BEFORE THE COMMISSIONER OF SECURITIES AND INSURANCE
OFFICE OF THE MONTANA STATE AUDITOR

In the matter of the adoption of New Rules I through IV and the amendment of ARM 6.6.3101, 6.6.3102, 6.6.3103, 6.6.3104, 6.6.3109, 6.6.3109A, 6.6.3114, 6.6.3117, 6.6.3118, 6.6.3119, 6.6.3120, 6.6.3121, 6.6.3122, and 6.6.3129, pertaining to long-term care insurance	))))))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT

TO: All Concerned Persons

1. On December 11, 2018, at 10:00 a.m., the Commissioner of Securities and Insurance, Office of the Montana State Auditor (CSI), will hold a public hearing in the basement conference room, at the Office of the Montana State Auditor, Commissioner of Securities and Insurance, 840 Helena Avenue, Helena, Montana, to consider the proposed adoption and amendment of the above-stated rules.

2. The CSI will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the CSI no later than 5:00 p.m. on November 27, 2018, to advise us of the nature of the accommodation that you need. Please contact Ramona Bidon, CSI, 840 Helena Avenue, Helena, Montana, 59601; telephone (406) 444-2726; TDD (406) 444-3246; fax (406) 444-3499; or e-mail rbidon@mt.gov.

3. The new rules as proposed to be adopted are as follows:

NEW RULE I RECOUPING PAST LOSSES (1) In reviewing loss ratio and premium rate schedule increases, the commissioner will ensure that any issuer does not recoup past losses.

(2) For premium rate increases, to ensure that issuers do not recoup past losses, premium deficiencies prior to a requested rate increase should not be included in the premium rate increase calculation. This is determined by comparing the originally filed lifetime loss ratio with the corrected lifetime loss ratio.

(a) The corrected lifetime loss ratio is found by recalculating the original premiums given the actual historical experience of that block of business combined with the company's revised projected assumptions.

(b) The originally filed lifetime loss ratio is found by:

(i) for blocks of business issued in Montana prior to January 1, 2009, following ARM 6.6.3112; or

(ii) for blocks of business issued in Montana on or after January 1, 2009, following ARM 6.6.3124.

(3) In order to review for past losses, insurers shall provide the following information in an actuarial memorandum accompanying any premium rate increase request:

(a) lifetime projections of earned premiums and incurred claims with the original pricing assumptions, including the originally filed discount rates;

(b) lifetime projections of earned premiums and incurred claims with actual experience;

(c) lifetime projections of earned premiums and incurred claims as required by (b), but with future premiums restated to reflect previously approved premium increases in Montana;

(d) lifetime projections of earned premiums and incurred claims as required by (c), but including persistency assumptions in the projected experience;

(e) lifetime projections of earned premiums and incurred claims as required by (d), but with revised claim assumptions (the lifetime loss ratio should reflect the expected lifetime loss ratio using best estimate assumptions besides the original discount rates);

(f) lifetime projections of earned premiums and incurred claims as required by (e), but including results both with and without the requested premium rate increase; and

(g) lifetime projections of earned premiums and incurred claims as required by (f), but including results with all past premium rate increases in Montana assumed to be implemented at policy issue.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 33-18-206, 33-18-1003, 33-22-1102, 33-22-1121, MCA

REASON: The CSI is codifying its longstanding approach to review of premium rate increases for long-term care policies. While the CSI has been transparent and consistent in its application of this methodology, putting this methodology in rule will provide more notice to long-term care companies of this approach to calculating past losses, and also ensure consistency in application of this methodology in the future.

NEW RULE II APPEALING AN INSURER'S DETERMINATION THAT THE BENEFIT TRIGGER IS NOT MET (1) For purposes of this rule, "authorized representative" means a person authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated by the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:

(a) a person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) a person authorized by law to provide substituted consent for a covered person; or

(c) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(2) If an insurer determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the

insured and the insured's authorized representative, if applicable, of all of the following:

(a) the reason that the insurer determined that the insured's benefit trigger has not been met;

(b) the insured's right to internal appeal in accordance with (3), and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and

(c) the insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with (4).

