licensure; and

(2) for producers issued a license before August 1, 2006, eight hours of training in every 24-month period after August 1, 2006.

(b) The training required by this section shall consist of topics related to long-term care insurance and long-term care services including, but not limited to:

(1) state and federal regulations and requirements;

(2) available long-term care services and providers;

(3) changes or improvements in long-term care services or providers;

(4) alternatives to the purchase of private long-term care insurance;

(5) differences in eligibility for benefits and tax treatment between policies intended to be federally qualified and those not intended to be federally qualified;

(6) the effect of inflation in eroding the value of benefits and the importance of inflation protection; and

(7) consumer suitability standards and guidelines.

The training required by this section shall not include any training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal laws or regulations.

(c) Every insurer and other entity providing long-term care insurance in this state shall obtain verification of the training required by this section before a producer is permitted to sell the entity's long-term care insurance products. Every insurer and other entity providing long-term care insurance or benefits in this state shall maintain an accurate record of producers authorized to sell the entity's long-term care insurance products to ensure continued compliance with the requirements of this section. All records of authorized producers, past and present, shall be made available to the commissioner upon request.

Sec. 21. **EFFECTIVE DATE.**

Sections 1 to 20 are effective July 1, 2006.

ARTICLE 2

LONG-TERM CARE PARTNERSHIP PROGRAM

Section 1. Minnesota Statutes 2005 Supplement, section 256B.0571, is amended to read:

256B.0571 LONG-TERM CARE PARTNERSHIP PROGRAM.

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

~~Subd. 2. **Home care service.** "Home care service" means care described in section 144A.43.~~

Subd. 3. **Long-term care insurance.** "Long-term care insurance" means a policy described in section 62S.01.

Subd. 4. **Medical assistance.** "Medical assistance" means the program of medical assistance established under section 256B.01.

~~Subd. 5. **Nursing home.** "Nursing home" means a nursing home as described in section 144A.01.~~

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10 ~~or 11, regardless of when the policy~~ and was first issued on or after July 1, 2006.

Subd. 7. **Partnership program.** "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident;

(2) purchase a partnership policy that is ~~delivered,~~ first issued ~~for delivery, or renewed~~ on or after ~~the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5~~ July 1, 2006, and maintain the partnership policy in effect throughout the period of participation in the partnership program; and

(3) exhaust the minimum benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before ~~the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5~~ July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.

Subd. 9. **Medical assistance eligibility.** (a) Upon application of an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) and (c).

(b) After disregarding financial assets exempted under medical assistance eligibility requirements, the commissioner shall disregard an additional amount of financial assets equal to the dollar amount of coverage utilized under the partnership policy.

(c) The commissioner shall consider the individual's income according to medical assistance eligibility requirements.

Subd. 10. ~~**Dollar-for-dollar asset protection policies**~~ **Long-term care partnership policy.** (a) A ~~dollar-for-dollar asset protection~~ long-term care partnership policy must meet all of the requirements in paragraphs (b) ~~to (c)~~ and (c).

(b) The policy must satisfy the requirements of chapter 62S.

(c) ~~The policy must offer an elimination period of not more than 180 days for an adjusted premium.~~

~~(d) The policy must satisfy the requirements established by the commissioner of human services under subdivision 14.~~

~~(e) Minimum daily benefits shall be $130 for nursing home care or $65 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.~~

(c) The policy must provide the inflation protection described in this paragraph. If the policy is sold to an individual who:

(1) is age 60 or younger on the date of purchase, the policy must provide compound annual inflation protection;

(2) is age 60 to 75 as of the date of purchase, the policy must provide some level of inflation protection; and

(3) is age 76 or older as of the date of purchase, the policy may, but is not required to, provide some level of inflation protection.

