THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

CHAPTER 39
LONG-TERM CARE INSURANCE

500.3901 Long-term care insurance; definitions.

Sec. 3901. As used in this chapter:

(a) "Acute condition" means that the individual is medically unstable, requiring frequent monitoring by medical professionals in order to maintain his or her health status.

(b) "Applicant" means:

(*i*) For an individual long-term care insurance policy, the person who seeks to contract for long-term care benefits.

(*ii*) For a group long-term care insurance certificate, the proposed certificate holder.

(c) "Group long-term care insurance" means a long-term care insurance certificate that is delivered or issued for delivery in this state and issued to any of the following:

(*i*) One or more employers or labor organizations, or to a trust or the trustees of a fund established by 1 or more employers or labor organizations for employees or former employees or members or former members of the labor organization.

(*ii*) A professional, trade, or occupational association for its members or former or retired members if the association is composed of individuals who were all actively engaged in the same profession, trade, or occupation and the association has been maintained in good faith for purposes other than obtaining insurance unless waived by the commissioner.

(*iii*) Subject to section 3903(2), an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of 1 or more associations.

(*iv*) A group other than that described in subparagraphs (*i*), (*ii*), or (*iii*) if the commissioner determines all of the following:

(A) The issuance of the group certificate is not contrary to the best interests of the public.

(B) The issuance of the group certificate would result in economies of acquisition or administration.

(C) The benefits are reasonable in relation to the premiums charged.

(d) "Guaranteed renewable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and the insurer does not have a unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(e) "Home care services" means 1 or more of the following prescribed services or assessment team recommended services for the long-term care and treatment of an insured that are to be provided in a noninstitutional setting according to a written diagnosis and plan of care or individual assessment and plan of care:

(*i*) Nursing services under the direction of a registered nurse, including the service of a home health aide.

(*ii*) Physical therapy.

(*iii*) Speech therapy.

(*iv*) Respiratory therapy.

(*v*) Occupational therapy.

(*vi*) Nutritional services provided by a registered dietitian.

(*vii*) Personal care services, homemaker services, adult day care, and similar nonmedical services.

(*viii*) Medical social services.

(*ix*) Other similar medical services and health-related support services.

(f) "Home health or care agency" means a person certified by medicare whose business is to provide to individuals in their places of residence other than in a hospital, nursing home, or county medical care facility, 1 or more of the following services: nursing services, therapeutic services, social work services, homemaker services, home health aide services, or other related services.

(g) "Intermediate care facility" means a facility, or distinct part of a facility, certified by the department of community health to provide intermediate care, custodial care, or basic care that is less than skilled nursing care but more than room and board.

(h) "Long-term care insurance" means an individual or group insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial

care services provided in a setting, including an assisted living facility operating legally in this state, but not including an acute care unit of a hospital. Long-term care insurance includes individual or group annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. Long-term care insurance does not include a life insurance policy that accelerates the death benefit specifically for 1 or more of the qualifying events of terminal illness or medical conditions requiring extraordinary medical intervention or permanent institutional confinement and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Long-term care insurance does not include an insurance policy offered primarily to provide coverage for rehabilitative and convalescent care and is not offered, advertised, or marketed as a long-term care policy, or offered primarily to provide basic medicare supplemental coverage, hospital confinement indemnity coverage, basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specific disease or specified accident coverage, or limited benefit health coverage.

(i) "Medicare" means title XVIII of the social security act, 42 USC 1395 to 1395ggg.

(j) "Nonprofit health care corporation" means a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(k) "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within the 6 months immediately before the effective date of coverage of an insured person.

(*l*) "Policy" means an insurance policy or certificate, rider, or endorsement delivered or issued for delivery in this state by an insurer or subsidiary of a nonprofit health care corporation.

(m) "Skilled nursing facility" means a facility, or a distinct part of a facility, certified by the department of community health to provide skilled nursing care.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 441, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3901a Long-term care insurance policies; discrimination against living donors; prohibition; definitions.

Sec. 3901a. (1) This section applies to all long-term care insurance policies or certificates delivered or issued for delivery after December 31, 2023.

(2) Unless there is an additional actuarial risk, as determined in accordance with sound actuarial principles as well as the individual's actual and reasonably anticipated experience, an insurer shall not do any of the following with respect to a long-term care insurance policy or certificate based solely on the individual's status as a living donor:

(a) Deny coverage.