(3) The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.

(a) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing in this rule shall require the insurer to offer any internal appeal rights other than those described in this rule.

(b) If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in (4) to the insured and the insured's authorized representative, if applicable.

(c) As part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy][certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."

(d) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured's authorized representative, if applicable, in writing and include in the notice that reasons for its determination of independent review ineligibility.

(e) The appeal process described in this section is not deemed to be a "new service or provider" as referenced in ARM 6.6.3128 and therefore does not trigger the notice requirements of that rule.

(4) The insured or the insured's authorized representative may request an independent review of the insurer's benefit trigger determination after the internal appeal process outlined in (3) has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within 120 calendar days after the insurer's written notice of the final internal appeal decision is received by the insured or the insured's authorized representative, if applicable.

(a) The cost of the independent review shall be borne by the insurer.

(b) Within five business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the commissioner. The insurer shall vary the selection of authorized independent review organizations on a rotating basis.

(c) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

(i) the independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this rule;

(ii) the independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer; and

(iii) such review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

(d) The insured or the insured's authorized representative may submit at any time new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in (3).

(i) If new information is received by the independent review organization from the insured or the insured's authorized representative, the independent review organization shall provide copies of any documentation or information provided to the insurer for its review.

(ii) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.

(iii) The insurer shall complete its review of the information and provide written notice of the analysis and results of the review to the insured, the insured's authorized representative, if applicable, and the independent review organization within five business days of the insurer's receipt of such new or additional information.

(iv) If the insurer maintains its denial after such review, the independent review organization shall continue its review, and render its decision within the time period specified in (4)(g). If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

(e) The insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, that the request for independent review has been received, accepted, and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.

(f) Within five business days of receipt of the request for independent review, the assigned independent review organization shall notify the insured, the insured's authorized representative, if applicable, and the insurer, that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization, within seven days following the date of receipt of the notice, additional information and supporting documentation that the independent review organization should consider when conducting its review.

(g) The independent review organization shall review all of the information received, and provide the insured, the insured's authorized representative, if applicable, and the insurer written notice of its decision within 30 calendar days from receipt of the referral referenced in (4)(c). If the independent review organization overturns the insurer's decision, it shall:

(i) establish the precise date within a specific period of time under review that the benefit trigger was deemed to have been met;

(ii) specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met; and

(iii) for tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in section 7702B(c)(4) of the Internal Revenue Code) that the insured is a chronically ill individual.

(h) The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer.

(5) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.

(6) Nothing in this rule shall restrict the insured's right to submit a new request for a benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.

(7) Nothing contained in this rule limits the insurer's ability to assert any rights it may have under the policy related to:

(a) an insured's misrepresentation;

(b) changes in the insured's benefit eligibility; or

(c) terms, conditions, or exclusions of the policy, other than failure to meet the benefit trigger.

(8) The requirements of this rule apply to a benefit trigger request made on or after January 1, 2019, under a long-term care insurance policy.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 33-18-201, 33-22-1102, 33-22-1121, 33-22-1124, 33-22-1125, MCA

REASON: These changes are to modernize Montana's long-term care regulations. The proposed language is part of model regulation 641 of the National Association of Insurance Commissioners (NAIC), most recently updated in 2017. With the aging population of long-term care insureds, claims to long-term care insurers are expected to rise. This rule will provide greater consistency and reliability in the claim review process for long-term care insurers, on par with other disability insurance products.

