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BILL ANALYSIS

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House Bill 5348 (as passed by the House)
House Bill 5349 (Substitute H-3 as passed by the House)
Sponsor: Representative Kevin Green (H.B. 5348)
Representative Paula Zelenko (H.B. 5349)
House Committee: Senior Health, Security, and Retirement
Senate Committee: Health Policy

Date Completed: 9-5-06

CONTENT

House Bill 5348 would repeal provisions of the Nonprofit Health Care Corporation Reform Act governing long-term care coverage offered by Blue Cross and Blue Shield of Michigan (BCBSM), and include them in provisions of the Insurance Code regulating long-term care coverage; and amend the Insurance Code to include services provided in an assisted living facility among the services covered by long-term care insurance.

House Bill 5349 (H-3) would amend the Insurance Code to do the following:

-- Include long-term care among the subjects to be covered in a life-health insurance agent program of study.
-- Prohibit an individual long-term care policy or certificate from being issued until the insurer received from the applicant a designation of an additional person to receive notice of lapse or termination of the policy for nonpayment of premium, or a waiver of the right to designate an additional person.
-- Prohibit the lapse or termination of an individual long-term care policy unless the insurer gave the insured and any designated additional person at least 30 days' notice.
-- Require a policy or certificate to provide for reinstatement of coverage if the insurer were given proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the policy's grace period expired.
-- Prohibit a long-term care policy from being delivered or issued unless the policyholder were offered the option of purchasing a policy or certificate including a nonforfeiture benefit, subject to certain exceptions; and require an insurer to provide a contingent benefit upon lapse to a person who declined the nonforfeiture benefit.
-- Require policyholders to be notified at least 45 days before the effective date of a premium increase.
-- Require an insurer to offer reduced policy benefits or a shortened benefit period before the effective date of a substantial premium increase.
-- Require an insurer to give an applicant information about previous and potential premium rate increases.
-- Require an insurer to give an actuarial certification to the Commissioner of the Office of Financial and Insurance Services (OFIS) 30 days before offering a long-term care policy or certificate available for sale; and allow the Commissioner to request an actuarial demonstration that benefits were reasonable in relation to premiums.
-- Require an insurer to give the Commissioner at least 30 days'

notice of a pending premium rate schedule increase.

-- **Allow the Commissioner to require an insurer to implement rate schedule adjustments if he or she determined that the actual experience following a rate increase did not adequately match the projected experience.**

-- **Require the Commissioner to review the projected lapse rates and past lapse rates following a rate increase to determine if significant adverse lapsation occurred or were anticipated, under certain circumstances; and allow the Commissioner to determine that a rate spiral existed and require an insurer to take certain actions.**

-- **Apply only to policies issued before January 1, 2007, a provision under which benefits under individual long-term care policies are considered reasonable in relation to premiums provided the expected loss ratio is at least 60%.**

-- **Require an insurer marketing long-term care insurance to develop suitability standards to determine whether the purchase of long-term care insurance was appropriate for the needs of an applicant.**

The bills are described below in further detail.

House Bill 5348

Assisted Living Facility

Under the Insurance Code, "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 one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial care services provided in a setting, other than an acute care unit of a hospital. The bill would add services provided in an assisted living facility operating legally in Michigan to the covered services.

Blue Cross and Blue Shield of Michigan

Currently, long-term care offered by BCBSM is regulated by Sections 420 through 430 of the Nonprofit Health Care Corporation Reform Act. The bill would repeal these sections and include in the Insurance Code's definition of "policy" an insurance policy or certificate, rider, or endorsement delivered or issued for delivery in Michigan by a subsidiary of a nonprofit health care corporation (i.e., BCBSM).

The Insurance Code contains provisions similar or identical to most, but not all, of those in Sections 420 through 430 of the Act. The Code also contains several provisions that are not found currently in the Act. These differences are described below.

Offering of Long-Term Care Coverage. The Act allows BCBSM to offer long-term care coverage only through a subsidiary of the nonprofit health care corporation, and specifies that the sale of that coverage is not exempt from taxation by the State or any of its political subdivisions. The bill would enact an identical provision in the Code.

