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Introduced by Reps. Zelenko, Kathleen Law, Byrum, Angerer, Spade, Williams, Bennett, Waters, Gillard, Gleason, Clack, Plakas, Donigan, Anderson, Vagnozzi, Leland, Miller, Murphy, Hopgood, Alma Smith, Sak, Meisner, Condino, Sheltrown, McDowell, Byrnes, Kolb, Bieda, Tobocman, Newell, Vander Veen, Green, Garfield, Polidori, Kehrl, Brown and Lemmons, III

ENROLLED HOUSE BILL No. 5349

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 1204a, 1204c, 3915, 3927, 3935, and 3942 (MCL 500.1204a, 500.1204c, 500.3915, 500.3927, 500.3935, and 500.3942), section 1204a as amended by 1987 PA 64, section 1204c as amended by 2006 PA 109, and sections 3915, 3927, 3935, and 3942 as added by 1992 PA 84, and by adding sections 1204f, 3906, 3910, 3910a, 3910b, 3925, 3926, 3926a, and 3941a.

The People of the State of Michigan enact:

Sec. 1204a. (1) To qualify as a registered insurance agent program of study, the program of study shall meet all of the following criteria:

(a) Be conducted through an educational institution offering home study courses that has been in existence for not less than 5 years, by an insurance trade association, by an authorized insurer as provided in subsection (2), or by an educational institution listed in the state board of education directory of institutions of higher learning.

(b) Except as provided in subsection (2), provide for a minimum number of hours of classroom instruction or its equivalent in home study or online courses as follows:

(*i*) In the case of a program of study for health insurance agents, 14 hours of instruction on the principles of health insurance and 6 hours of instruction on the requirements of the insurance laws of this state.

(*ii*) In the case of a program of study for life insurance agents, 20 hours of instruction on the principles of life insurance and 6 hours of instruction on the requirements of the insurance laws of this state.

(*iii*) In the case of a combined program of study for life and health insurance agents, 14 hours of instruction on the principles of health insurance, 20 hours of instruction on the principles of life insurance, and 6 hours of instruction on the requirements of the insurance laws of this state.

(*iv*) In the case of a program of study for property and casualty insurance agents and solicitors, 12 hours of instruction on the principles of property insurance, 6 hours of instruction on the requirements of the insurance laws of this state, and 22 hours of instruction on the principles of liability insurance.

(c) Include instruction in ethical practices in the marketing and selling of insurance.

(d) Instruction shall be given only by individuals who meet the qualifications required by the commissioner. The commissioner, after consulting the insurance agent education advisory council, shall promulgate rules prescribing the criteria which must be met by a person in order to render instruction in a registered insurance agent program of study.

(2) An authorized insurer may conduct that portion of the minimum number of hours of instruction under subsection (1) as the commissioner deems appropriate. Any combination of classroom, online, or self-study hours may be used in satisfying the minimum number of hours of instruction under subsection (1).

(3) The commissioner shall promulgate rules prescribing the subject matter that a program of study must possess to qualify for registration under this section.

(4) The commissioner may make recommendations for improvements in course materials as deemed necessary by the commissioner. The commissioner may, after notice and opportunity for a hearing, withdraw the registration of a program of study which does not maintain reasonable standards as determined by the commissioner for the protection of the public.

Sec. 1204c. (1) As used in this section:

(a) "Hour" means a period of time of not less than 50 minutes.

(b) "Insurance producer" means a life-health agent or property-casualty agent.

(c) "Life-health agent" means a resident or nonresident individual insurance producer licensed for life, limited life, mortgage redemption, accident and health, or any combination thereof.

(d) "Property-casualty agent" means a resident or nonresident individual insurance producer or solicitor licensed for automobile, fire, multiple lines, any limited or minor property and casualty line, or any combination thereof.