(b) Cancel coverage.

(c) Refuse to issue the policy or certificate.

(d) Determine the price or premium for the policy or certificate.

(e) Otherwise vary a term or condition of the policy or certificate.

(3) As used in this section:

(a) "Living donor" means an individual who is not deceased and has donated any of the following:

(*i*) All or part of an organ.

(*ii*) A tissue.

(b) "Organ" means a human kidney, liver, heart, lung, pancreas, esophagus, stomach, or small or large intestine, a portion of the gastrointestinal tract, or another part of the human body designated by the department by rule.

(c) "Tissue" means a portion of the human body other than an organ, including, but not limited to, an eye, skin, bone, bone marrow, a heart valve, a spermatozoon, an ova, an artery, a vein, a tendon, a ligament, blood, blood derivatives, a pituitary gland, or fluid.

History: Add. 2023, Act 192, Imd. Eff. Nov. 7, 2023.

Popular name: Act 218

500.3902 Offer of long-term care coverage by subsidiary of health care corporation.

Sec. 3902. A nonprofit health care corporation shall only offer long-term care coverage through a subsidiary of the health care corporation and as provided in this chapter. If a health care corporation subsidiary offers long-term care coverage in this state, the sale of that coverage is not exempt from taxation by this state or any political subdivision of this state.

History: Add. 2006, Act 441, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3903 Group long-term care insurance; coverage offered to groups described in MCL 500.3901(c)(iv) and 500.3901(c)(iii).

Sec. 3903. (1) Group long-term care insurance coverage shall not be offered to a resident of this state under a group certificate issued in another state to a group described in section 3901(c)(*iv*), unless this state or another state which the commissioner determines has and enforces statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that those requirements have been met.

(2) Before advertising, marketing, or offering a group long-term care insurance certificate within this state to a group described in section 3901(c)(*iii*), the group or the insurer shall file evidence with the commissioner that the group meets all of the following requirements:

(a) Consists of at least 100 members.

(b) Has been in active existence for at least 1 year.

(c) Holds regular meetings at least annually.

(d) Except for credit unions, the group collects dues or solicits contributions from members.

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

(f) Has been organized and maintained in good faith for purposes other than obtaining insurance unless the commissioner waives this requirement.

(3) Thirty days after making the filing under this section, the group described in section 3901(c)(*iii*) shall be considered to satisfy subsection (2) organizational requirements, unless the commissioner makes a finding that the group does not satisfy those organizational requirements.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3905 Long-term care coverage; requirements; certain coverages requiring care recommendations.

Sec. 3905. (1) Long-term care coverage shall meet all of the following requirements:

(a) Shall include coverage for intermediate/basic care, which shall not be significantly less than the coverage provided for skilled nursing care.

(b) Shall not limit or exclude coverage by type of illness, type of provider, territorial limitations, treatment, medical condition, or accident other than a motor vehicle accident, except as follows:

(*i*) Preexisting conditions.

(*ii*) Mental or nervous disorders; however, this shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder and shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or related disorders.

(*iii*) Alcoholism or drug addiction.

(*iv*) Illness, treatment, or medical condition arising out of any of the following:

(A) War or act of war, whether declared or undeclared.

(B) Participation in a felony, riot, or insurrection.

(C) Service in the armed forces or units auxiliary to the armed forces.

(D) Suicide, whether or not the individual was sane or insane at the time of the suicide, attempted suicide, or intentionally self-inflicted injury.

(2) Long-term care coverage other than home care coverage may provide that before certain coverages in the policy take effect, care must first be recommended by a person or persons as provided in the policy and approved by the commissioner or prescribed by a licensed treating physician. Long-term care coverage for home care may provide that before coverage for home care in the policy takes effect, care must first be prescribed or recommended by a person or persons as provided in the policy and approved by the commissioner.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3906 Designation of person to receive notice of termination; reinstatement of coverage; effective date of section.

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.

History: Add. 2006, Act 442, Eff. Mar. 1, 2007.

Popular name: Act 218

500.3907 Individual long-term care policy; guaranteed renewable provision; conversion; new limitation period; intermediate care facility or skilled nursing facility; home care services.