Conversion Provision. Both the Act and the Code require that each group long-term care certificate contain a conversion provision permitting an individual entitled to benefits under the group certificate to elect to convert to an individual long-term care policy with the option of receiving benefits substantially similar to the prior coverage. Under the Act, if BCBSM offers long-term care coverage, it is not required to offer coverage to a State resident who is hospitalized or institutionalized, or who has been informed by a physician that he or she will require hospitalization or institutionalization within 30 days after he or she applies for the coverage, until the day after the date of discharge from the facility. The Code does not contain this provision.

Under the Code, an individual is entitled to convert to an individual policy at all times except under the following circumstances:

-- Termination of the individual's group coverage resulted from his or her failure to make any required payment of premium when due.

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

Additionally, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group certificate.

Both the Code and the Act require a policy or certificate that provides coverage for care in an intermediate care facility or a skilled nursing facility also to provide coverage for home care services. The Code specifies that the coverage for home care services must be a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy at the time covered home health services are being received.

Institutionalization of the Insured. The Act and the Code both prohibit a long-term care insurance policy from conditioning benefits on the prior institutionalization of the insured. The Code also prohibits a policy from conditioning benefits on prior receipt of a higher level of institutionalized care.

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

Inflation Protection. The Insurance Code prohibits an insurer from offering 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. The Act does not contain a similar provision.

Home Health Care Benefits. The Code contains several provisions regarding home health care benefits that are not found in the Act. Under the Code, a long-term care insurance policy may not limit or exclude services for home health care benefits in any of the following ways:

-- By requiring that the insured would need skilled care in a skilled nursing facility if home health care services were not provided.
-- 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.
-- By limiting eligible services to services provided by registered nurses or licensed practical nurses.
-- 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.
-- By requiring that the insured have an acute condition before home health care services are covered.
-- By limiting benefits to services provided by Medicare-certified agencies or providers.

Under the Code, 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. A long-term care insurance policy that provides coverage for home care services or assisted living services, or assisted living facility stays, must define and provide a detailed explanation in plain English of what home care services or assisted living services or facilities are covered.

Replacement Policy. The Code contains a provision not found in the Act requiring a replacing insurer to waive any time periods applicable to preexisting conditions and probationary periods for similar benefits in a new long-term care policy to the extent that similar exclusions have been satisfied in the original policy.

Application Questions. Under the Code, all applications for long-term care insurance policies except those that are guaranteed issue must contain clear and unambiguous questions designed to ascertain the applicant's health condition. If an application asks whether the applicant has had medication prescribed by a physician, it also must ask the applicant to list that medication. If the insurer knew or should have been known at the time of application that any listed medication was directly related to a medical condition for which

coverage otherwise would be denied, then the policy may not be rescinded for that condition.

The Code also requires the following language to be set out in conspicuously and in close conjunction with the applicant's signature block: "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]".

Under the Code, before issuing a long-term care policy to an applicant who is at least 80 years old, the insurer must obtain a report of a physical examination, an assessment of functional capacity, an attending physician's statement, or copies of medical records.

Additionally, the Code requires every insurer or other entity selling or issuing long-term care insurance benefits to maintain a record of all policy rescissions, both State- and countrywide, except those the insured voluntarily effectuated, and annually furnish this information to the OFIS Commissioner.

Reduced Benefits & Premium Increases. Under the Code, except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual policy, all riders or endorsements added to a long-term care insurance policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage must 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 must be agreed to in writing and signed by the insured, unless 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 must be set forth in the policy, rider, or endorsement.

Reasonableness of Premiums. The Code provides that benefits under individual long-term care insurance policies are 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. The Code requires that due consideration be given to specified relevant factors in evaluating the expected loss ratio.

Also, under the Code, 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 certain provisions.

Restriction on Increasing Premiums. Under the Code, the premiums charged to an insured for long-term care insurance may not increase due to the increasing age of the insured at ages beyond 65, or the duration the insured has been covered under the policy.

Advertising. The Code requires every insurer providing long-term care insurance coverage to file with the OFIS Commissioner for review a copy of any written, radio, or television advertisement intended for use in Michigan at least 45 days before the insurer desires to use the advertising.

Marketing. The Code requires every insurer marketing long-term care insurance coverage in Michigan to do all of the following:

-- Establish marketing procedures to assure that any comparison of policies by its agents or other producers is fair and accurate.
-- Establish marketing procedures to assure excessive insurance is not sold or issued.
-- Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, a notice to the buyer that the policy may not cover all of the costs associated with long-term care that the buyer might incur.
-- 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.