(2) Unless the insurance producer has renewed his or her license pursuant to subsection (4), an insurance producer's hours of study accrued under this section shall be reviewed for license continuance as follows:

(a) If the insurance producer's license number ends in "1" as follows:

(*i*) If the insurance producer's last name starts with A to L, on January 1, 1995 and on January 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on January 1, 1996 and on January 1 every 2 years thereafter.

(b) If the insurance producer's license number ends in "2" as follows:

(*i*) If the insurance producer's last name starts with A to L, on February 1, 1995 and on February 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on February 1, 1996 and on February 1 every 2 years thereafter.

(c) If the insurance producer's license number ends in "3" as follows:

(*i*) If the insurance producer's last name starts with A to L, on March 1, 1995 and on March 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on March 1, 1996 and on March 1 every 2 years thereafter.

(d) If the insurance producer's license number ends in "4" as follows:

(*i*) If the insurance producer's last name starts with A to L, on June 1, 1995 and on June 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on June 1, 1996 and on June 1 every 2 years thereafter.

(e) If the insurance producer's license number ends in "5" as follows:

(*i*) If the insurance producer's last name starts with A to L, on July 1, 1995 and on July 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on July 1, 1996 and on July 1 every 2 years thereafter.

(f) If the insurance producer's license number ends in "6" as follows:

(*i*) If the insurance producer's last name starts with A to L, on August 1, 1995 and on August 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on August 1, 1996 and on August 1 every 2 years thereafter.

(g) If the insurance producer's license number ends in "7" as follows:

(*i*) If the insurance producer's last name starts with A to L, on September 1, 1995 and on September 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on September 1, 1996 and on September 1 every 2 years thereafter.

(h) If the insurance producer's license number ends in "8" as follows:

(*i*) If the insurance producer's last name starts with A to L, on October 1, 1995 and on October 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on October 1, 1996 and on October 1 every 2 years thereafter.

(i) If the insurance producer's license number ends in "9" as follows:

(*i*) If the insurance producer's last name starts with A to L, on November 1, 1995 and on November 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on November 1, 1996 and on November 1 every 2 years thereafter.

(j) If the insurance producer's license number ends in "0" as follows:

(*i*) If the insurance producer's last name starts with A to L, on December 1, 1995 and on December 1 every 2 years thereafter.

(*ii*) If the insurance producer's last name starts with M to Z, on December 1, 1996 and on December 1 every 2 years thereafter.

(3) If an insurance producer's hours of study would be reviewed according to the schedule under subsection (2) within 23 months after issuance of the initial license, the hours shall not be reviewed on the first scheduled date following the issuance of the initial license and shall be reviewed on the next scheduled review date following the first review date according to the schedule under subsection (2), unless the insurance producer has renewed his or her license pursuant to subsection (4).

(4) Except as provided in subsections (11) to (14), before the review date of each applicable 2-year period provided for under subsection (2) or (3), an insurance producer wishing to renew his or her license shall renew his or her license by attending or instructing not less than 24 hours of continuing education classes approved by the commissioner or 24 hours of home study if evidenced by successful completion of course work approved by the commissioner. Of the 24 hours of continuing education required, not less than 3 hours shall be in ethics in insurance classes or course work.

(5) After reviewing recommendations made by the council under section 1204b, the commissioner shall approve a program of study if the commissioner determines that the program increases knowledge of insurance and related subjects as follows:

(a) For a life-health agent program of study, the program offers instruction in 1 or more of the following:

(*i*) The fundamental considerations and major principles of life insurance.

(*ii*) The fundamental considerations and major principles of health insurance.

(*iii*) Estate planning and taxation as related to insurance.

(*iv*) Industry and legal standards concerning ethics in insurance.

(*v*) Legal, legislative, and regulatory matters concerning insurance, the insurance code, and the insurance industry.

(*vi*) Principal provisions used in life insurance contracts, health insurance contracts, or annuity contracts and differences in types of coverages.

(*vii*) Accounting and actuarial considerations in insurance.

(*viii*) Principles of agency management, excluding telemarketing or other marketing instruction.

(*ix*) The fundamental considerations, major principles, and statutory requirements of long-term care insurance.