Sec. 3907. (1) Each individual long-term care policy shall contain a guaranteed renewable provision. An insurer shall not cancel or otherwise terminate a long-term care insurance policy on the grounds of the age or the deterioration of the mental or physical health of the insured.

(2) Each group long-term care certificate shall contain a conversion provision permitting an individual entitled to benefits under the group certificate to elect to convert from the group certificate to an individual long-term care policy with the option of receiving benefits substantially similar to the prior coverage. An individual shall be entitled to convert to the individual policy at all times except under the following circumstances:

(a) Termination of the individual's group coverage resulted from the individual's failure to make any required payment of premium when due.

(b) The terminating coverage is replaced by other group coverage effective on the day following the termination of the other group coverage.

(3) If existing coverage is converted to or replaced by a long-term care insurance policy with the same insurer, the long-term care insurance policy shall not contain a provision establishing a new limitation period except with respect to an increase in benefits voluntarily selected by the insured. The premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group certificate.

(4) A long-term care insurance policy that provides coverage for care in an intermediate care facility or a skilled nursing facility shall also provide coverage for home care services that is a dollar amount equivalent to at least 1/2 of 1 year's coverage available for nursing home benefits under the policy at the time covered home health services are being received.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3908 Long-term care partnership program policy; conversion or replacement.

Sec. 3908. (1) Subject to subsection (2), long-term care insurance that is delivered or issued for delivery in this state after December 31, 2007, and before long-term care partnership program policies are approved for sale in this state, may be converted to or replaced with a long-term care partnership program policy.

(2) Before converting the long-term care insurance to, or replacing the long-term care insurance with, a long-term care partnership program policy under this section, the insured and the insurer shall both agree to the conversion or the replacement.

(3) As used in this section, "long-term care partnership program policy" means that term as defined in section 3957.

History: Add. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

500.3909 Option to purchase inflation protection; summary of coverage; applicability of section.

Sec. 3909. (1) An insurer shall not offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than 1 of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be not less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) If the policy is issued to a group, the required offer in subsection (1) shall be made to the group policyholder. However, if the policy is issued to a group defined in section 3901(c)(*iv*) other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(3) Insurers shall include all of the following information in or with the summary of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(4) This section does not apply to life insurance products that accelerate the death benefit to provide long-term care benefits.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3910 Option of purchasing policy or certificate including nonforfeiture benefits; offer.

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.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3910a Nonforfeiture benefits; coverage elements, eligibility, benefit triggers, and benefit length; contingent benefit; premium increase; notification; duties of insurer; limitation on maximum benefits; effective date of section; premiums subject to loss ratio requirements; conditions for offering nonforfeiture benefit.

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*).

History: Add. 2006, Act 442, Eff. June 1, 2007.

Popular name: Act 218

***** *500.3910b SEE SUBSECTION (7) FOR APPLICABILITY* *****

500.3910b Reduction options; applicability of section to long-term care policies and certificates issued on or after June 1, 2007.

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.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3911 Preexisting condition; limitation period; definition.

Sec. 3911. (1) A preexisting condition limitation period in a long-term care insurance policy, other than a group long-term care certificate described in section 3901(c)(*i*), shall not exceed 1 of the following:

(a) Six months after the effective date of coverage.

(b) A period of time set by the commissioner if the commissioner has found that a longer limitation period than provided for in subdivision (a) is justified because the group is specially limited by age, group categories, or other specific policy provisions and that the longer limitation period will be in the best interest of the public.

(2) A long-term care insurance policy, other than a group long-term care certificate described in section 3901(c)(*i*) , shall not use a definition of preexisting condition that is more restrictive than the definition in section 3901.

(3) The definition of preexisting condition 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 answers on that application, underwrite in accordance with that insurer's established underwriting standards.

(4) Unless otherwise provided in the policy, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until after the limitation period. A long-term care insurance policy shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting conditions beyond the limitation period.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3913 Home health care benefits.

Sec. 3913. (1) A long-term care insurance policy shall not limit or exclude services for home health care benefits in any of the following ways:

(a) By requiring that the insured would need skilled care in a skilled nursing facility if home health care services were not provided.

(b) By requiring that the insured first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered.

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses.