NEW RULE III LONG-TERM CARE INDEPENDENT REVIEW ORGANIZATIONS (1) The commissioner shall certify or approve a qualified long-term care insurance independent review organization, provided the organization demonstrates to the satisfaction of the commissioner that it is unbiased and that:

(a) the organization will have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment (e.g., physical therapy, occupational therapy, neurology, physical medicine and rehabilitation) to conduct the review;

(b) neither the organization, nor any of its licensed health care professionals, may be related to or affiliated with, in any manner, an entity that previously provided medical care to the insured;

(c) the organization will utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured;

(d) neither the organization, nor its licensed health care professionals who conduct the reviews, may receive compensation of any type that is dependent on the outcome of the review;

(e) the organization will be approved or certified by Montana before conducting such reviews;

(f) the organization provides a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision;

(g) the organization's fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review;

(h) the organization provides the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure; and

(i) the organization will have on staff or contract with a licensed health care practitioner, as defined by Section 7702B(c)(4) of the Internal Revenue Code, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

(2) Each certified independent review organization shall:

(a) maintain written documentation, in an easily accessible and retrievable format for the year in which it received information plus two calendar years, establishing the date it received a request for independent review, the date each review was conducted, the resolution, the date such resolution was communicated to the insurer and the insured, and the name and professional status of the reviewer who conducted the review;

(b) be able to document measures taken to appropriately safeguard the confidentiality of its records and prevent unauthorized use and disclosures in accordance with applicable federal and state law;

(c) report annually to the commissioner, by June 1, in the aggregate and for each long-term care insurer all of the following:

(i) the total number of requests received for independent review of long-term care benefit trigger decisions;

(ii) the total number of reviews conducted and the resolution of such reviews (i.e., the number of reviews which upheld or overturned the long-term care insurer's determination that the benefit trigger was not met);

(iii) the number of reviews withdrawn prior to review; and

(iv) the percentage of reviews conducted within the prescribed timeframe set forth in [New Rule II];

(d) report immediately to the commissioner any change in its status which would cause it to cease meeting any of the qualifications required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

(3) The insurance department shall utilize the criteria set forth in ARM 6.6.3120(1)(h), in certifying or approving entities to review long-term care insurance benefit trigger decisions.

(4) The commissioner shall maintain and periodically update a list of approved independent review organizations.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 33-18-201, 33-22-1102, 33-22-1121, 33-22-1124, 33-22-1125, MCA

REASON: With New Rule II requiring the use of independent review organizations, this rule is necessary to clarify how the CSI will review and approve independent review organizations for long-term care insurers to use. See also the reason for New Rule II.

NEW RULE IV PERMITTED COMPENSATION ARRANGEMENTS (1) An insurer or other person may provide commission or other compensation to an agent

or other representative for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

(3) No person shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

(4) For purposes of this rule, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, or finders fees.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 33-22-1102, 33-22-1117, 33-22-1121, 33-22-1128, MCA

REASON: The CSI includes this new language from NAIC model regulation 641. Because long-term care insurance is marketed primarily to senior citizens, additional protections are warranted to curb commission structures which may provide incentives to producers to push seniors into products they do not want.

4. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

6.6.3101 PURPOSE, SCOPE, AND AUTHORITY (1) remains the same.

(2) Except as otherwise specifically provided, these rules apply to:

(a) all long-term care insurance policies or certificates including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after January 1, 1991, by issuers, fraternal benefit societies, nonprofit health, hospital, medical service corporations, prepaid health plans, health maintenance organizations, and all similar organizations~~.~~; and

(b) policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(i) the benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(ii) the disability income policy is advertised, marketed, or offered as insurance for long-term care services; or

(iii) benefits under the policy may commence after the policyholder has reached social security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

(3) Notwithstanding (2), ~~C~~certain provisions of these rules apply only to qualified long-term care insurance contracts, as noted.

~~(3)~~(4) Group policies or certificates issued for delivery outside this state to Montana residents are subject to these rules and Title 33 of the Montana Code Annotated.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: These changes are to modernize the scope of Montana's long-term care regulations, consistent with the language from the latest version of NAIC model regulation 641.

6.6.3102 DEFINITIONS For purposes of these rules, in addition to the definitions in 33-22-1107, MCA, the following definitions apply:

(1) ~~"Applicant" is defined in 33-22-1107(2), MCA.~~ "Benefit trigger," for the purposes of independent review, means a contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in Section 770B of the Internal Revenue Code of 1986, as amended, "benefit trigger" shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

~~(2) "Certificate" is defined in 33-22-1107(4), MCA.~~

~~(3)~~(2) "Commissioner" means the Montana State Auditor and Ex Officio Commissioner of Insurance.

