SENATE
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03/12/2026	6665	Introduction and first reading Referred to Commerce and Consumer Protection
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A bill for an act

relating to insurance; establishing a supplemental health insurance product to cover short-term home health and nursing care; providing civil penalties; amending Minnesota Statutes 2024, sections 62A.135, subdivision 1; 62A.46, subdivision 2; 72A.13, subdivision 1; 256B.0913, subdivision 4; 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 62A.135, subdivision 1, is amended to read:

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

~~(a)~~ (1) "fixed indemnity policy" is a policy form, other than an accidental death and dismemberment policy, a disability income policy, or a long-term care policy as defined in section 62A.46, subdivision 2, that pays a predetermined, specified, fixed benefit for services provided. Fixed indemnity policy includes short-term home health and nursing care insurance under section 62A.70. Claim costs under these forms are generally not subject to inflation, although they may be subject to changes in the utilization of health care services. For policy forms providing both expense-incurred and fixed benefits, the policy form is a fixed indemnity policy if 50 percent or more of the total claims are for predetermined, specified, fixed benefits;

~~(b)~~ (2) "guaranteed renewable" means that, during the renewal period (to a specified age) renewal cannot be declined nor coverage changed by the insurer for any reason other than nonpayment of premiums, fraud, or misrepresentation, but the insurer can revise rates on a class basis upon approval by the commissioner;

~~(c)~~ (3) "noncancelable" means that, during the renewal period (to a specified age) renewal cannot be declined nor coverage changed by the insurer for any reason other than nonpayment of premiums, fraud, or misrepresentation and that rates cannot be revised by the insurer. This includes policies that are guaranteed renewable to a specified age, such as 60 or 65, at guaranteed rates; and

~~(d)~~ (4) "average annualized premium" means the average of the estimated annualized premium per covered person based on the anticipated distribution of business using all significant criteria having a price difference, such as age, sex, amount, dependent status, mode of payment, and rider frequency. For filing of rate revisions, the amount is the anticipated average assuming the revised rates have fully taken effect.

Sec. 2. Minnesota Statutes 2024, section 62A.46, subdivision 2, is amended to read:

Subd. 2. **Long-term care policy.** (a) "Long-term care policy" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for prescribed long-term care, including nursing facility services or home care services, or both nursing facility services and home care services, pursuant to the requirements of sections 62A.46 to 62A.56. Long-term care policy does not include short-term home health and nursing care insurance under section 62A.70.

(b) Sections 62A.46, 62A.48, and 62A.52 to 62A.56 do not apply to a long-term care policy issued to ~~(a)~~ (1) an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage or ~~(b)~~ (2) to a labor union or similar employee organization. ~~The associations exempted from the requirements of sections 62A.3099 to 62A.44 under 62A.31, subdivision 1, clause (c) shall not be subject to the provisions of sections 62A.46 to 62A.56 until July 1, 1988.~~

Sec. 3. **[62A.70] SHORT-TERM HOME HEALTH AND NURSING CARE INSURANCE.**

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

(b) "Activities of daily living" has the meaning given in section 62S.01, subdivision 2.

(c) "Cognitive impairment" has the meaning given in section 62S.01, subdivision 9.

(d) "Free-look period" means a period with a duration of at least 30 days, beginning the date the policy, certificate, contract, or other evidence of coverage is issued and delivered

to the insured, during which an insured may cancel the policy, certificate, contract, or other evidence of coverage and receive a full refund of all paid insurance premiums.

(e) "Home health agency" has the meaning given in section 62A.46, subdivision 10.

(f) "Insured" means a person covered under a short-term home health and nursing care insurance policy.

(g) "Nursing facility" has the meaning given in section 62A.46, subdivision 3.

(h) "Plan of care" has the meaning given in section 62A.46, subdivision 8.

(i) "Qualified insurer" means an entity licensed under chapter 62A or 62C.

(j) "Short-term home health and nursing care insurance" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for short-term home health services or short-term nursing care services. Short-term home health and nursing care insurance does not include:

(1) a long-term care policy, as defined in section 62A.46, subdivision 2;

(2) long-term care insurance, as defined in section 62S.01, subdivision 18;

(3) Medicare supplement policies, as defined in section 62A.3099, subdivision 18; or

(4) major medical, disability income, or hospital confinement indemnity policies.

