SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 2457

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DATE	D-PG	OFFICIAL STATUS
03/13/2025	755	Introduction and first reading Referred to Commerce and Consumer Protection
04/02/2025	1274a	Comm report: To pass as amended and re-refer to Judiciary and Public Safety
04/03/2025	1355	Author added Seeberger

A bill for an act

relating to insurance; authorizing certain data calls; providing for and regulating limited long-term care insurance; classifying certain data; authorizing administrative rulemaking; providing penalties; making technical changes; amending Minnesota Statutes 2024, section 45.027, subdivisions 1, 2, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62A.

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

Section 1. Minnesota Statutes 2024, section 45.027, subdivision 1, is amended to read:

Subdivision 1. **General powers.** (a) In connection with the duties and responsibilities entrusted to the commissioner, and Laws 1993, chapter 361, section 2, the commissioner of commerce may:

(1) make public or private investigations within or without this state as the commissioner considers necessary to determine whether any person has violated or is about to violate any law, rule, or order related to the duties and responsibilities entrusted to the commissioner;

(2) require or permit any person to file a statement in writing, under oath or otherwise as the commissioner determines, as to all the facts and circumstances concerning the matter being investigated;

(3) hold hearings, upon reasonable notice, in respect to any matter arising out of the duties and responsibilities entrusted to the commissioner;

(4) conduct investigations and hold hearings for the purpose of compiling information related to the duties and responsibilities entrusted to the commissioner;

(5) examine the books, accounts, records, and files of every licensee, and of every person who is engaged in any activity regulated; the commissioner or a designated representative

shall have free access during normal business hours to the offices and places of business of the person, and to all books, accounts, papers, records, files, safes, and vaults maintained in the place of business;

(6) publish information which is contained in any order issued by the commissioner;

(7) require any person subject to duties and responsibilities entrusted to the commissioner, to report all sales or transactions that are regulated. The reports must be made within ten days after the commissioner has ordered the report. The report is accessible only to the respondent and other governmental agencies unless otherwise ordered by a court of competent jurisdiction; ~~and~~

(8) assess a natural person or entity subject to the jurisdiction of the commissioner the necessary expenses of the investigation performed by the department when an investigation is made by order of the commissioner. The cost of the investigation shall be determined by the commissioner and is based on the salary cost of investigators or assistants and at an average rate per day or fraction thereof so as to provide for the total cost of the investigation. All money collected must be deposited into the general fund. A natural person or entity licensed under chapter 60K, 82, or 82B shall not be charged costs of an investigation if the investigation results in no finding of a violation. This clause does not apply to a natural person or entity already subject to the assessment provisions of sections 60A.03 and 60A.031~~.~~; and

(9) issue data calls.

(b) For purposes of this section, "data call" means a written request from the commissioner to two or more companies or persons subject to the commissioner's jurisdiction to provide data or other information within a reasonable time period for a targeted regulatory oversight purpose. A data call is not market analysis, as defined under section 60A.031, subdivision 4, paragraph (f), and is not subject to section 60A.033.

Sec. 2. Minnesota Statutes 2024, section 45.027, is amended by adding a subdivision to read:

Subd. 1b. **Data calls.** (a) Information provided in response to a data call issued by the commissioner or the commissioner's authorized representative: (1) must be treated as nonpublic data, as defined under section 13.02, subdivision 9; and (2) is not subject to subpoena. The commissioner may create and make public summary data derived from data classified as nonpublic under this paragraph.

(b) The commissioner may grant access to data submitted by insurers in response to a data call issued by the commissioner or the commissioner's authorized representative to the National Association of Insurance Commissioners (NAIC) if NAIC agrees in writing to hold the data as nonpublic data.

Sec. 3. Minnesota Statutes 2024, section 45.027, subdivision 2, is amended to read:

Subd. 2. **Power to compel production of evidence.** For the purpose of any investigation, hearing, proceeding, or inquiry related to the duties and responsibilities entrusted to the commissioner, the commissioner or a designated representative may issue data calls, administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of books, papers, correspondence, memoranda, agreements, or other documents or records that the commissioner considers relevant or material to the inquiry.

A subpoena issued pursuant to this subdivision must state that the person to whom the subpoena is directed may not disclose the fact that the subpoena was issued or the fact that the requested records have been given to law enforcement personnel except:

(1) insofar as the disclosure is necessary to find and disclose the records; or

(2) pursuant to court order.