~~(4)~~(3) "Exceptional increase" means a premium rate increase filed by an insurer as exceptional; and

(a) for which the commissioner determines the need for a rate increase to be justified~~;~~:

(i) due to a change in laws or rules applicable to long-term care coverage in this state; ~~and~~ or

(ii) and (b) remain the same.

(c) the commissioner may request a review of the basis for the exceptional increase by an independent actuary or a professional actuarial body~~professional actuarial review of the basis for an exceptional increase submitted for commissioner approval~~;

(d) the commissioner, in determining whether there is a necessary basis for an exceptional increase, shall also determine any potential offsets to higher claims costs.

~~(5) "Group long-term care insurance" is defined in 33-22-1107(5), MCA.~~

(6) remains the same but is renumbered (4).

~~(7) "Long-term care insurance" is defined in 33-22-107(6), MCA.~~

~~(8) "Policy" is defined in 33-22-1107(7), MCA.~~

(5) "Independent review organization" has the same meaning as in 33-32-402, MCA.

(6) "Insurer" or "issuer" means an insurance company, health service corporation, health maintenance organization, or other entity providing long-term care insurance or benefits in Montana.

(7) "Licensed health care professional" means an individual qualified by

education and experience in an appropriate field to determine, by record review, an insured's actual functional or cognitive impairment.

(9) remains the same but is renumbered (8).

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: These changes are meant to reduce conflicting or redundant definitions, and to include modernized language from the latest version of NAIC model regulation 641.

6.6.3103 POLICY DEFINITIONS (1) through (13) remain the same.

(14) "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(15) through (19) remain the same.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: This change is meant to correct an inadvertent drafting error in the original rule.

6.6.3104 POLICY PRACTICES AND PROVISIONS (1) through (9)(f)(i) remain the same.

(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) through (11) remain the same.

(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.

(12) and (13) remain the same, but are renumbered (13) and (14).

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The change to (9)(f)(ii) is meant to correct an inadvertent drafting error in the original rule. The language in new (12) is to modernize the rule consistent with the language contained in the latest version of NAIC model regulation 641.

6.6.3109 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE (1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care insurance policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing the following questions shall be used.:

(a) 1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(b) 2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(i) a. If so, with which company?

(ii) b. If that policy or certificate lapsed, when did it lapse?

(c) 3. Are you covered by Medicaid?

(d) 4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate].?

(2) Producers shall list any other health insurance policies they have sold to the applicant., including:

(a) List policies sold that are still in force.; and

(b) List policies sold in the past five years that are no longer in force.

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance Company's Name and Address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own

information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

STATEMENT TO APPLICANT BY PRODUCER [OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

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

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present issuer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Producer or Other Representative)

[Typed Name and Address of Producer]

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance Company's Name and Address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

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

2. Montana law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

~~2.~~3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present issuer or its producer regarding the proposed replacement of your present policy or certificate. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

~~3.~~4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy or certificate and replace it with new coverage, read the copy of the application attached to your new policy or certificate and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

~~(Company Name)~~

(5) and (6) remain the same.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The changes to (1) and (2) are meant to correct an inadvertent drafting error in the original rule. The changes to (3) and (4) are to modernize the rule consistent with the language contained in the latest version of NAIC model regulation 641.

6.6.3109A REPORTING REQUIREMENTS (1) through (8) remain the same
(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.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 33-22-1113, MCA

REASON: Section (9) includes language contained in the latest version of NAIC model regulation 641, which applies to long-term care policies issued under post-rate stabilization requirements, which in Montana apply on or after January 1, 2009.

6.6.3114 STANDARD FORMAT OUTLINE OF COVERAGE (1) through (5) remain the same.

(6) Format for outline of coverage:

[COMPANY NAME]

[ADDRESS-CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number of Group Master Policy and Certificate Number]
[Except for policies or certificates which are guaranteed issue, the following caution

statement, or language substantially similar, must appear as follows in the outline of coverage.] Caution: The issuance of this long-term care insurance [policy] [certificate] 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 may have the right to deny benefits, or rescind your policy or certificate. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).
2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy or certificate contains governing contractual provisions. This means that the policy or certificate or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!
3. FEDERAL TAX CONSEQUENCES.