-- Establish auditable procedures for verifying compliance with these provisions.

Reporting Requirements. Under the Code, every insurer marketing long-term care insurance in Michigan must comply with all of the following reporting requirements for the purpose of reviewing agent activities regarding the sale of such insurance:

-- Maintain records for each 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 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.
-- 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.
-- 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.

Violation & Penalty. Under the Code, in addition to any other penalties provided by the laws of Michigan, 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 is subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or a maximum of $10,000, whichever is greater.

House Bill 5349 (H-3)

Agent Continuing Education

Under the Code, the Insurance Education Advisory Council must review continuing education programs of study and make recommendations to the Commissioner on whether those programs meet the Code's requirements. After reviewing the Council's recommendations, the Commissioner must approve a program of study if he or she determines that it increases knowledge of insurance and specified related subjects. The bill would add to the subjects in which a life-health agent program of study must offer instruction the fundamental considerations, major principles, and statutory requirements of long-term care insurance.

The bill also would require each insurer that sells, solicits, or negotiates long-term care insurance to ensure that each producer whose duties include selling, soliciting, or negotiating long-term care insurance completed a program of instruction as described above before engaging in those activities. The program of instruction could be provided in conjunction with other producer training or separately. To satisfy this requirement, a producer could document to an insurer that he or she had obtained the required training described below from any insurer that sells, solicits, or negotiates long-term care insurance; or a program of instruction qualified under the Code.

A required program of instruction would have to consist of topics related to long-term care insurance and services, including all of the following:

-- State regulations and requirements, including laws relating to adult financial exploitation.
-- Available long-term care services and providers.
-- Changes or improvements in long-term care services or providers.
-- Alternatives to the purchase of private long-term care insurance.
-- Differences in eligibility for benefits and tax treatment between policies intended to be Federally qualified and those not intended to be Federally qualified.
-- The effect of inflation in eroding the value of benefits and the importance of inflation protection.
-- Consumer suitability standards and guidelines.

A required program of instruction could not include any training that was oriented solely to the sales or marketing of an insurer-specific long-term care product.

(Under the Code, "insurance producer" means a life-health agent or property-casualty agent. "Life-health agent" means a resident or nonresident individual insurance producer licensed for life, limited life, mortgage redemption, accident and health, or any combination of those categories.)

Designation of Additional Person to be Notified of Lapse

Under the bill, an individual long-term care policy or certificate could not be issued until the insurer received from the applicant either a written designation of at least one person, in addition to the applicant, who was 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 people to receive notice. The applicant could designate at least one person who was to receive the notice, in addition to the insured. A designation would not constitute acceptance of any liability on the third party for services provided to the insured.

The form used for the written designation would have to provide space clearly designated for listing at least one person. The designation would have to include each person's full name and home address. For an applicant who elected not to designate an additional person, the waiver would have to 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 would have to notify the insured of the right to change the written designation at least once every two years.

If the policyholder or certificateholder paid premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the provisions related to the designation would not apply until 60 days after the policy- or certificateholder was no longer on such a payment plan. The application or enrollment form for such policies or certificates would have to indicate clearly the payment plan selected by the applicant.

An individual long-term care policy or certificate could 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, gave notice to the insured and to his or her designated people, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice would have to be given by first-class United States mail, postage prepaid, and notice could not be given until 30 days after a premium was due and unpaid. Notice would be considered given five days after the date of mailing.

A policy or certificate would have to provide for reinstatement of coverage if the insurer were given 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 would have to be available to the insured if requested within five months after termination and would have to allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity could not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

These provisions would take effect on October 1, 2006, and would apply to long-term care policies and certificates issued on or after that date.

Offer of Nonforfeiture Benefit

Except as provided below, a long-term care insurance policy could not be delivered or issued for delivery in this State unless the policyholder or certificateholder was offered the option of purchasing a policy or certificate including a nonforfeiture benefit. An offer would have to be in writing if the nonforfeiture benefit were not otherwise described in the outline of coverage or other materials given to the prospective policyholder or certificateholder. The offer of a nonforfeiture benefit could be in the form of a rider that was attached to the policy. If the policyholder or certificateholder declined the nonforfeiture benefit, the insurer would have to provide a contingent benefit upon lapse that would have to be available for a specified period of time following a substantial increase in premium rates.