(d) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

(e) By requiring that the insured have an acute condition before home health care services are covered.

(f) By limiting benefits to services provided by medicare-certified agencies or providers.

(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy when determining maximum coverage under the terms of the policy.

(3) A long-term care insurance policy that provides coverage for home care services or assisted living services shall define and provide a detailed explanation in plain English of what home care services or assisted living services are covered. A long-term care insurance policy that provides coverage for assisted living facility stays shall define in plain English what assisted living facilities are covered.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2001, Act 4, Imd. Eff. Mar. 30, 2001.

Popular name: Act 218

500.3915 Certain conditions prohibited.

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.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3917 Replacement policy; waiver of time periods applicable to preexisting conditions and probationary periods.

Sec. 3917. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods for similar benefits in the new long-term care policy to the extent that similar exclusions have been satisfied under the original policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3919 Institutionalization; extension of benefits; limitations.

Sec. 3919. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care coverage was in force and continues without interruption after termination. An extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period and all other applicable provisions of the policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3921 Application; questions relating to health condition; delivery; record of policy rescissions; annual report to commissioner.

Sec. 3921. (1) All applications for long-term care insurance policies except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.

(2) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.

(3) If any medications listed in an application were known by the insurer or should have been known at the time of application to be directly related to a medical condition for which coverage would otherwise be denied, then the policy shall not be rescinded for that condition.

(4) Except for policies that are guaranteed issue, all of the following apply:

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy:

"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy at the time of delivery:

"Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]"

(c) Prior to issuance of a long-term care policy to an applicant age 80 or older, the insurer shall obtain 1 of the following:

(*i*) A report of a physical examination.

(*ii*) An assessment of functional capacity.

(*iii*) An attending physician's statement.

(*iv*) Copies of medical records.

(5) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy unless it was retained by the applicant at the time of application.

(6) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy rescissions, both state and countrywide, except those the insured voluntarily effectuated, and shall annually furnish this information to the commissioner.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3923 Riders or endorsements; certain changes in benefits or premiums; definition, explanation, description, and labeling of certain terms.

Sec. 3923. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to a long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured individual. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, except if the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, that premium charge shall be set forth in the policy, rider, or endorsement.

(2) A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying summary of coverage.

(3) If a long-term care insurance policy contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and shall be labeled as "preexisting condition limitations".

(4) A long-term care insurance policy containing any limitations or conditions for eligibility shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy and shall label the paragraph "limitations or conditions on eligibility for benefits".

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

****** 500.3925 SEE SUBSECTION (1) FOR APPLICABILITY ******

500.3925 Applicability of section to long-term care policy or certificate issued on or after June 1, 2007; information to be provided on forms; acknowledgment of disclosure; notice of premium rate schedule increase; personal worksheet; availability of free and independent insurance purchasing and public benefits counseling.

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.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

***** *500.3926 SEE SUBSECTION (1) FOR APPLICABILITY* *****

500.3926 Applicability of section to long-term care policy or certificate issued on or after June 1, 2007; information to be provided to commissioner; premium rate schedule; statement; request by commissioner for actuarial demonstration; additional information.

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.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

***** *500.3926a SEE SUBSECTION (1) FOR APPLICABILITY* *****

500.3926a Applicability of section to long-term care policy or certificate issued on or after June 1, 2007; notice of pending premium rate schedule increase; requirements; review and approval by commissioner; eligibility for contingent benefit upon lapse; applicability of subsections to certain policies or certificates; exceptional increases; definitions.

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.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3927 Reasonableness of benefits relative to premiums; expected loss ratio; evaluation of factors; applicability of section.

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).

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3928 Fixed indivisible premium life insurance policy funding long-term care benefits by accelerating death benefit; reasonableness of benefits relative to premiums; provisions.

Sec. 3928. A fixed indivisible premium life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums provided that the policy complies with all of the following provisions:

(a) Premiums required to be paid are fixed and guaranteed for the life of the policy.

(b) The guaranteed cash surrender value is stated in the policy.

(c) The death benefit and long-term care benefits are guaranteed for the life of the policy, and the policy contains the schedule of the guarantees.

(d) The risk charges for mortality and morbidity benefits and any other charges made internally to determine cash value accumulations, if any, are guaranteed not to exceed the maximum charges set forth in the policy.