(b) For a property-casualty agent program of study, the program offers instructions in 1 or more of the following:

(*i*) The fundamental considerations and major principles of property insurance.

(*ii*) The fundamental considerations and major principles of casualty insurance.

(*iii*) Basic principles of risk management.

(*iv*) Industry and legal standards concerning ethics in insurance.

(*v*) Legal, legislative, and regulatory matters concerning insurance, the insurance code, and the insurance industry.

(*vi*) Principal provisions used in casualty insurance contracts, no-fault insurance contracts, or property insurance contracts and differences in types of coverages.

(*vii*) Accounting and actuarial considerations in insurance.

(*viii*) Principles of agency management, excluding telemarketing or other marketing instruction.

(6) A provider of a program of study for insurance producers applying for approval or reapproval from the commissioner under this section shall file, on a form provided by the commissioner, a description of the course of study including a description of the subject matter and course materials, hours of instruction, location of classroom, qualifications of instructors, and maximum student-instructor ratio and shall pay a nonrefundable $25.00 filing fee. Any material change in a program of study shall require reapproval by the commissioner. If the information in an application for approval or reapproval is insufficient for the commissioner to determine whether the program of study meets the requirements under subsection (5), the commissioner shall give written notice to the provider, within 15 days after the provider's filing of the application for approval or reapproval, of the additional information needed by the commissioner. An application for approval or reapproval shall be considered approved unless disapproved by the commissioner within 90 days after the application for approval or reapproval is filed, or within 90 days after the receipt of additional information if the information was requested by the commissioner, whichever is later.

(7) A provider of a program of study approved by the commissioner under this section shall pay a provider authorization fee of $500.00 for the first year the provider's program of study was approved under this section and a $100.00 provider renewal fee for each year thereafter that the provider offers the approved program of study.

(8) A person dissatisfied with an approved program of study may petition the commissioner for a hearing on the program or the commissioner on his or her own initiative may request a hearing on a program of study. If the commissioner finds the petition to have been submitted in good faith, that the petition if true shows the program of study does not satisfy the criteria in subsection (5), or that the petition otherwise justifies holding a hearing, the commissioner shall hold a hearing pursuant to chapter 4 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to 24.287, within 30 days after receipt of the petition and upon not less than 10 days' written notice to the petitioner and the provider of the program of study. If the commissioner requests a hearing on a program of study on his or her own initiative, the commissioner shall hold a hearing pursuant to chapter 4 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to 24.287, upon not less than 10 days' written notice to the provider of the program of study.

(9) If after a hearing under subsection (8) the commissioner finds that the program of study does not satisfy the requirements under subsection (5), the commissioner shall state, in a written order mailed first-class to the petitioner and provider of the program of study, his or her findings and the date upon which the commissioner will revoke approval of the program of study which date shall be within a reasonable time of the issuance of the order.

(10) A certificate of attendance or instruction of an approved program of study or a certificate of successful completion of course work shall be filed as directed by the commissioner on a form prescribed by the commissioner and shall indicate the name and number of the course of study, the number of hours, dates of completion, and the name and number of schools attended or taught by the insurance producer or the evidence of successful completion of course work. A representative of the approved program of study shall file the form and a fee of $1.00 per hour for course credit for each insurance producer license renewal as directed by the commissioner within 30 days after the insurance producer completes the program. A copy of the form shall also be mailed first-class to the insurance producer who attended, taught, or successfully completed the program of study. The commissioner may enter into contracts to provide for the administrative functions of this subsection.

(11) The commissioner shall waive the continuing education requirements of this section for an insurance producer if the producer is unable to comply with the continuing education requirements of this section due to military service

or if the commissioner determines that enforcement of the requirements would cause a severe hardship. The commissioner shall waive the continuing education requirements of this section for the following insurance producers:

(a) An insurance producer who is licensed to write only travel or baggage insurance policies and whose employment is for a purpose other than the sale of those policies.