When a group long-term care policy was issued, the offer of the nonforfeiture benefit would have to be made to the group policyholder. If the policy were issued as group long-term care insurance, however, other than to a continuing care retirement community or other similar entity, the

offering would have to be made to each proposed certificateholder.

These provisions would not apply to life insurance policies or riders containing accelerated benefits for long-term care.

Nonforfeiture & Contingent Benefit

A policy or certificate offered with nonforfeiture benefits would have to have coverage elements, eligibility, benefit triggers, and benefit length that were the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer would have to be the benefits continued as nonforfeiture benefits (described below).

If the offer including a nonforfeiture benefit were rejected, the insurer would have to provide a contingent benefit upon lapse as described for individual and group policies without nonforfeiture benefits issued on and after January 1, 2007.

If a group policyholder elected to make the nonforfeiture benefit an option to the certificateholder, a certificate would have to provide either the nonforfeiture benefit or the contingent benefit upon lapse.

Except as otherwise required, policyholders would have to be notified at least 45 days before the due date of a premium increase and of the amount of the increase.

The contingent benefit on lapse would be triggered every time an insurer increased the premium rates to a level that resulted in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium according to a schedule based on the insured's issue age, and the policy or certificate would lapse within 120 days of the due date of the increased premium. The schedule, entitled "Triggers for a Substantial Premium Increase", begins with an issue age of 29 and under and an increase of 200% over the initial premium, and ends with age 90 and over and an increase of 10% over the initial premium.

By the effective date of a substantial premium increase, the insurer would have to do all of the following:

-- Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments were not increased.
-- Offer to convert the coverage to a paid-up status with a shortened benefit period as provided below, which option could be elected at any time during the 120-day period described above.
-- Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period would be considered to be the election of the offer to convert the coverage to a paid-up status with a shortened benefit period.

Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, would be as follows:

-- For purposes of this provision, attained age rating would be defined as a schedule of premiums starting from the issue date that increased age at least 1% per year before age 50 and at least 3% per year beyond age 50.
-- The nonforfeiture benefit would have to begin by the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse would be effective during the first three years as well as thereafter. For a policy or certificate with attained age rating, however, the nonforfeiture benefit would have to begin on the earlier of the end of the 10th year following the policy or certificate issue date or the end of the second year following the date the policy or certificate was no longer subject to attained age rating.
-- Nonforfeiture credits could be used for all care and services qualifying for benefits under the terms of or up to the limits specified in the policy or certificate.
-- For purposes of this provision, the nonforfeiture benefit would have to be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse.

The same benefits would be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits would have to be determined as provided below. ("Same benefits" would mean amounts and frequency in effect at the time of lapse but not increased thereafter.)

Additionally, the standard nonforfeiture credit would be equal to 100% of the sum of all premiums paid, including the premiums paid before any changes in benefits. The insurer could offer additional shortened benefit period options, as long as the benefits for each duration equaled or exceeded the standard nonforfeiture credit for that duration. The minimum nonforfeiture credit, however, could 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 would be subject to the limitation described below.

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

There could be no difference in the minimum nonforfeiture benefits as required under the bill for group and individual policies.

These provisions would not apply to life insurance policies or riders containing accelerated benefits for long-term care. They would take effect on January 1, 2007. Except as otherwise provided below, these provisions would apply to any long-term care policy issued in Michigan on or after January 1, 2007. They would not apply to certificates issued on or after January 1, 2007, under a group long-term care insurance policy as defined in Section 3901(c)(i), that was in force at the time the provisions became effective.

(Under Section 3901(c)(i), "group long-term care insurance" means a long-term care insurance certificate that is delivered or issued for delivery in Michigan and issued to one or more employers or labor organizations, or to a trust or the trustees of a fund established by one or more employers or labor organizations for employees or former employees or members or former members of the labor organization.)

Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse would be subject to the loss ratio requirements the bill would add (described below) treating the policy as a whole.

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

For qualified long-term care insurance contracts that were level premium contracts, an insurer would have to offer a nonforfeiture benefit that was captioned appropriately, and that provided a benefit available in the event of a default in the payment of any premiums and stated that the amount of the benefit could 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 OFIS Commissioner for the same contract form. Additionally, the benefit would have to provide at least one of the following:

-- Reduced paid-up insurance.
-- Extended term insurance.
-- Shortened benefit period.
-- Other similar offerings approved by the Commissioner.