(k) "Short-term home health services" means one or more of the following services to care for and treat an insured that are provided by a home health agency in a noninstitutional setting pursuant to a written diagnosis or assessment and plan of care:

(1) nursing and related personal care services under the direction of a registered nurse, including the services of a home health aide;

(2) physical therapy;

(3) speech therapy;

(4) respiratory therapy;

(5) occupational therapy;

(6) nutritional services provided by a licensed dietitian;

(7) homemaker services, meal preparation, and similar nonmedical services;

(8) medical social services; and

(9) other similar medical services and health-related support services.

(l) "Short-term nursing care services" means services to care for and treat an insured that are provided by a nursing facility pursuant to a written diagnosis or assessment and plan of care.

(m) "Waiting period" means a specified time period that an insured must wait before some or all of the insured's coverage becomes effective.

Subd. 2. **Short-term home health and nursing care insurance approval.** (a) A qualified insurer may offer, issue, deliver, and renew short-term home health and nursing care insurance if the insurance meets the requirements of this section.

(b) Short-term home health and nursing care insurance may be offered, issued, delivered, or renewed only by a qualified insurer.

(c) Short-term home health and nursing care insurance must not be offered, issued, delivered, or renewed until the short-term home health and nursing care insurance is approved by the commissioner as necessary under sections 62A.02 and 62A.135.

Subd. 3. **Policy requirements.** (a) Short-term home health and nursing care insurance must provide benefits upon:

(1) cognitive impairment; or

(2) the insured's inability to perform at least two activities of daily living without substantial assistance.

(b) Short-term home health and nursing care insurance must not provide coverage for a period exceeding 360 days.

(c) Short-term home health and nursing care insurance must provide a free-look period.

(d) Short-term home health and nursing care insurance must not be canceled due to an insured's deterioration in health status or use of benefits.

(e) An insurer may deny the renewal of a policy, certificate, contract, or other evidence of coverage of short-term home health and nursing care insurance only for:

(1) nonpayment of a premium by the insured;

(2) fraud or misrepresentation by the insured;

(3) termination of the insurer's authority to transact business in the state; or

(4) the insured's exhaustion of the maximum benefit period.

(f) Upon the conversion or replacement by an insurer of a policy, certificate, contract, or other evidence of coverage containing a waiting period, the insurer is prohibited from establishing a waiting period that differs from the original waiting period.

Subd. 4. **Required disclosures.** Short-term home health and nursing care insurance must not be offered or issued without providing the following written disclosures:

(1) a statement, in bold text, that the policy, certificate, contract, or other evidence of coverage is supplemental health insurance; is not long-term care insurance; and is not a policy under the Minnesota partnership for long-term care program;

(2) a clear and understandable explanation of the free-look period; and

(3) a clear and understandable explanation of all renewability and continuity provisions.

Sec. 4. Minnesota Statutes 2024, section 72A.13, subdivision 1, is amended to read:

Subdivision 1. **Penalties.** Any company, corporation, association, society, or other insurer, or any officer or agent thereof, which or who solicits, issues or delivers to any person in this state any policy in violation of the provisions of sections 60A.06, subdivision 3 ~~or~~, 62A.01 to 62A.10, or 62A.70 may be punished by a fine of not more than $200 for each offense, and the commissioner may revoke the license of any company, corporation, association, society, or other insurer of another state or country, or of the agent thereof, which or who willfully violates any provision of sections 60A.06, subdivision 3 ~~or~~, 62A.01 to 62A.10, or 62A.70.

Sec. 5. Minnesota Statutes 2024, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person is a citizen of the United States or a United States national;

(2) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 26, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

(4) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(5) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(6) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance. For purposes of this clause, short-term home health and nursing care insurance under section 62A.70 does not constitute health or other third-party insurance;

(7) except for individuals described in clause (8), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256S.04, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(8) for individuals assigned a case mix classification A as described under section 256S.18, with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (7) for case mix classification A;

(9) the person is making timely payments of the assessed monthly fee. A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments; and

(10) for a person participating in consumer-directed community supports, the person's monthly service limit must be equal to the monthly service limits in clause (7), except that a person assigned a case mix classification L must receive the monthly service limit for case mix classification A.

(b) The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(c) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(d) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(e) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256S.05, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care

eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.