(e) The interest credited internally to determine cash value accumulations, if any, are guaranteed not to be less than the minimum interest rate set forth in the policy.

(f) The benefits cannot be terminated by the insurer except for nonpayment of premium.

(g) The policy meets the nonforfeiture requirements of chapter 40.

(h) At the time of issue, the policy is accompanied by an illustration that clearly discloses the year-by-year progression of cash values and face amount.

(i) The policy provides that the policy owner is supplied annually with a report showing the current cash value, death benefit, and long-term care benefits, and shows the calculation of the change in the cash value from the previous report by the addition of interest and premium payments, if any, and the deduction of the risk charges and any other charges.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3929 Increasing premiums prohibited; conditions.

Sec. 3929. The premiums charged to an insured for long-term care insurance shall not increase due to either of the following:

(a) The increasing age of the insured at ages beyond 65.

(b) The duration the insured has been covered under the policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3930 Acceleration of benefits under group or individual life policies or riders; determination of policy reserves.

Sec. 3930. (1) If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to those policies, policy reserves for the benefits must be determined in accordance with section 834(1)(g). Claim reserves must also be established if the policy or rider is in claim status.

(2) Reserves for policies and riders subject to subsection (1) must be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations may be used if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, the reserves for the long-term care benefit and the life insurance benefit must not be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(3) In the development and calculation of reserves for policies and riders subject to subsection (1), due regard must be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations that have an impact on projected claim costs, including, but not limited to, all of the following:

(a) Definition of insured events.
(b) Covered long-term care facilities.
(c) Existence of home convalescence care coverage.
(d) Definition of facilities.
(e) Existence or absence of barriers to eligibility.
(f) Premium waiver provision.
(g) Renewability.
(h) Ability to raise premiums.
(i) Marketing method.
(j) Underwriting procedures.
(k) Claims adjustment procedures.
(*l*) Waiting period.
(m) Maximum benefit.
(n) Availability of eligible facilities.
(o) Margins in claim costs.
(p) Optional nature of benefit.
(q) Delay in eligibility for benefit.
(r) Inflation protection provisions.
(s) Guaranteed insurability option.

(4) Any applicable valuation morbidity table must be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

500.3931 Rules.

Sec. 3931. The commissioner may promulgate rules including the following:

(a) Rules establishing standards for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents if provided in the policy, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, definitions of terms, and for full and fair disclosure setting forth the manner, content, and required disclosures.

(b) Rules establishing loss ratio standards for long-term care insurance policies.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3933 Summary of coverage.

Sec. 3933. An insurer that offers long-term care insurance shall provide to a prospective applicant before application and upon request before renewal a summary of coverage and shall obtain an acknowledgment of receipt of the summary on the application form or renewal form by obtaining the applicant's signature. An insurer using direct sales response shall provide the summary of coverage to an applicant in conjunction with the initial application and upon request before renewal. The summary of coverage shall be a free-standing document, using no smaller than 10-point type, and shall not contain advertising material. The summary of coverage shall be in substantially the following form:

(COMPANY NAME)
(ADDRESS: CITY AND STATE)
(TELEPHONE)

LONG-TERM CARE POLICY SUMMARY OF COVERAGE

[Policy number or group master policy and certificate number] Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [use 1 of the following:] an individual policy of insurance; a group certificate that was issued in the [indicate jurisdiction in which group certificate was issued].

2. Purpose of the summary of coverage. This summary of coverage provides a very brief description of the important features of the policy. You should compare this summary of coverage to summaries of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you read your policy carefully.

3. The following are terms under which the policy may be returned and premium refunded:

(a) Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy.

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy. If the policy contains these provisions, include a description of them.]

4. This is not medicare supplemental coverage. If you are eligible for medicare, review the medicare supplemental buyer's guide available from the insurance company. [For agents] neither [insert company name] nor its agents represent medicare, the federal government, or any state government. [For direct response] [insert company name] is not representing medicare, the federal government, or any state government.