Options for Reduced Coverage & Lower Premiums

A long-term care insurance policy or certificate would have to provide that a policyholder or certificateholder who wished to reduce coverage and lower the premium could choose at least one of the following options:

-- Reducing the lifetime maximum benefit.
-- Reducing the daily, weekly, or monthly benefit amount.

A long-term care insurer also could offer additional reduction options that were consistent with the policy or certificate design or the insurer's administrative processes. An insurer would have to include in the policy or certificate a description of the ways in which coverage could be reduced and the process for requesting and implementing a reduction in coverage. The age to determine the premium for reduced coverage would have to be based on the age

used to determine the premiums for the coverage currently in force.

An insurer could limit any reduction in coverage to plans available for that policy from and to those for which benefits would be available after consideration of claims paid or payable.

If a long-term care insurance policy or certificate were about to lapse, the insurer would have to provide written notice to the insured of the reduction options to lower the premium by reducing coverage and of the premiums applicable to the reduced coverage options. The insurer could include in the notice options in addition to those required under the bill. The notice would have to give the insured at least 30 days in which to elect reduced coverage, and the policy or certificate would have to be reinstated without underwriting if the insured elected the reduced coverage.

These provisions would apply to long-term care policies and certificates issued on or after January 1, 2007.

Institutionalization of the Insured

Under the Code, a long-term care insurance policy may not condition benefits on the prior institutionalization of the insured, or prior receipt of a higher level of institutional care. The bill specifies that this provision would apply to a policy sold before, on, or after June 2, 1992.

Information for Applicants

The provisions described below would apply to any long-term care policy or certificate issued in Michigan on or after January 1, 2007. For a long-term care certificate issued on or after January 1, 2007, however, under a group long-term care insurance policy described in Section 3901 (c)(i), that was in force on that date, these provisions would apply on the policy anniversary date following January 1, 2007.

Other than policies or certificates for which no applicable premium rate or rate schedule increases could be made, an insurer would have to provide on forms approved by the OFIS Commissioner all of the following information to the applicant at the time of application or enrollment, or, if the application method did not allow for delivery at that time, an insurer would have to provide on approved forms all of the following information to the applicant by the time of delivery of the policy or certificate:

-- A statement that the policy could be subject to rate increases in the future.
-- An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision.
-- The premium rate or rate schedules applicable to the applicant that would be in effect until a request was made for a rate increase.
-- A general explanation for applying premium rate or rate schedule adjustments, which would have to include a description of when the adjustments would be effective and the right to a revised premium rate or rate schedule if the rate or rate schedule were changed.

Additionally, the insurer would have to provide information concerning each premium rate increase on the policy or certificate or similar policies or certificates over the past 10 years for Michigan or any other state that, at a minimum, identified all of the following:

-- The policies or certificates for which premium rates had been increased.
-- The calendar years when the policy or certificate was available for purchase.
-- The amount or percent of each increase.

The percentage could be expressed as a percentage of the premium rate before the increase and also could be expressed as minimum and maximum percentages if the rate increase were variable by rating characteristics. An insurer could exclude from this disclosure premium rate increases that applied only 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 before the acquisition. If an acquiring insurer filed 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 January 1, 2007, or the end of a 24-month period following the acquisition of the block of policies or certificates, the acquiring insurer could exclude that rate increase from this disclosure. The nonaffiliated selling company, however, would have to include the disclosure of that

rate increase as provided in the bill. If the acquiring insurer filed for a subsequent rate increase, even within the 24-month period, on the same policy or certificate acquired from a nonaffiliated insurer, the acquiring insurer would have to make all disclosures required by the bill, including disclosure of the earlier rate increase.

("Similar policies" would mean 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 employers or labor organizations described in the bill would not be considered similar to policies or certificates otherwise issued as long-term care insurance, but would be similar to other comparable certificates with the same long-term care benefit classification. For purposes of determining similar policies, long-term care benefit classifications would be defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.)

The insurer could, in a fair manner, give explanatory information related to the rate increases in addition to the information required under the bill.