Sec. 4. **[62A.481] LIMITED LONG-TERM CARE INSURANCE.**

Subdivision 1. **Short title.** This section may be known and cited as the "Limited Long-Term Care Insurance Act."

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Applicant" means:

(1) in the case of an individual limited long-term care insurance policy, the person who seeks to contract for benefits; or

(2) in the case of a group limited long-term care insurance policy, the proposed certificate holder.

(c) "Certificate" means a certificate issued under a group limited long-term care insurance policy that has been delivered or issued for delivery in Minnesota.

(d) "Commissioner" means the commissioner of commerce.

(e) "Elimination period" means the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer.

(f) "Group limited long-term care insurance" means a limited long-term care insurance policy that is delivered or issued for delivery in Minnesota and issued to:

(1) one or more employers or labor organizations, a trust or the trustees of a fund established by one or more employers, labor organizations, or a combination of employers and labor organizations for: (i) employees, former employees, or a combination of employees or former employees; or (ii) members, former members, or a combination of members or former members of the labor organizations;

(2) a professional, trade, or occupational association for the association's members, former members, retired members, or a combination of members, former members, or retired members, if the association:

(i) is composed of individuals, all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance;

(3) an association, a trust, or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within Minnesota, the association or associations, or the insurer of the association or associations, must file evidence with the commissioner that the association or associations have at the outset: (i) a minimum of 100 persons; (ii) been organized and maintained in good faith for purposes other than obtaining insurance; (iii) been in active existence for at least one year; and (iv) a constitution and bylaws that provide:

(A) the association or associations hold regular meetings not less than annually to further purposes of the members;

(B) except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) the members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association or associations are deemed to satisfy the organizational requirements unless the commissioner makes a finding that the association or associations do not satisfy the organizational requirements; or

(4) a group other than a group described in clauses (1) to (3), subject to the commissioner finding that:

(i) issuing the policy is not contrary to the public interest;

(ii) issuing the policy results in acquisition or administrative economies; and

(iii) the policy's benefits are reasonable in relation to the premiums charged.

(g) "Limited long-term care insurance" means an insurance policy or rider:

(1) issued by: (i) an insurer; (ii) a fraternal benefit society; (iii) a nonprofit health, hospital, or medical service corporation; (iv) a prepaid health plan; (v) a health maintenance organization; or (vi) a similar organization, to the extent the organization is authorized to issue life or health insurance;

(2) advertised, marketed, offered, or designed to provide coverage for less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis; and

(3) for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than a hospital's acute care unit.

Limited long-term care insurance includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Limited long-term care insurance does not include an insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(h) "Policy" means a policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in Minnesota by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization; or any similar organization.

(i) "Waiting period" means the time an insured individual must wait before some or all of the insured individual's coverage becomes effective.

Subd. 3. **Scope.** (a) This section applies to policies delivered or issued for delivery in Minnesota on or after January 1, 2026. This section does not supersede an obligation that an entity subject to this section has to comply with other applicable insurance laws to the

extent the other insurance laws do not conflict with this section, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies must not be applied to limited long-term care insurance.

(b) Notwithstanding any other provision of this section, a product, policy, certificate, or rider advertised, marketed, or offered as limited long-term care insurance is subject to this section.

Subd. 4. **Group limited long-term care insurance; extra-territorial jurisdiction.** Group limited long-term care insurance coverage must not be offered to a Minnesota resident under a group policy issued in another state to a group described in subdivision 2, paragraph (f), clause (4), unless Minnesota or another state having statutory and regulatory limited long-term care insurance requirements substantially similar to those adopted in Minnesota makes a determination that the statutory and regulatory limited long-term care insurance requirements have been met.

Subd. 5. **Limited long-term care insurance; disclosure and performance standards.** (a) A limited long-term care insurance policy must not:

(1) cancel, not renew, or otherwise terminate on the basis of the insured individual's or certificate holder's age, gender, or deterioration of mental or physical health;

(2) contain a provision that establishes a new waiting period in the event existing coverage is converted to or replaced by a new or other form of coverage within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) provide coverage for only skilled nursing care or provide significantly more coverage for skilled nursing care in a facility than coverage provided for lower levels of care.