(b) An insurance producer who is licensed to write only limited line credit insurance.

(12) The commissioner may enter into reciprocal continuing education agreements with insurance commissioners from other states.

(13) If an insurance producer has not met his or her continuing education requirements by the expiration date of his or her license, the insurance producer shall have a 90-day grace period in which to meet the continuing education requirements of this section. During the 90-day grace period, the insurance producer shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an insurance producer except that the insurance producer may continue to service policies previously sold and may receive commissions on policies previously sold. If the insurance producer has not met his or her continuing education requirements by the expiration of the 90-day grace period, the insurance producer's license shall be canceled. An insurance producer whose license has been canceled under this section may reapply for license to act as an insurance producer under section 1204, except that the program of study requirements under section 1204 shall not be waived.

(14) An insurance producer who has sold his or her insurance business and who has not met the continuing education requirements of this section shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an insurance producer except that the insurance producer may continue to service policies previously sold and may receive commissions on policies previously sold as well as receive partial commissions on policies of insurance sold by a purchasing insurance producer. An insurance producer who is in the process of selling his or her insurance business and who has not met the continuing education requirements of this section shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an insurance producer except that the insurance producer may continue to service policies previously sold and may receive commissions on policies previously sold as well as receive partial commissions on policies of insurance sold by a purchasing insurance producer, for a period not to exceed 12 months after the selling insurance producer's license review date under subsection (2). An insurance producer whose license has been canceled and who wishes to resume soliciting or selling new policies of insurance, bind coverage, or otherwise act as an insurance producer and who has not met the continuing education requirements within the immediately preceding 2-year period may reapply for license to act as an insurance producer under section 1204.

Sec. 1204f. (1) Each insurer that sells, solicits, or negotiates long-term care insurance shall ensure that each producer whose duties include selling, soliciting, or negotiating long-term care insurance completes a program of instruction as described in subsection (3) before selling, soliciting, or negotiating long-term care insurance.

(2) A program of instruction required under this section may be provided in conjunction with other producer training or separately. To satisfy subsection (1), a producer may document to an insurer that he or she has obtained training as described in subsection (3) from any of the following:

(a) Any insurer that sells, solicits, or negotiates long-term care insurance.

(b) A program of instruction qualified under section 1204a.

(c) A program of instruction qualified under section 1204c.

(3) A program of instruction required under this section shall consist of topics related to long-term care insurance and long-term care services, including, but not limited to, all of the following:

(a) State regulations and requirements, including, but not limited to, laws relating to adult financial exploitation.

(b) Available long-term care services and providers.

(c) Changes or improvements in long-term care services or providers.

(d) Alternatives to the purchase of private long-term care insurance.

(e) Differences in eligibility for benefits and tax treatment between policies intended to be federally qualified and those not intended to be federally qualified.

(f) The effect of inflation in eroding the value of benefits and the importance of inflation protection.

(g) Consumer suitability standards and guidelines.

(4) A program of instruction required under this section shall not include any training that is solely oriented to the sales or marketing of an insurer-specific long-term care product.

Sec. 3906. (1) An individual long-term care policy or certificate shall not be issued until the insurer has received from the applicant either a written designation of at least 1 person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant may designate at least

1 person who is to receive the notice of termination, in addition to the insured. A designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation shall provide space clearly designated for listing at least 1 person. The designation shall include each person's full name and home address. For an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least 1 person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every 2 years.

(2) If the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, subsection (1) does not apply until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) An individual long-term care policy or certificate shall not lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under subsection (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, and notice shall not be given until 30 days after a premium is due and unpaid. Notice shall be considered given 5 days after the date of mailing.

(4) A long-term care insurance policy or certificate shall provide for reinstatement of coverage if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

(5) This section takes effect March 1, 2007 and applies to long-term care policies and certificates issued on or after March 1, 2007.

Sec. 3910. (1) This section does not apply to life insurance policies or riders containing accelerated benefits for long-term care.