Except as otherwise provided, an applicant would have to sign an acknowledgement at the time of application that the insurer made the required disclosure. If, due to the application method, the applicant could not sign an acknowledgement at the time of application, the applicant would have to sign an acknowledgement by the time of delivery of the policy or certificate.

An insurer would have to give notice of an upcoming premium rate schedule increase to all policyholders and certificateholders, if applicable, at least 45 days before the implementation of the increase. The notice would have to include the required information described above regarding rate increases when the increase was implemented.

A long-term care insurer would have to give an applicant a long-term care insurance personal worksheet approved by the OFIS Commissioner that the applicant could use for help in determining whether long-term care insurance should be purchased.

An insurer also would have to give an applicant who was at least 60 years old or who was disabled a current brochure, or the web address where the brochure could be obtained and the telephone number for the agency that could provide the brochure, from the State's Medicare Medicaid Assistance Program, that contained information on the availability of free and independent insurance purchasing and public benefits counseling.

Documentation to the OFIS Commissioner

This section would apply to any long-term care policy or certificate issued in Michigan on or after January 1, 2007.

Thirty days before making a long-term care insurance policy or certificate available for sale, an insurer would have to give to the OFIS Commissioner a copy of the required disclosure documents, and an actuarial certification consisting of at least all of the following:

-- A statement that the initial premium rate schedule was sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule was reasonably expected to be sustainable over the life of the policy or certificate with no future premium increases anticipated.
-- A statement that the policy or certificate design and coverage provided had been reviewed and taken into consideration.
-- A statement that the underwriting and claims adjudication processes had been reviewed and taken into consideration.
-- A statement that the premium rate schedule was 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 were currently available from the insurer with an explanation of the differences.

The actuarial certification also would have to contain a complete description of the basis for contract reserves that were 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 contained reasonable margins for

adverse experience, a statement that the net valuation premium for renewal years would 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 was sufficient to cover expected renewal expenses or, if such a statement could not be made, a complete description of the situations in which this did not occur.

An aggregate distribution of anticipated issues could be used as long as the underlying gross premiums maintained a reasonably consistent relationship. If the gross premiums for certain age groups appeared to be inconsistent with this requirement, the Commissioner could request a demonstration based on a standard age distribution.

Before the expiration of the 30 days, the OFIS Commissioner could request an actuarial demonstration that benefits were reasonable in relation to premiums. The demonstration would have to include either premium and claim experience on similar policies or certificates, adjusted for any premium or benefit differences and/or relevant and credible data from other studies. If the Commissioner asked for this additional information, the 30-day time period would be tolled until the Commissioner received the requested information.

Review of Proposed Rate Increases

The following provisions would apply to any long-term care policy or certificate issued in Michigan on or after January 1, 2007. For certificates issued on or after that date under a group long-term care insurance policy that was in force on January 1, 2007, however, this section would apply on the policy anniversary date following January 1, 2007.

An insurer would have to provide notice of a pending premium rate schedule increase, including an "exceptional increase", to the OFIS Commissioner at least 30 days before the notice to the policyholders. The notice to the Commissioner would have to include all of the following:

-- Information described above required to be given to an applicant.
-- Certification by a qualified actuary that if the requested premium rate schedule increase were implemented and the underlying assumptions, which reflected moderately adverse conditions, were realized, no further premium rate schedule increases would be anticipated and that the premium rate filing was in compliance with these provisions.
-- A statement that renewal premium rate schedules were not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification was given to the Commissioner.
-- Sufficient information for review and approval of the rate schedule increase by the Commissioner.

(Under the bill, "exceptional increase" would mean only those increases filed by an insurer as exceptional for which the OFIS Commissioner determined the need for the premium rate increase was justified due to changes in laws or regulations applicable to long-term care coverage in Michigan or due to increased and unexpected use that affected the majority of insurers of similar products.)

Additionally, the notice would have to include an actuarial memorandum justifying the rate schedule change request that included 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 deviated from those used for pricing other policies or certificates currently available for sale. Annual values for the five years preceding and the three years following the valuation date would have to be provided separately. The projections would have to include the development of the lifetime loss ratio, unless the rate increase was an exceptional increase. The projections would have to demonstrate compliance with the requirements described below applicable to premium rate schedule increases. For exceptional increases, the projected experience would have to be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase, and if the Commissioner determined that offsets could exist, the insurer would have to use appropriate net projected experience.