~~Subd. 11. **Total asset protection policies.** (a) A total asset protection policy must meet all of the requirements in subdivision 10, paragraphs (b) to (d), and this subdivision.~~

~~(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c).~~

~~(c) Minimum daily benefits shall be $150 for nursing home care or $75 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall also be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially~~

~~qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.~~

~~(d) The policy must cover all of the following services:~~

~~(1) nursing home stay;~~

~~(2) home care service; and~~

~~(3) care management.~~

Subd. 12. **Compliance with federal law.** An issuer of a partnership policy must comply with ~~any federal law authorizing partnership policies in Minnesota~~ Public Law 109-171, section 6021, including any federal regulations, as amended, adopted under that law. This subdivision does not require compliance with any provision of this federal law until the date upon which the law requires compliance with the provision. The commissioner has authority to enforce this subdivision.

Subd. 13. **Limitations on estate recovery.** ~~(a)~~ For an individual who exhausts the minimum benefits of a ~~dollar-for-dollar asset protection~~ long-term care partnership policy under subdivision 10, and is determined eligible for medical assistance under subdivision 9, the state shall limit recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual to an amount that exceeds the dollar amount of coverage utilized under the partnership policy.

~~(b) For an individual who exhausts the minimum benefits of a total asset protection policy under subdivision 11, and is determined eligible for medical assistance under subdivision 9, the state shall not seek recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual.~~

Subd. 14. **Implementation.** ~~(a) If federal law is amended or a federal waiver is granted to permit implementation of this section, the commissioner, in consultation with the commissioner of commerce, may alter the requirements of subdivisions 10 and 11, and may establish additional requirements for approved policies in order to conform with federal law or waiver authority. In establishing these requirements, the commissioner shall seek to maximize purchase of qualifying policies by Minnesota residents while controlling medical assistance costs.~~

~~(b) The commissioner is authorized to suspend implementation of this section until the next session of the legislature if the commissioner, in consultation with the commissioner of commerce, determines that the federal legislation or federal waiver authorizing a partnership program in Minnesota is likely to impose substantial unforeseen costs on the state budget.~~

~~(c) The commissioner must take action under paragraph (a) or (b) within 45 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(d) The commissioner must notify the appropriate legislative committees of action taken under this subdivision within 50 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(e) The commissioner must publish a notice in the State Register of implementation decisions made under this subdivision as soon as practicable.~~ The commissioner shall submit a state plan amendment to the federal government by September 30, 2006, to implement the long-term care partnership program in accordance with this section, in order that the program may take effect for policies issued on or after July 1, 2006.

EFFECTIVE DATE. This section is effective July 1, 2006.

Senator ..... moves to amend S.F. No. 2898 as follows:

Page 17, delete article 2 and insert:

"

ARTICLE 2

LONG-TERM CARE PARTNERSHIP PROGRAM

Section 1. Minnesota Statutes 2005 Supplement, section 256B.0571, is amended to read:

256B.0571 LONG-TERM CARE PARTNERSHIP PROGRAM.

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

~~Subd. 2. **Home care service.** "Home care service" means care described in section 144A.43.~~

Subd. 3. **Long-term care insurance.** "Long-term care insurance" means a policy described in section 62S.01.

Subd. 4. **Medical assistance.** "Medical assistance" means the program of medical assistance established under section 256B.01.

~~Subd. 5. **Nursing home.** "Nursing home" means a nursing home as described in section 144A.01.~~

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10 ~~or 11, regardless of when the policy~~ and was first issued on or after July 1, 2006.

Subd. 7. **Partnership program.** "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 7a. **Protected assets.** "Protected assets" means assets or proceeds of assets that are protected from recovery under subdivisions 13 and 15.

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident at the time coverage first became effective under the partnership policy;

(2) ~~purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5, and maintain the partnership policy in effect throughout the period of participation in the partnership program~~ be a beneficiary of a partnership policy issued no earlier than July 1, 2006; and

(3) ~~exhaust the minimum~~ have exhausted all of the benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before ~~the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5~~ July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.

Subd. 9. **Medical assistance eligibility.** (a) Upon application ~~of~~ for medical assistance program payment of long-term care services by an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) ~~and (c)~~ to (i).