(2) Except as provided in subsection (3), a long-term care insurance policy shall not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. An offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder or certificateholder. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(3) When a group long-term care insurance policy is issued, the offer required in subsection (2) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in section 3901(c)(*iv*), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

Sec. 3910a. (1) This section does not apply to life insurance policies or riders containing accelerated benefits for long-term care.

(2) A policy or certificate offered with nonforfeiture benefits shall 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 shall be the benefits described in subsection (8).

(3) If the offer required to be made under section 3910 is rejected, the insurer shall provide a contingent benefit upon lapse as described in this section for individual and group policies without nonforfeiture benefits issued on and after June 1, 2007.

(4) If a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(5) Except as otherwise required, policyholders shall be notified not less than 45 days before the due date of a premium increase and of the amount of the increase.

(6) The contingent benefit on lapse is triggered every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial

annual premium as follows based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased:

TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(7) On or before the effective date of a substantial premium increase as defined in subsection (6), the insurer shall do all of the following:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period as provided in subsection (8). This option may be elected at any time during the 120-day period under subsection (6).

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period under subsection (6) is considered to be the election of the offer to convert under subdivision (b).

(8) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are as follows:

(a) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least 1% per year prior to age 50 and at least 3% per year beyond age 50.

(b) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as provided in subdivision (c). As used in this subdivision, "same benefits" means amounts and frequency in effect at the time of lapse but not increased thereafter.

(c) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (9).

(d) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first 3 years as well as thereafter. However, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of the end of the tenth year following the policy or certificate issue date or the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(9) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium paying status.

(10) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(11) This section is effective June 1, 2007 and shall apply as follows:

(a) Except as otherwise provided in subdivision (b), this section applies to any long-term care policy issued in this state on or after June 1, 2007.

(b) This section does not apply to certificates issued on or after June 1, 2007, under a group long-term care insurance policy as defined in section 3901(c)(*i*), which policy was in force at the time this section became effective.

(12) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of section 3926a treating the policy as a whole.

(13) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (6), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(14) For qualified long-term care insurance contracts that are level premium contracts, an insurer shall offer a nonforfeiture benefit that meets all of the following:

(a) Is appropriately captioned.

(b) Provides a benefit available in the event of a default in the payment of any premiums and states that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form.

(c) Provides at least 1 of the following:

(*i*) Reduced paid-up insurance.

(*ii*) Extended term insurance.

(*iii*) Shortened benefit period.

(*iv*) Other offerings approved by the commissioner that are similar to subparagraphs (*i*) to (*iii*).

Sec. 3910b. (1) A long-term care insurance policy or certificate shall provide that a policyholder or certificateholder who wishes to reduce coverage and lower the policy or certificate premium may choose at least 1 of the following options:

(a) Reducing the lifetime maximum benefit.

(b) Reducing the daily, weekly, or monthly benefit amount.

(2) In addition to the reduction options listed in subsection (1), a long-term care insurer may offer additional reduction options that are consistent with the policy or certificate design or the insurer's administrative processes.

(3) A long-term care insurer shall include in the long-term care insurance policy or certificate a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(4) The age to determine the premium for reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(5) A long-term care insurer may limit any reduction in coverage to plans available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(6) If a long-term care insurance policy or certificate is about to lapse, the insurer shall provide written notice to the insured of the options in subsection (1) to lower the premium by reducing coverage and of the premiums applicable to

the reduced coverage options. The insurer may include in the notice additional options to those required in subsection (1). The notice shall provide the insured at least 30 days in which to elect to reduce coverage, and the policy or certificate shall be reinstated without underwriting if the insured elects the reduced coverage.

(7) This section applies to long-term care policies and certificates issued on or after June 1, 2007.

Sec. 3915. A long-term care insurance policy sold before, on, or after June 2, 1992 shall not condition benefits on any of the following:

(a) The prior institutionalization of the insured.

(b) Prior receipt of a higher level of institutional care.