The memorandum also would have to include the following:

-- Disclosure of how reserves had been incorporated in the rate increase, if the increase would trigger contingent benefit upon lapse.
-- A statement that policy design, underwriting, and claims adjudication practices had been taken into consideration.
-- If it were necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer would need to file composite rates reflecting projections of new certificates.

All premium rate schedule increases would have to be determined in accordance with the following requirements:

-- Exceptional increases would have to provide that 70% of the present value of projected additional premiums from the exceptional increase would be returned to policyholders in benefits.
-- Premium rate schedule increases would have to be calculated so 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, would not be less than the sum of the following: the accumulated value of the initial earned premium times 58%; 85% of the accumulated value of previous rate schedule increases on an earned basis; the present value of future projected initial earned premiums times 58%; and 85% of the present value of other future projected premiums on an earned basis.
-- If a policy or certificate had both exceptional and other increases, the values of 85% of the accumulated value of prior premium rate schedule increases on an earned basis and the present value of future projected initial earned premiums times 58%, also would include 70% for exceptional rate increase amounts.
-- All present and accumulated values used to determine rate increases would have to use the maximum valuation interest rate for contract reserves as specified in Section 733(1) (which prescribes the maximum interest rate for contract reserves related to disability insurance).

The actuary would have to disclose as part of the actuarial memorandum the use of any appropriate averages.

For each rate increase that was implemented, the insurer would have to file for review and approval by the OFIS Commissioner updated projections (as described above regarding lifetime projections of earned premiums and incurred claims) annually for the next three years and include a comparison of actual results to projected values. The Commissioner could extend the period to more than three years if actual results were not consistent with projected values from prior projections. For certain group insurance certificates, the required projection would have to be given to the policyholder in lieu of filing with the Commissioner. (This would apply to a group policy if it insured 250 people and the policyholder had at least 5,000 eligible employees of a single employer or the policyholder, and not the certificate holders, paid a material portion of the premium, which would have to be at least 20% of the total premium for the group in the calendar year before the year a rate increase was filed.)

If any premium rate in the revised premium rate schedule exceeded 200% of the comparable rate in the initial premium schedule, lifetime projections would have to be filed for review and approval by the Commissioner every five years following the end of the required period. For group insurance certificates that met the conditions described above, the required projections would have to be provided to the policyholder in lieu of filing with the Commissioner.

If the Commissioner had determined that the actual experience following a rate increase did not match adequately the projected experience and that the current projections under moderately adverse conditions demonstrated that incurred claims would not exceed proportions of premium specified in the bill, the Commissioner could 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 matched the projected experience, consideration would have to be given to a provision

requiring the notice to the Commissioner to include disclosure of the analysis performed to determine why a rate adjustment was necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer had been relied on by the actuary.

If the majority of the policies or certificates to which an increase applied were eligible for the contingent benefit upon lapse, the insurer would have to file both of the following with the Commissioner:

-- 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 had been implemented or were in effect.
-- The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to the bill had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations of the accumulated value of the initial earned premium times 58%, and the present value of future projected initial earned premiums times 58%.

The OFIS Commissioner would have to 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 had occurred or was anticipated for any rate increase filing meeting the following criteria:

-- The rate increase was not the first rate increase requested for the specific policy or certificate.
-- The rate increase was not an exceptional increase.
-- The majority of the policies or certificates to which the increase applied were eligible for the contingent benefit upon lapse.

(Under the bill, these provisions would not apply to a group insurance policy if the policy insured at least 250 people and the policyholder had at least 5,000 eligible employees of a single employer or the policyholder, and not the certificate holders, paid a material portion of the premium, which could not be less than 20% of the total premium for the group in the calendar year before the year a rate increase was filed.)

If significant adverse lapsation had occurred, were anticipated in the filing, or were evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner could determine that a rate spiral existed. Following that determination, the Commissioner could require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. An offer under this provision would be subject to the Commissioner's approval and would have to be based on actuarially sound principles, but could not be based on attained age, and would have to provide that maximum benefits under any new policy or certificate accepted by an insured would have to be reduced by comparable benefits already paid under the existing policy or certificate.

The insurer would have to maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy or certificate. If a rate increase were requested on the policy or certificate, the increase would have to 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%.