   This [POLICY][CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

   OR

   This [POLICY][CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY][CERTIFICATE] may be taxable as income.
4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

   (a) [For long-term care health insurance policies or certificates, describe one of the following policy renewability provisions:]

   (1) [Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy [certificate] on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

   (2) [Policies and certificates that are noncancelable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy or certificate, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot

change the premium you currently pay. However, if your policy or certificate contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation conversion provisions applicable to the certificate and group policy.]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. [In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

~~3.~~6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return--"free look" provision of the policy or certificate.]

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

~~4.~~7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement buyer's guide available from the insurance company.

(a) [For producers] Neither [insert company name] nor its producers represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

~~5.~~8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This policy or certificate provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

~~6.~~9. BENEFITS PROVIDED BY THIS POLICY/CERTIFICATE.

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) [Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.] [Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers

should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

~~7.~~10. LIMITATIONS AND EXCLUSIONS

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.)

(d) Exclusions/exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in ~~(6)~~ (9) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

~~8.~~11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

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

(b) Any automatic benefit adjustment provisions;

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

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

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

~~9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.~~

~~(a) [For long-term care health insurance policies or certificates, describe one of the following policy renewability provisions:~~

~~(i) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy [certificate] on its own, except that, in the future, it may increase the premium you pay.~~

~~(ii) [Policies and certificates that are noncancelable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy or certificate, to continue this policy as long as you pay your premiums on time. [Company Name]~~

~~cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy or certificate contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.~~

~~(b) For group coverage, specifically describe continuation conversion provisions applicable to the certificate and group policy;~~

~~(c) Describe waiver of premium provisions or state that there are not such provisions;~~

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

~~10.~~12. ALZHEIMER'S DISEASE, IRREVERSIBLE DEMENTIA, AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy or certificate provides coverage for insured clinically diagnosed as having Alzheimer's disease, irreversible dementia, or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

~~11.~~13. PREMIUM.

[(a) State the total annual premium for the policy or certificate;

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

~~12.~~14. ADDITIONAL FEATURES.

~~(a) QUALIFIED LONG-TERM CARE INSURANCE. Indicate whether or not the policy or certificate is intended to be a federally tax-qualified long-term care insurance contract.~~

[(~~b~~a) Indicate if medical underwriting is used;

(~~c~~b) Describe other important features.]

15. CONTACT THE MONTANA STATE AUDITOR'S OFFICE, COMMISSIONER OF SECURITIES AND INSURANCE, IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: These changes are meant to modernize the language of the outline of coverage, consistent with NAIC model regulation 641.

6.6.3117 STANDARDS FOR MARKETING (1) and (1)(a) remain the same.

(i) any marketing activities, including comparison of policies, by its producers

or other producers, will be fair and accurate; and

~~(b)~~(ii) ~~establish marketing procedures to assure~~ excessive insurance is not sold or issued;

(c) through (i) remain the same, but are renumbered (b) through (h).

(2) remains the same.

(3) With respect to the obligations set forth in this rule~~, the primary responsibility of an association, as defined in 33-22-1107, MCA, when endorsing long-term care insurance shall be~~:

(a) the primary responsibility of an association, as defined in 33-22-1107, MCA, when endorsing long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) through (i) remain the same.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The changes are meant to improve the organization and readability of the rule.

6.6.3118 SUITABILITY STANDARDS (1) remains the same.

~~(2) To determine whether the applicant meets the standards developed by the issuer, the issuer shall:~~

~~(a) develop procedures that take the following into consideration:~~

~~(i) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;~~

~~(ii) the applicants' goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and~~

~~(iii) the values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.~~

~~(3)~~(2) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall~~:~~

~~(a)~~ develop procedures that take the following into consideration:

(i) through (iii) remain the same, but are renumbered (a) through (c).

