



ADMINISTRATIVE RULES OF MONTANA



6.6.3109A REPORTING REQUIREMENTS

- (1) Every issuer shall maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percentage of the producer's total annual sales.
- (2) Every issuer shall report annually by June 30, on LTC Form G in ARM 6.6.3120(1)(g), the 10% of its producers with the greatest percentages of lapses and replacements as measured by (1).
- (3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.
- (4) Every issuer shall report annually by June 30, on LTC Form E in ARM 6.6.3120(1)(e), the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year.
- (5) Every issuer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year.
- (6) Every issuer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of an applicable preexisting condition.
- (7) For purposes of this rule:
 - (a) "policy" means only long-term care insurance;
 - (b) subject to (7)(c) "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
 - (c) "denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and
 - (d) "report" means on a statewide basis.
- (8) Reports required under this rule shall be filed with the commissioner on the applicable forms contained in ARM 6.6.3120.
- (9) The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies issued in this state on or after January 1, 2009:

- (a) An actuarial certification based on calendar year data, submitted annually no later than May 1st of each year, and prepared, dated, and signed by a member of the American Academy of Actuaries who provides the information. The actuarial certification shall provide at least the following information:
 - (i) for the rate schedules currently marketed, a description of the review performed and a statement of the sufficiency of the current premium rate schedule including:
 - (A) that the premium rate schedule continues to be 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 form with no future premium increases anticipated; or
 - (B) if the statement in (A) cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within 60 days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify approval of the form for future sales;
 - (ii) for the rate schedules that are no longer marketed, a description of the review performed and a statement:
 - (A) that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or
 - (B) that the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within 60 days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.
- (b) An actuarial memorandum submitted at least once every three years with the certification required in (a), and dated and signed by a member of the American Academy of Actuaries who prepares the information. The actuarial memorandum shall provide at least the following information:
 - (i) a detailed explanation of the data sources and review performed by the actuary prior to making the statement required by (a);
 - (ii) a complete description of experience assumptions and their relationship to the initial pricing assumptions;
 - (iii) a description of the credibility of the experience data; and
 - (iv) an explanation of the analysis and testing performed in determining the current presence of margins.

Authorizing statute(s): 33-1-313, 33-22-1121, MCA

Implementing statute(s): 33-22-1113, MCA

History: NEW, 1998 MAR p. 3271, Eff. 12/18/98; AMD, 2008 MAR p. 615, Eff. 10/1/08; AMD, 2019 MAR p. 126, Eff. 1/1/20.