



ADMINISTRATIVE RULES OF MONTANA



6.6.3104 POLICY PRACTICES AND PROVISIONS

- (1) The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy or certificate without further explanatory language in accordance with the disclosure requirements of ARM 6.6.3105.
- (2) No such policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable." The commissioner of insurance may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the commissioner of insurance, to best protect the interests of the insureds, if the issuer demonstrates:
 - (a) that renewal will jeopardize the issuer's solvency; or
 - (b) that the actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and
 - (c) the policies will continue to experience substantial and unexpected losses over their lifetime; and
 - (d) the projected loss experience of the policies cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and
 - (e) the issuer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.
- (3) The term "guaranteed renewable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the issuer has no unilateral right to make any change in any provision of the policy, certificate, or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the issuer on a class basis.
- (4) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the issuer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.
- (5) The term "level premium" may only be used when the insurer does not have the right to change the premium.
- (6) In addition to the other requirements of this rule, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

- (7) A policy or certificate may not be delivered or issued for delivery in this state as long-term care insurance if the policy or certificate limits or excludes coverage by type of illness, treatment, medical condition, or accident, except it may include exclusions or limits for:
- (a) preexisting conditions or diseases;
 - (b) mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or irreversible dementia;
 - (c) alcoholism and drug addiction;
 - (d) illness, treatment or medical condition arising out of:
 - (i) war or act of war, whether declared or undeclared;
 - (ii) participation in a felony, riot or insurrection;
 - (iii) service in the armed forces or units auxiliary thereto;
 - (iv) sane or insane suicide, attempted suicide or intentionally self-inflicted injury; or
 - (v) aviation, provided this exclusion applies only to nonfare-paying passengers.
 - (e) treatment provided in a government facility, unless coverage is otherwise required by law;
 - (f) services for which benefits are available under Medicare or a governmental program other than Medicaid, or under a state or federal worker's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
 - (g) services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;
 - (h) expenses for services or items available or paid under another long-term care insurance or health insurance policy;
 - (i) in the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;
 - (j) this rule is not intended to prohibit exclusions and limitations by type of provider; however:
 - (i) no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued, under the following conditions:
 - (A) when the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or
 - (B) when the state other than the state of policy issue issues licenses, certifies, or registers the provider under another name.
 - (ii) for purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.
 - (k) this rule is not intended to prohibit exclusions or limitations by territorial limitations.

- (8) 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 insurance was in force and continues without interruption after termination. Such 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 or certificate.
- (9) Group long-term care insurance policies or certificates issued in Montana on or after January 1, 1991, shall provide covered individuals with a basis for continuation or conversion of coverage.
- (a) For the purposes of this rule, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy or certificate when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies or certificates which restrict provision of benefits and services to, or contain incentives to use certain health care providers or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy or certificate. The Commissioner of Insurance may make a determination as to the substantial equivalency of benefits, and in doing so, may take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, health care provider system arrangements, service availability, benefit levels and administrative complexity.
- (b) For the purposes of this rule, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy or certificate would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy or certificate in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or certificate and any group policy or certificate which it replaced, for at least three months immediately prior to termination, shall be entitled to the issuance of a converted policy or certificate by the issuer under whose group policy or certificate the individual is covered, without evidence of insurability.
- (c) For the purposes of this rule, "converted policy" means a policy or certificate of long-term care insurance providing benefits identical to or benefits determined by the Commissioner of Insurance to be substantially equivalent to or in excess of those provided under the group policy or certificate from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain health care providers or facilities, the Commissioner of Insurance, in making a determination as to the substantial equivalency of benefits, may take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, health care provider system arrangements, service availability, benefit levels, and administrative complexity.
- (d) Written application for the converted policy or certificate shall be made and the first premium due, if any, shall be paid as directed by the issuer not later than 31 days after termination of coverage under the group policy or certificate. The converted policy or certificate shall be issued effective on the day following the termination of coverage under the group policy or certificate, and shall be renewable annually.
- (e) Unless the group policy or certificate from which conversion is made replaced previous group coverage, the premium for the converted policy or certificate shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which

conversion is made. Where the group policy or certificate from which conversion is made replaced previous group coverage, the premium for the converted policy or certificate shall be calculated on the basis of the insured's age at inception of coverage under the group policy or certificate replaced.

- (f) Continuation of coverage or issuance of a converted policy or certificate shall be mandatory except where:
 - (i) termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
 - (ii) the terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:
 - (A) providing benefits identical to or benefits determined by the Commissioner of Insurance to be substantially equivalent to or in excess of those provided by terminating coverage; and
 - (B) the premium for which is calculated in a manner consistent with the requirements of (9)(e).
 - (g) Notwithstanding any other provision of this rule, a converted policy or certificate issued to an individual who at the time of conversion is covered by another long-term care insurance policy or certificate which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy or certificate, would result in payment of more than 100% of incurred expenses. The provision shall only be included in the converted policy or certificate if the converted policy or certificate also provides for a premium decrease or refund which reflects the reduction in benefits payable.
 - (h) The converted policy or certificate may provide that the benefits payable under the converted policy or certificate, together with the benefits payable under the group policy or certificate from which conversion is made, may not exceed those that would have been payable had the individual's coverage under the group policy or certificate remained in force and effect.
 - (i) Notwithstanding any other provision of these rules, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy or certificate upon termination of the qualifying relationship by death or dissolution of marriage.
 - (j) For the purposes of these rules, a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific health care provider networks.
- (10) If a group long-term care policy or certificate is replaced by another group long-term care policy or certificate issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy or certificate:
- (a) shall not result in an exclusion for preexisting conditions that would have been covered under the group policy or certificate being replaced; and

- (b) shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.
- (11) The premium charged to an insured shall not increase due to either:
- (a) the increasing age of the insured at ages beyond 65; or
 - (b) the duration the insured has been covered under the policy.
- (12) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under ARM 6.6.3128, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under ARM 6.6.3128, the initial annual premium shall be based on the reduced benefits.
- (13) In the case of a group defined in 33-22-1107(5)(a), MCA, any requirement that a signature of an insured be obtained by an agent or issuer shall be deemed satisfied if:
- (a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or issuer. A verification of enrollment information shall be provided to the enrollee;
 - (b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and
 - (c) The telephonic or electronic enrollment providing necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information," as defined by 33-19-104(24), MCA, is maintained.
 - (d) The issuer shall make available, upon request of the commissioner, records that will demonstrate the issuer's ability to confirm enrollment and coverage amounts.
- (14) For a policy or certificate that has been in force for less than six months an issuer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.
- (a) For a policy or certificate that has been in force for at least six months but less than two years an issuer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.
 - (b) After a policy or certificate has been in force for two years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.
 - (c) No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this rule, "field issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an issuer.
 - (d) If an issuer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the issuer in the event that the policy or certificate is rescinded.

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

Implementing statute(s): 33-22-1101, 33-22-1102, 33-22-1103, 33-22-1107, 33-22-1108, 33-22-1111, 33-22-1112, 33-22-1113, 33-22-1114, 33-22-1115, 33-22-1116, 33-22-1117, 33-22-1119, 33-22-1120, 33-22-1121, MCA

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