If the Commissioner determined that an insurer had exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner, in addition to acting under the provisions described above, could prohibit the insurer from doing either of the following:

-- Filing and marketing comparable coverage for a period of up to five years.
-- Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

These provisions would not apply to policies or certificates for which the long-term care benefits provided by the policy or certificate were incidental, if the policy or certificate complied with all of the following:

-- For any plan that could have a cash value, the interest credited internally to determine cash value accumulations, including long-term care, if any, was 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.
-- The portion of the policy or certificate that provided insurance benefits other than long-term care coverage met the nonforfeiture requirements of life insurance or individual deferred annuities, as applicable.
-- The policy or certificate met Sections 3928, 3933, 3951, and 3953 (described below).
-- The portion of the policy or certificate that provided insurance benefits other than long-term care coverage met, as applicable, the policy illustrations and disclosure requirements applicable to a universal life insurance policy under Section 4038.

(Section 3928 applies to a fixed indivisible premium life insurance policy that funds long-term care benefits entirely by accelerating the death benefit and that meets specified criteria. Section 3933 requires an insurer that offers long-term care insurance to provide to a prospective applicant before application and upon request before renewal a summary of coverage. Under Section 3951, 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 must be provided to the policyholder. Under Section 3953, a life insurance policy that provides an accelerated benefit for long-term care must provide a disclosure statement at the time of application 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.)

("Incidental" would mean that the value of the long-term care benefits provided was 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.)

Additionally, an actuarial memorandum would have to be filed with OFIS. The memorandum would have to include all of the following:

-- A description of the basis on which the long-term care rates were determined.
-- A description of the basis for the reserves.
-- A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance.
-- 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.
-- The estimated average annual premium per policy or certificate and the average issue age.
-- 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.

The actuarial memorandum also would have to include a description and a table of each actuarial assumption used. For expenses, an insurer would have to include percent of premium dollars per policy or certificate and dollars per unit of benefits, if any. Additionally, the memorandum would have to include a statement as to whether underwriting was performed at the time of application. The statement would have to include whether underwriting was used and, if so, include a description of the type or types of underwriting used, such as medical or functional assessment underwriting. For a group certificate, the statement would have to indicate whether the enrollee or dependent would be underwritten and when underwriting occurred.

Except as otherwise provided, exceptional increases would be subject to the same requirements as other premium rate schedule increases. The Commissioner could request a review by an independent qualified actuary or a professional qualified actuary 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 existed, also would have to

determine any potential offsets to higher claims costs.

Reasonable Benefits

Under Section 3927, benefits under individual long-term care insurance policies are 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 must be given to all relevant factors, including factors specified in the Code. This provision does not apply to fixed indivisible premium life insurance policies that fund long-term care benefits entirely by accelerating the death benefit.

The bill specifies that Section 3927 would apply to all long-term care insurance policies or certificates except those issued in Michigan on or after January 1, 2007.

Marketing & Suitability Standards

Every insurer or other entity marketing long-term care insurance would have to do all of the following:

-- Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance was appropriate for the needs of the applicant.
-- Train its producers in the use of and require producers to use its suitability standards.
-- Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

To determine whether an applicant met the developed suitability standards, the insurer would have to make reasonable efforts to obtain all of the following information:

-- The applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.
-- 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.
-- The values, benefits, and costs of the applicant's existing insurance, if any, when compared with the values, benefits, and costs of the recommended purchase or replacement.

If the insurer determined that the applicant did not meet its suitability standards, or if the applicant had declined to provide the necessary information, the insurer could reject the application for long-term care insurance.

These provisions would not apply to life insurance policies or riders containing accelerated benefits for long-term care.

The bill would prohibit an insurer marketing long-term care insurance coverage in Michigan from using the term "level premium" or "noncancelable" unless the insurer did not have the right to change the premium for the product being marketed.

MCL 500.3901 et al. (H.B. 5348)
500.1204c et al. (H.B. 5349)

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

House Bill 5348

The bill would have no fiscal impact on State or local government.

House Bill 5349 (H-3)

The bill would likely lead to an expansion of the long-term care insurance market. Such an expansion would, in the long run, reduce Medicaid long-term care expenditures. Some of the individuals who would buy long-term care insurance would have been covered by Medicaid if they had not bought policies.

Fiscal Analyst: Steve Angelotti

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