5. Long-term care coverage. Policies of this category are designed to provide coverage for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. Benefits provided by this policy are the following:

Category	**Definition**	**Company Benefits**
Skilled nursing care	Requires daily attendance, monitoring, evaluation and/or observation by licensed health personnel in a licensed skilled nursing care facility	$___ per day
Maximum days payable		___ days
Intermediate/basic/custodial nursing care	Is care that includes assistance in activities of daily living that can be provided by persons without medical skill in a licensed intermediate or skilled nursing care facility	$___ per day
Maximum days payable		___ days
Home health benefits:— Daily benefit—Maximum days payable—Restrictions	Will this policy cover home care and what are the restrictions?	___Yes ___No $___ per day ___ days
Prior hospitalization	Policies may not require that you be placed in a hospital for a certain number of days before you can receive coverage for nursing home care	
Day benefits begin	After you have entered the nursing home, when will the policy start to pay for coverage?	
Preexisting conditions waiting period	If you have been treated in the last 6 months for a condition, will this policy cover your treatment?	___Yes ___No
	Does this policy cover you only after a waiting period?	___Yes ___No
	How long is the waiting period?	___ days

Prior approval for coverage	Is prior approval needed before your policy will give you coverage?	___Yes ___No
Motor vehicle accidents	Will this policy provide coverage for long-term care needed as a result of a motor vehicle accident?	___Yes ___No
Evidence of insurability	Is a physical examination required?	___Yes ___No
	Do you have to answer a series of health questions?	___Yes ___No
Guaranteed renewal	As long as you pay your premiums on time, the company will continue to insure you.	
Waiver of premium	Are there circumstances under which you receive coverage, but do not have to pay the premium?	___Yes ___No

7. This policy may not cover all the expenses associated with your long-term care needs. [Provide a brief specific description of any policy provisions that limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits.]

8. Relationship of cost of care and benefits. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. Terms under which the policy may be continued in force or discontinued.

[(a) Describe the policy renewability provisions.

(b) For group coverage, specifically describe applicable continuation/conversion provisions.

(c) Describe waiver of premium provisions or state that there are no such provisions.

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which the premium may change.]

10. Organic brain disorders and dementia, including Alzheimer's disease.

[State that the policy provides coverage for insureds who are clinically diagnosed as having dementia or related degenerative illnesses including Alzheimer's disease. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for such an insured including whether there is a screen for cognitive impairment.]

11. Premium.

[(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.]

12. Additional features.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

I have read this summary and understand that this summary is for my own use and is mine to keep.

Prospective Applicant's Signature

Date

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3935 Statement relating to request for additional information.

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.".

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3937 Shopper's guide; format; providing to applicants; exception.

Sec. 3937. (1) A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy in the following manner:

(a) For agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) For direct response solicitations, the shopper's guide shall be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing long-term care benefits are not required to furnish a shopper's guide pursuant to subsection (1), but shall furnish a summary of coverage as provided in section 3951.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3939 Application; questions relating to other policies in force or use as replacement; agent's list of other policies sold; notice to applicant and existing insurer; appropriateness of recommended purchase or replacement.

Sec. 3939. (1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force:

(a) Do you have another long-term care insurance policy or certificate in force?

(b) Do you have other long-term care coverage through a health care corporation or a health maintenance organization?

(c) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(*i*) If so, with which company?

(*ii*) If that policy lapsed, when did it lapse?

(d) Are you covered by medicaid?

(e) Do you intend to replace any of your medical or health insurance coverage with this policy?

(2) Unless the coverage is sold without an agent, a supplementary application or other form containing the questions in subsection (1) requiring the applicant's and agent's signatures may be used.

(3) With regard to a replacement policy issued to a group under section 3904(c)(*iv*), the questions in subsection (1) may be modified but only to the extent necessary to elicit information about health or long-term care insurance policies other than the group certificate being replaced and provided that the certificate holder has been notified of the replacement.

(4) Agents shall list any other health insurance policies they have sold to the applicant in the past 5 years and indicate whether or not they are still in force.