(b) A limited long-term care insurance policy or certificate issued to a group identified in subdivision 2, paragraph (f), clauses (2) to (4), is prohibited from: (1) using a definition for preexisting condition that is more restrictive than or excludes a condition for which medical advice or treatment was recommended by or received from a health care services provider within the six months preceding the date an insured individual's coverage is effective; and (2) excluding coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months of the date an insured individual's coverage is effective. The commissioner may extend the limitation periods established in clauses (1) and (2) with respect to specific age group categories in specific policy forms upon a finding that the extension is in the public interest. The definition of preexisting condition required under clause (1) does not prohibit an insurer from using

an application form designed to elicit the complete health history of an applicant and, on the basis of the applicant's answers on the application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, an insurer is not required to cover a preexisting condition, regardless of whether the preexisting condition is disclosed on the application, until the waiting period under clause (2) expires. A limited long-term care insurance policy or certificate is prohibited from excluding or using waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period established in clause (2).

(c) A limited long-term care insurance policy must not be delivered or issued for delivery in Minnesota if the policy conditions eligibility: (1) for any benefits, on a prior hospitalization requirement; (2) for benefits provided in an institutional care setting, on the receipt of a higher level of institutional care; or (3) for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits, on a prior institutionalization requirement. A limited long-term care insurance policy, certificate, or rider is prohibited from conditioning eligibility for noninstitutional benefits on the prior or continuing receipt of skilled care services.

(d) The commissioner may adopt administrative rules that establish loss ratio standards for limited long-term care insurance policies if a specific reference to limited long-term care insurance policies is contained in the administrative rule.

(e) A limited long-term care insurance applicant has the right to: (1) return the policy, certificate, or rider to the company or the company's agent or insurance producer within 30 days of the date the policy, certificate, or rider is received; and (2) have the premium refunded if, after examination of the policy, certificate, or rider, the applicant is not satisfied with the policy, certificate, or rider for any reason.

(f) A limited long-term care insurance policy, certificate, or rider must have a notice prominently printed on the first page or attached to the policy, certificate, or rider that includes specific instructions for a limited long-term care insurance applicant to return a policy, certificate, or rider under paragraph (e). The following statement or a substantially similar statement must be included with the instructions:

"You have 30 days from the date you receive this policy, certificate, or rider to review and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide to not keep the policy, certificate, or rider, simply return it to the company at the company's administrative office, or you may return it to the

agent or insurance producer that you bought it from. You must return the policy, certificate, or rider within 30 days of the date you first received it. The company must refund the full amount of any premium paid within 30 days of the date the company receives the returned policy, certificate, or rider. The premium refund is sent directly to the person who paid it. A returned policy, certificate, or rider is void, as if it never was issued."

This paragraph does not apply to certificates issued pursuant to a policy issued to a group defined in subdivision 2, paragraph (f), clause (1).

(g) A coverage outline must be delivered to a prospective applicant for limited long-term care insurance at the time an initial solicitation is made, using a means that prominently directs the recipient's attention to the coverage outline and the coverage outline's purpose. The commissioner must prescribe: (1) a standard format, including style, arrangement, and overall appearance; and (2) the content that must be contained on a coverage outline. With respect to an agent solicitation, the agent must deliver the coverage outline before presenting an application or enrollment form. With respect to a direct response solicitation, the coverage outline must be provided in conjunction with an application or enrollment form. Delivery of a coverage outline is not required for a policy issued to a group defined in subdivision 2, paragraph (f), clause (1), if the information described in paragraph (h) is contained in other materials relating to enrollment. A copy of the other materials must be made available to the commissioner upon request.

(h) The coverage outline provided under paragraph (g) must include:

(1) a description of the principal benefits and coverage provided in the policy;

(2) a description of the eligibility triggers for benefits and how the eligibility triggers are met;

(3) a statement identifying the principal exclusions, reductions, and limitations contained in the policy;

(4) a statement describing the terms under which the policy, certificate, or both may be continued in force or discontinued, including any reservation in the policy of a right to change premium. A continuation or conversion provision for group coverage must be specifically described;

(5) a statement indicating that coverage outline is a summary only and not an insurance contract, and that the policy or group master policy contains the governing contractual provisions;

(6) a description of the terms under which the policy or certificate may be returned and premium refunded;

(7) a brief description of the relationship between cost of care and benefits; and

(8) a statement that discloses to the policyholder or certificate holder that the policy is not long-term care insurance.