(b) After ~~disregarding financial~~ determining assets ~~exempted under medical assistance eligibility requirements~~ subject to the asset limit under section 256B.056, subdivision 3 or 3c, or section 256B.057, subdivision 9 or 10, the commissioner shall ~~disregard an additional amount of financial assets equal~~ allow the individual to designate assets to be protected from recovery under subdivisions 13 and 15 of this section up to the dollar amount of ~~coverage~~ the benefits utilized under the partnership policy. Designated assets shall be disregarded for purposes of determining eligibility for payment of long-term care services.

(c) ~~The commissioner shall consider the individual's income according to medical assistance eligibility requirements.~~ The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of initial application for medical assistance. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value for property tax purposes for the real property, unless the individual provides a complete

professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) If the dollar amount of the benefits utilized under a partnership policy is greater than the full fair market value of all assets protected at the time of the application for medical assistance long-term care services, the individual may designate additional assets that become available during the individual's lifetime for protection under this section. The individual must make the designation in writing to the county agency no later than the last date on which the individual must report a change in circumstances to the county agency, as provided for under the medical assistance program. Any excess used for this purpose shall not be available to the individual's estate to protect assets in the estate from recovery under section 256B.15, section 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1496p, subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

(h) Assets designated under this subdivision shall not be subject to penalty under section 256B.0595.

(i) The commissioner shall otherwise determine the individual's eligibility for payment of long-term care services according to medical assistance eligibility requirements.

Subd. 10. ~~**Dollar-for-dollar asset protection policies**~~ **Long-term care partnership policy requirements.** (a) A ~~dollar-for-dollar asset protection~~ long-term care partnership policy must meet all of the requirements in paragraphs (b) ~~to (c)~~ and (c).

(b) The policy must satisfy the requirements of chapter 62S.

(c) ~~The policy must offer an elimination period of not more than 180 days for an adjusted premium.~~

~~(d) The policy must satisfy the requirements established by the commissioner of human services under subdivision 14.~~

~~(e) Minimum daily benefits shall be $130 for nursing home care or $65 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.~~ The policy must provide the inflation protection described in this paragraph. If the policy is sold to an individual who:

(1) is age 60 or younger as of the date of purchase, the policy must provide compound annual inflation protection;

(2) is age 61 to 75 as of the date of purchase, the policy must provide some level of inflation protection; and

(3) is age 76 or older as of the date of purchase, the policy may, but is not required to, provide some level of inflation protection.

~~Subd. 11. **Total asset protection policies.** (a) A total asset protection policy must meet all of the requirements in subdivision 10, paragraphs (b) to (d), and this subdivision.~~

~~(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c).~~

~~(c) Minimum daily benefits shall be $150 for nursing home care or $75 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall also be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.~~

~~(d) The policy must cover all of the following services:~~

~~(1) nursing home stay;~~

~~(2) home care service; and~~

~~(3) care management.~~

Subd. 12. **Compliance with federal law.** An issuer of a partnership policy must comply with ~~any federal law authorizing partnership policies in Minnesota~~ Public Law 109-171, section 6021, including any federal regulations, as amended, adopted under that law. ~~This subdivision does not require compliance with any provision of this federal law until the date upon which the law requires compliance with the provision. The commissioner has authority to enforce this subdivision.~~

Subd. 13. **Limitations on estate recovery.** (a) ~~For an individual who exhausts the minimum benefits of a dollar-for-dollar asset protection policy under subdivision 10, and is determined eligible for medical assistance under subdivision 9, the state shall limit recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual to an amount that exceeds the dollar amount of coverage utilized under the partnership policy.~~ Protected assets of the individual shall not be subject to recovery under section 256B.15 or section 524.3-1201 for medical assistance or alternative care paid on behalf of the individual. Protected assets of the individual in the estate of the individual's surviving spouse shall not be liable to pay a claim for recovery of medical assistance paid for the predeceased individual that is filed in the estate of the surviving spouse under section 256B.15. Protected assets of the individual shall not be protected assets in the surviving spouse's estate by reason of the preceding sentence and shall be subject to recovery under section 256B.15 or section 524.3-1201 for medical assistance paid on behalf of the surviving spouse.