Sec. 3925. (1) Except as provided in subsection (2), this section applies to any long-term care policy or certificate issued in this state on or after June 1, 2007.

(2) For a long-term care certificate issued on or after June 1, 2007 under a group long-term care insurance policy described in section 3901(c)(*i*), which policy was in force on June 1, 2007, this section applies on the policy anniversary date following June 1, 2007.

(3) Other than long-term care policies or certificates for which no applicable premium rate or rate schedule increases can be made, an insurer shall provide on forms approved by the commissioner all of the following information to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, an insurer shall provide on forms approved by the commissioner all of the following information to the applicant no later than at the time of delivery of the policy or certificate:

(a) A statement that the policy may be subject to rate increases in the future.

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision.

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.

(d) A general explanation for applying premium rate or rate schedule adjustments that shall include a description of when premium rate or rate schedule adjustments will be effective and the right to a revised premium rate or rate schedule if the premium rate or rate schedule is changed.

(e) Information concerning each premium rate increase on the policy or certificate or similar policies or certificates over the past 10 years for this state or any other state that, at a minimum, identifies all of the following:

(*i*) The policies or certificates for which premium rates have been increased.

(*ii*) The calendar years when the policy or certificate was available for purchase.

(*iii*) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics. An insurer may exclude from this disclosure premium rate increases that only apply to blocks of business acquired from another nonaffiliated insurer or the long-term care policies or certificates acquired from another nonaffiliated insurer when those increases occurred prior to the acquisition. If an acquiring insurer files for a rate increase on a long-term care policy or certificate acquired from a nonaffiliated insurer or a block of policies or certificates acquired from a nonaffiliated insurer before the later of June 1, 2007 or the end of a 24-month period following the acquisition of the block of policies or certificates, the acquiring insurer may exclude that rate increase from this disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase as provided in subparagraph (*i*). If the acquiring insurer files for a subsequent rate increase, even within the 24-month period, on the same policy or certificate acquired from a nonaffiliated insurer or block of policies or certificates acquired from a nonaffiliated insurer, the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase.

(4) The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to that required under subsection (3).

(5) Except as otherwise provided in this subsection, an applicant shall sign an acknowledgment at the time of application that the insurer made the disclosure required under subsection (3). If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign an acknowledgment that the insurer made the disclosure required under subsection (3) no later than at the time of delivery of the policy or certificate.

(6) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (3) when the rate increase is implemented.

(7) A long-term care insurer shall provide to an applicant a long-term care insurance personal worksheet approved by the commissioner that the applicant can use for help in determining whether long-term care insurance should be purchased.

(8) A long-term care insurer shall provide to an applicant who is 60 years of age or older or who is disabled a current brochure, or the web address where the brochure can be obtained and the telephone number for the agency that can provide the brochure, from the state's medicare medicaid assistance program that contains information on the availability of free and independent insurance purchasing and public benefits counseling.

Sec. 3926. (1) This section applies to any long-term care policy or certificate issued in this state on or after June 1, 2007.

(2) An insurer shall provide all of the following information to the commissioner 30 days prior to making a long-term care insurance policy or certificate available for sale:

(a) A copy of the disclosure documents required in section 3925.

(b) An actuarial certification consisting of at least all of the following:

(*i*) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the policy or certificate with no future premium increases anticipated.

(*ii*) A statement that the policy or certificate design and coverage provided have been reviewed and taken into consideration.

(*iii*) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.

(*iv*) A complete description of the basis for contract reserves that are anticipated to be held under the policy or certificate, with sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held, a statement that the assumptions used for reserves contain reasonable margins for adverse experience, a statement that the net valuation premium for renewal years does not increase except for attained-age rating where permitted, and a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subsection (3) based on a standard age distribution.

(*v*) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policies or certificates also available from the insurer except for reasonable differences attributable to benefits or a comparison of the premium schedules for similar policies or certificates that are currently available from the insurer with an explanation of the differences.