(i) A certificate issued pursuant to a group limited long-term care insurance policy that is delivered or issued for delivery in Minnesota must include:

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement identifying the principal exclusions, reductions, and limitations contained in the policy; and

(3) a statement indicating that the group master policy determines governing contractual provisions.

(j) If an application for a limited long-term care insurance contract or certificate is approved, the issuer must deliver the contract or certificate of insurance to the applicant no later than 30 days after the date the application is approved.

(k) If a claim under a limited long-term care insurance contract is denied, the issuer must, within 60 days of the date the policyholder, certificate holder, or a representative of the policyholder or certificate holder submits a written request:

(1) provide a written explanation detailing the reasons for the denial; and

(2) make available all information directly related to the denial.

(l) A disclosure, statement, or written information and explanation required in this section, whether in print or electronic form, must accommodate the communication needs of individuals with disabilities and persons with limited English proficiency, as required by law.

Subd. 6. **Incontestability period.** (a) An insurer may (1) rescind a limited long-term care insurance policy or certificate, or (2) deny an otherwise valid limited long-term care insurance claim, for a policy or certificate that has been in force for less than six months upon a showing of misrepresentation that is material to the coverage acceptance.

(b) An insurer may (1) rescind a limited long-term care insurance policy or certificate, or (2) deny an otherwise valid limited long-term care insurance claim, for a policy or certificate that has been in force for at least six months but less than two years upon a

showing of misrepresentation that is both material to the coverage acceptance and that pertains to the condition for which benefits are sought.

(c) A policy or certificate that has been in force for two years is not contestable upon the grounds of misrepresentation alone. A policy or certificate that has been in force for two years may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured individual's health.

(d) A limited long-term care insurance policy or certificate may be field issued if compensation to the field issuer is not based on the number of policies or certificates issued. For purposes of this paragraph, "field issued" means a policy or certificate issued by a producer or a third-party administrator (1) pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer, and (2) using the insurer's underwriting guidelines.

(e) If an insurer paid benefits under the limited long-term care insurance policy or certificate, the benefit payments are not recoverable by the insurer if the policy or certificate is rescinded.

Subd. 7. **Nonforfeiture benefits.** (a) A limited long-term care insurance policy may offer the option to purchase a policy or certificate that includes a nonforfeiture benefit. A nonforfeiture benefit may be offered in the form of a rider that is attached to the policy. If the policyholder or certificate holder does not purchase the nonforfeiture benefit, the insurer must provide a contingent benefit upon lapse that must be available for a specified period of time after a substantial increase in premium rates, as determined by the commissioner under paragraph (c).

(b) When a group limited long-term care insurance policy is issued, a nonforfeiture benefit offer must be made to the group policyholder. If the policy is issued as group limited long-term care insurance, as defined in subdivision 2, paragraph (f), clause (4), to an entity other than a continuing care retirement community or other similar entity, a nonforfeiture benefit offer must be made to each proposed certificate holder.

(c) The commissioner must adopt administrative rules that specify: (1) the type or types of nonforfeiture benefits that must be offered as part of limited long-term care insurance policies and certificates; (2) the standards for nonforfeiture benefits; and (3) requirements regarding contingent benefit upon lapse, including determining the specified period of time during which a contingent benefit upon lapse is available and the substantial premium rate increase that triggers a contingent benefit upon lapse, as described in paragraph (a).

Subd. 8. **Administrative rulemaking.** (a) The commissioner must adopt reasonable administrative rules to: (1) promote premium adequacy; (2) protect a policyholder in the event of a substantial rate increase; and (3) establish minimum standards for producer education, marketing practices, producer compensation, producer testing, independent review of benefit determinations, penalties, and reporting practices for limited long-term care insurance.

(b) Administrative rules adopted under this section are subject to chapter 14.

Subd. 9. **Severability.** If any provision of this section or the application of the provision to any person or circumstance is held invalid for any reason, the remainder of the section and the application of the invalid provision to other persons or circumstances is not affected.

Subd. 10. **Penalties.** In addition to any other penalties provided by the laws of Minnesota, an insurer or producer that violates any requirement under this section or other law relating to the regulation of limited long-term care insurance or the marketing of limited long-term care insurance is subject to a fine of up to three times the amount of commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

EFFECTIVE DATE. This section is effective January 1, 2026.