(b) ~~For an individual who exhausts the minimum benefits of a total asset protection policy under subdivision 11, and is determined eligible for medical assistance under subdivision 9, the state shall not seek recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual.~~ The personal representative may protect the full fair market value of an individual's unprotected assets in the individual's estate in an amount equal to the unused amount of asset protection the individual had on the date of death. The personal representative shall apply the asset protection so that the full fair market value of any unprotected asset in the estate is protected. When or if the asset protection available to the personal representative is or becomes less than the full fair market value of any remaining unprotected asset, it shall be applied to partially protect one unprotected asset.

(c) The asset protection described in paragraph (a) terminates with respect to an asset includable in the individual's estate under chapter 524 or section 256B.15:

(1) when the estate distributes the asset; or

(2) if the estate of the individual has not been probated within one year from the date of death.

(d) If an individual owns a protected asset on the date of death and the estate is opened for probate more than one year after death, the state or a county agency may file and collect claims in the estate under section 256B.15, and no statute of limitations in chapter 524 that would otherwise limit or bar the claim shall apply.

(e) Except as otherwise provided, nothing in this section shall limit or prevent recovery of medical assistance.

Subd. 14. **Implementation.** ~~(a) If federal law is amended or a federal waiver is granted to permit implementation of this section, the commissioner, in consultation with the commissioner of commerce, may alter the requirements of subdivisions 10 and 11, and may establish additional requirements for approved policies in order to conform with federal law or waiver authority. In establishing these requirements, the commissioner shall seek to maximize purchase of qualifying policies by Minnesota residents while controlling medical assistance costs.~~

~~(b) The commissioner is authorized to suspend implementation of this section until the next session of the legislature if the commissioner, in consultation with the commissioner of commerce, determines that the federal legislation or federal waiver authorizing a partnership program in Minnesota is likely to impose substantial unforeseen costs on the state budget.~~

~~(c) The commissioner must take action under paragraph (a) or (b) within 45 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(d) The commissioner must notify the appropriate legislative committees of action taken under this subdivision within 50 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(e) The commissioner must publish a notice in the State Register of implementation decisions made under this subdivision as soon as practicable.~~ The commissioner shall submit a state plan amendment to the federal government by September 30, 2006, to implement the long-term care partnership program in accordance with this section, in order that the program may take effect for policies issued on or after July 1, 2006.

Subdivision 15. **Limitations on liens.** (a) If the interest of an individual in real property is designated as protected under subdivision 9 or is protected property in the estate of the individual and is subject to a medical assistance lien under sections 514.980

to 514.985, or a lien arising under section 256B.15, the gross proceeds from the gross sale price of any sale of the property by that individual or the individual's estate that are allocable to the protected interest are not subject to recovery of medical assistance under the lien.

(b) Paragraph (a) applies to protected real property to the extent an heir or devisee of the estate of the individual owns the protected property or an interest in the protected property in the individual's own name when the individual sells it. Paragraph (a) does not apply to any of the heirs, successors, assigns, or transferees of those individuals.

Subd. 16. **Burden of proof.** Any individual or the personal representative of the individual's estate who asserts that an asset is a disregarded or protected asset under this section in connection with any determination of eligibility for benefits under the medical assistance program or any appeal, case, controversy, or other proceedings, shall have the initial burden of:

(1) documenting and proving by convincing evidence that the asset or source of funds for the asset in question was designated as disregarded or protected;

(2) tracing the asset and the proceeds of the asset from that time forward; and

(3) documenting that the asset or proceeds of the asset remained disregarded or protected at all relevant times.

EFFECTIVE DATE. This section is effective July 1, 2006."

Amend the title accordingly