(3) Prior to the expiration of the 30 days under subsection (2), the commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policies or certificates, adjusted for any premium or benefit differences, or relevant and credible data from other studies, or both. If the commissioner asks for this additional information, the 30-day time period under subsection (2) is tolled until the commissioner receives the requested information.

Sec. 3926a. (1) Except as provided in subsection (2), this section applies to any long-term care policy or certificate issued in this state on or after June 1, 2007.

(2) For certificates issued on or after June 1, 2007 under a group long-term care insurance policy described in section 3901(c)(*i*), which policy was in force on June 1, 2007, this section applies on the policy anniversary date following June 1, 2007.

(3) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days prior to the notice to the policyholders. This notice to the commissioner shall include all of the following:

(a) Information required by section 3925.

(b) Certification by a qualified actuary that if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated and that the premium rate filing is in compliance with the provisions of this section.

(c) An actuarial memorandum justifying the rate schedule change request that includes all of the following:

(*i*) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other policies or certificates currently available for sale. Annual values for the 5 years preceding and the 3 years following the valuation date shall be provided separately. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase. The projections shall demonstrate compliance with subsection (4). For exceptional increases, the projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and if the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience.

(*ii*) If the rate increase will trigger contingent benefit upon lapse, disclosure of how reserves have been incorporated in this rate increase.

(*iii*) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer have been relied on by the actuary.

(*iv*) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration.

(*v*) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates.

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner.

(e) Sufficient information for review and approval of the premium rate schedule increase by the commissioner.

(4) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits.

(b) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(*i*) The accumulated value of the initial earned premium times 58%.

(*ii*) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis.

(*iii*) The present value of future projected initial earned premiums times 58%.

(*iv*) Eighty-five percent of the present value of future projected premiums not in subparagraph (*iii*) on an earned basis.

(c) If a policy or certificate has both exceptional and other increases, the values in subdivision (b)(*ii*) and (*iv*) shall also include 70% for exceptional rate increase amounts.

(d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in section 733(1). The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(5) For each rate increase that is implemented, the insurer shall file for review and approval by the commissioner updated projections, as described in subsection (3)(c)(*i*), annually for the next 3 years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections. For group insurance certificates that meet the conditions in subsection (13), the projection required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(6) If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as described in subsection (3)(c)(*i*), shall be filed for review and approval by the commissioner every 5 years following the end of the required period in subsection (5). For group insurance certificates that meet the conditions in subsection (13), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(7) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (4), the commissioner may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (3)(c)(*iii*), if applicable.

(8) If the majority of the policies or certificates to which an increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file both of the following with the commissioner:

(a) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy or certificate requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect.

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (4) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsection (4)(b)(*i*) and (*iii*).

(9) The commissioner shall review, for all policies and certificates included in a filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated for any rate increase filing meeting the following criteria:

(a) The rate increase is not the first rate increase requested for the specific policy or certificate.

(b) The rate increase is not an exceptional increase.

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(10) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with 1 or more reasonably comparable products being offered by the insurer or its affiliates. An offer under this subsection is subject to the commissioner's approval, shall be based on actuarially sound principles, but shall not be based on attained age, and shall provide that maximum benefits under any new policy or certificate accepted by an insured shall be reduced by comparable benefits already paid under the existing policy or certificate. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy or certificate. If a rate increase is requested on the policy or certificate, the rate increase shall be limited to the lesser of the maximum rate increase determined based on the combined experience and the maximum rate increase determined based only on the experience of the insureds originally issued the policy or certificate plus 10%.

(11) If the commissioner determines that an insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner, in addition to the provisions of subsections (9) and (10), may prohibit the insurer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to 5 years.

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(12) Subsections (1) to (11) do not apply to policies or certificates for which the long-term care benefits provided by the policy or certificate are incidental, if the policy or certificate complies with all of the following:

(a) For any plan that may have a cash value, 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 or certificate.

(b) The portion of the policy or certificate that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in section 4060 or 4072.

(c) The policy or certificate meets sections 3928, 3933, 3951, and 3953.

