



ADMINISTRATIVE RULES OF MONTANA

6.6.3124 PREMIUM RATE SCHEDULE INCREASES

- (1) Except as provided in (2), this rule applies to any long-term care policy issued in this state on or after January 1, 2009.
- (2) For policies issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in 33-22-1107(5), MCA, which policy was in force at the time this amended rule became effective, the provisions of this rule shall apply on the policy anniversary following January 1, 2009.
- (3) An issuer 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 policyholders and shall include:
 - (a) information required by ARM 6.6.3121;
 - (b) certification by a qualified actuary that:
 - (i) 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
 - (ii) the premium rate filing is in compliance with the provisions of this rule.
 - (c) an actuarial memorandum justifying the rate schedule change request that includes:
 - (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 forms currently available for sale;
 - (A) annual values for the five years preceding and the three years following the valuation date shall be provided separately;
 - (B) the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - (C) the projections shall demonstrate compliance with (4); and
 - (D) for exceptional increases the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase;

- (i) in the event the commissioner determines, as provided in ARM 6.6.3102(4)(d) that offsets may exist, the issuer shall use appropriate net projected experience;
 - (ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
 - (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 company have been relied on by the actuary;
 - (iv) a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration;
 - (v) in the event that it is necessary to maintain consistent premium rates for new business premium rate schedules, except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
 - (vi) sufficient information for review 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 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 will not be less than the sum of the following:
 - (i) the accumulated value of the initial earned premium times 58%;
 - (ii) 85% 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%; and
 - (iv) 85% of the present value of future projected premiums not in (4)(b)(iii) on an earned basis.
 - (c) in the event that a policy form has both exceptional and other increases, the values in (4)(b)(ii) and (4)(b)(iv), will also include 70% for exceptional rate increase amounts; and
 - (d) all present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in 33-2-514, MCA. 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 issuer shall file for review by the commissioner updated projections, as defined in (3)(c)(i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in (12), the projections required by this rule 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 defined in (3)(c)(i), shall be filed for review by the commissioner every five years following the end of the required period in (5). For group insurance policies that meet the conditions in (12), the projections required by (6) 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 (4), the commissioner may require the insurer to implement any of the following:
 - (a) premium rate schedule adjustments; or
 - (b) other measures to reduce the difference between the projected and actual experience.
 - (i) In determining whether the actual experience adequately matches the projected experience, consideration should be given to (3)(c)(v), if applicable.
- (8) If the majority of the policies to which the increase is applicable are eligible for the contingent benefit upon lapse, the issuer shall file:
 - (a) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in (9); and
 - (b) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to (4), had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in (4)(b)(i) and (iii).
- (9) For a rate increase filing that meets the criteria in (9)(b)(i), (ii), and (iii), the commissioner shall review, for all policies included in the filing:
 - (a) the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated.
 - (b) the following criteria triggers a lapsation review:
 - (i) the rate increase is not the first rate increase requested for the specific policy form or forms;
 - (ii) the rate increase is not an exceptional increase; and
 - (iii) the majority of the policies to which an increase is applicable are eligible for the contingent benefit upon lapse.
 - (c) in the event 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 issuer 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 issuer 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 issuer or its affiliates.

- (i) The offer shall:
 - (A) be subject to the approval of the commissioner;
 - (B) be based on actuarially sound principles, but not be based on attained age; and
 - (C) provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
- (d) the issuer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
 - (i) the maximum rate increase determined based on the combined experience; and
 - (ii) the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.
- (10) If the commissioner determines that the issuer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of (9), prohibit the issuer from either of the following:
 - (a) filing or marketing comparable coverage for a period of up to five years; or
 - (b) offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- (11) Sections (1) through (10) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in ARM 6.6.3102(6), if the policy complies with all of the following provisions:
 - (a) 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;
 - (b) the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
 - (i) 30-20-201 et seq., MCA; and
 - (ii) 30-20-501 et seq., MCA.
 - (c) the policy meets the disclosure requirements of 33-22-1123 and 33-22-1124, MCA;
 - (d) the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
 - (i) policy illustrations as required by ARM 6.6.701 et seq.; and
 - (ii) disclosure requirements in ARM 6.6.805.
 - (e) an actuarial memorandum is filed with the insurance department that includes:
 - (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 issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (vi) the estimated average annual premium per policy 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, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - (viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- (12) ARM 6.6.3124(7) and (9) do not apply to group insurance policies defined in 33-22-1107(5), MCA, where:
- (a) the policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
 - (b) the policyholder, and not the certificateholder, pays a material portion of the premium that 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.

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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