(5) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

```
     "Notice to applicant regarding replacement of individual
        accident and sickness or long-term care insurance
             [Insurance company's name and address]
   Save this notice! It may be important to you in the future.
According to [your application] [information you have
furnished], you intend to lapse or otherwise terminate existing
accident and sickness or long-term care insurance and replace
it with an individual long-term care insurance policy to be
issued by [company name] insurance company. Your new policy
provides 30 days within which you may decide, without cost,
whether you desire to keep the policy. For your own information
and protection, you should be aware of and seriously consider
certain factors that may affect the insurance protection
available to you under the new policy.
```

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you

find that purchase of this long-term care coverage is a wise decision. Statement to applicant by agent [broker or other representative]: (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate cannot contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature agent, broker, or other representative)

[Typed name and address of agent or broker]

The above "notice to applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's signature)"

(6) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

"Notice to applicant regarding replacement of accident and sickness or long-term care insurance

[Insurance company's name and address]

Save this notice! It may be important to you in the future. According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy issued by [company name] insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under

the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate cannot contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company name)"

(7) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address including zip code. The notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(8) In recommending the purchase or replacement of any long-term care insurance policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3941 Advertising; filing copy with commissioner.

Sec. 3941. Every insurer providing long-term care insurance coverage in this state shall file with the commissioner for review a copy of any written, radio, or television advertisement for long-term care insurance intended for use in this state at least 45 days before the date the insurer desires to use the advertising. The filing shall include a sample or photocopy of all applicable long-term care policies and related forms and the approval status of the policies and forms. In addition, all advertisements shall be retained by the insurer or other entity for at least 3 years from the date the advertisement was first used.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3941a Inapplicability of section to life insurance policies or riders containing accelerated benefits; development of suitability standards.

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.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3942 Marketing; duties of insurer; use of "level premium" or "noncancelable" prohibited; exception.

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.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3942a Reporting requirements; agent activities; preparation of report.

Sec. 3942a. (1) Every insurer marketing long-term care insurance in Michigan shall comply with all of the following reporting requirements for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance:

(a) Maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales and report annually by June 30 the top 10% of its agents that have the greatest percentages of lapses and replacements.

(b) Report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(c) Report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(2) All reports prepared pursuant to subsection (1) shall be on a statewide basis.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3943 Right to return policy; notice; “direct response solicitation” defined.

Sec. 3943. (1) Except as otherwise provided in subsection (2), an applicant for long-term care insurance shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the applicant is not satisfied for any reason and benefits have not been incurred under the policy. Long-term care insurance policies shall have a notice prominently printed on the first page of the policy and the summary of coverage stating in substance that the applicant has the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the applicant is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the policy and the summary of coverage stating in substance that the insured person shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. As used in this section, "direct response solicitation" means solicitation in which a representative of the insurer does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3945 Violation; penalty.

Sec. 3945. In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000.00, whichever is greater.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3949 Life and long-term care benefits; marketing; compliance.

Sec. 3949. (1) An insurer that has both life and disability authority in this state may market policies containing both life benefits and long-term care benefits.

(2) Except as otherwise provided in this act, if life insurance products contain long-term care benefits, the life insurance benefits in those products shall comply with the requirements of chapters 40 and 44 and the long-term care benefits shall comply with this chapter.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3951 Policy summary; compliance with MCL 500.3933; additional provisions; monthly report.

Sec. 3951. (1) A policy summary shall be delivered for a life insurance policy or certificate that provides long-term care benefits. The summary shall comply with the requirements in section 3933. For direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request and shall make the delivery no later than at the time of policy delivery. In addition to the policy summary provisions in section 3933, the policy summary shall include all of the following:

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits.

(b) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person.

(c) Any exclusions, reductions, and limitations on benefits of long-term care.

(d) If applicable to the policy type, the summary shall also include all of the following:

(*i*) A disclosure of the effects of exercising other rights under the policy.

(*ii*) A disclosure of guarantees related to long-term care costs of insurance charges.

(*iii*) Current and projected maximum lifetime benefits.

(2) If a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include all of the following:

(a) Any long-term care benefits paid out during the month.

(b) An explanation of any changes in the policy, for example, death benefits or cash values due to long-term care benefits being paid out.

(c) The amount of long-term care benefits existing or remaining.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3953 Disclosure statement.

Sec. 3953. A life insurance policy that provides an accelerated benefit for long-term care shall provide a disclosure statement at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted stating that receipt of accelerated benefits may be taxable and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3955 Compliance with chapter and applicable laws.

Sec. 3955. Each insurance policy that is advertised, marketed, or offered as long-term care insurance or nursing home insurance shall comply with this chapter and the other applicable provisions of this act.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218