(d) The portion of the policy or certificate that provides insurance benefits other than long-term care coverage meets, as applicable, the policy illustrations and disclosure requirements under section 4038.

(e) An actuarial memorandum is filed with the office of financial and insurance services that includes all of the following:

(*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 shall include percent of premium dollars per policy or certificate and dollars per unit of benefits, if any.

(*v*) A description and a table of the anticipated policy or certificate reserves and additional reserves to be held in each future year for active lives.

(*vi*) The estimated average annual premium per policy or certificate 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, shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. For a group certificate, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

(*viii*) A description of the effect of the long-term care policy or certificate provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy or certificate, both for active lives and those in long-term care claim status.

(13) Subsections (7), (8), and (9) do not apply to a group insurance policy described in section 3901(c)(*i*) if the policy insures 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer or the policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(14) Except as otherwise provided in this section, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent qualified actuary or

a professional qualified actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(15) As used in this section:

(a) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy or certificate as measured on the date of issue.

(c) "Qualified actuary" means a member in good standing of the American academy of actuaries.

(d) "Similar policies" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy or certificate being considered. Certificates of groups described in section 3901(c)(*i*) are not considered similar to policies or certificates otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policies, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

Sec. 3927. (1) Benefits under individual long-term care insurance policies shall be considered reasonable in relation to premiums provided the expected loss ratio is at least 60%, calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(a) Statistical credibility of incurred claims experience and earned premiums.

(b) The period for which rates are computed to provide coverage.

(c) Experienced and projected trends.

(d) Concentration of experience within early policy duration.

(e) Expected claim fluctuation.

(f) Experience refunds, adjustments, or dividends.

(g) Renewability features.

(h) All appropriate expense factors.

(i) Interest.

(j) Experimental nature of the coverage.

(k) Policy reserves.

(*l*) Mix of business by risk classification.

(m) Product features such as long elimination periods, high deductibles, and high maximum limits.

(n) Premiums charged and losses incurred for other similar policies.

(2) This section does not apply to fixed indivisible premium life insurance policies that fund long-term care benefits entirely by accelerating the death benefit.

(3) This section applies to all long-term care insurance policies or certificates except those described in sections 3926(1) and 3926a(1) and (2).

Sec. 3935. An application for a long-term care policy shall contain the following statement printed, stamped, or as part of a sticker permanently affixed to the application in capital letters on the first page:

"For additional information about long-term care coverage write to the office of financial and insurance services, P.O. Box 30220, Lansing, MI 48909 or call the area agency on aging in your community.".

Sec. 3941a. (1) This section does not apply to life insurance policies or riders containing accelerated benefits for long-term care.

(2) Every insurer or other entity marketing long-term care insurance shall do all of the following:

(a) 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.

(b) Train its producers in the use of and require producers to use its suitability standards.

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(d) To determine whether the applicant meets the developed suitability standards, the insurer shall make reasonable efforts to obtain all of the following information:

(*i*) The applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(*ii*) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(*iii*) 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.

(3) If the insurer determines that the applicant does not meet its suitability standards, or if the applicant has declined to provide the necessary information, the insurer may reject the application for long-term care insurance.

Sec. 3942. (1) Every insurer marketing long-term care insurance coverage in this state, directly or through its producers, shall do all of the following:

(a) Establish marketing procedures to assure that any comparison of policies by its producers or other producers are fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) 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.".

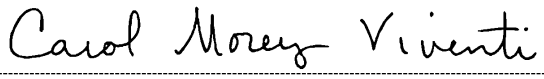
(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of such insurance.

(e) Establish auditable procedures for verifying compliance with this section.

(2) An insurer marketing long-term care insurance coverage in this state shall not use the term "level premium" or "noncancelable" unless the insurer does not have the right to change the premium for the product being marketed.

This act is ordered to take immediate effect.

Clerk of the House of Representatives



Secretary of the Senate

Approved _____

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Governor