~~(4)~~(3) To determine whether the applicant meets the standards required by (2), ~~developed by~~ the issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in (2)~~(a)~~. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in ARM 6.6.3120(1)(b) in not less than 12 point type. The issuer may request the applicant

to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

(a) and (b) remain the same.

(5) through (10) remain the same, but are renumbered (4) through (9).

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The changes are meant to correct a drafting error in the original rule, and improve the organization and readability of the rule.

6.6.3119 NONFORFEITURE BENEFIT REQUIREMENT (1) through (4)(b) remain the same.

(c) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an issuer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy lapses within 120 days of the due date of the premium so increased, and the ratio in (4)(e)(ii), is 40% or more. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by (4)~~(c)~~(b), and where both are triggered, the benefit provided shall be at the option of the insured.

(d) remains the same.

(i) offer to reduce policy benefits provided by the current coverage consistent with the requirements of ARM 6.6.3129~~without the requirement of additional underwriting~~ so that required premium payments are not increased;

(ii) remains the same.

(iii) notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in (4)(b) shall be deemed to be the election of the offer to convert in (4)(c)(ii), unless the automatic option in (4)(e)(iii) applies.

(e) remains the same.

(i) offer to reduce policy benefits provided by the current coverage consistent with the requirements of ARM 6.6.3129 ~~without the requirement of additional underwriting~~ so that required premium payments are not increased;

(ii) offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90% of the amount payable, in effect immediately prior to lapse, times the ratio of the number of completed months of paid premiums, divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in (4)~~(d)~~(c); and

(iii) notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in (4)(c) shall be deemed to be the election of the offer to convert in ~~(2)~~(4)(e)(ii), if the ratio is 40% or more.

(5) through (8) remain the same.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of ARM 6.6.3112 or ARM 6.6.3124, whichever is applicable, treating the policy or certificate as a whole.

(10) through (12) remain the same.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The changes to (4)(d)(i), (4)(e)(i), and (9) are meant to modernize the rule, consistent with language contained in the latest version of NAIC model regulation 641. The other changes are meant to correct inadvertent drafting errors in the original rule.

6.6.3120 ADOPTION OF FORMS (1) and (1)(a) remain the same.

(b) LTC Form B Long-Term Care Insurance Personal Worksheet

LTC FORM B

Long-Term Care Insurance
Personal Worksheet

~~People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.~~

~~By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.~~

This worksheet will help you understand some important information about this type of insurance. Montana law requires companies issuing this [policy][certificate][rider] to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you

should buy this [policy][certificate][rider]. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

Policy Form Numbers~~_____~~

~~The premium for the coverage you are considering will be [$____ per month, or $ _____ per year,] [a one-time single premium of $_____.]~~

The premium for the coverage you are considering will be $[__] per [insert payment interval] **or a total of** [**$**[__] per year][a one-time single premium of $[__]].

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this [policy][certificate][rider] is in force.

~~**Type of Policy** (noncancelable/guaranteed renewable):~~**_____**

~~**The Company's Right to Increase Premiums**~~:

~~[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future provided it raises rates for all policies in the same class in this state.][Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]~~

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

[Noncancellable – The company cannot increase your premiums on this [policy][certificate][rider]].
[Guaranteed renewable – The company can increase your premiums on this [policy][certificate][rider] in the future if it increases the premiums for all [policies][certificates][riders] like yours in Montana.]
[Paid-up – This [policy][certificate][rider] will be paid-up after you have paid all of the premiums specified in your [policy][certificate][rider]].

~~**Rate Increase History**~~**Premium Increase History**

~~The~~ [Name of company] has sold long-term care insurance since [year] and has sold this [policy][certificate][rider] since [year]. ~~[The last rate increase for this policy in this state was in [year], when premiums went up by an average of ___%]. [The company has not raised its rates for this policy.]~~ [The company has never raised its ~~rates~~ premiums for any long-term care [policy][certificate][rider] it has sold in this state or any other state.]

[The company has not ~~raised its rates~~increased its premiums for this [policy][certificate][rider] ~~form~~ or similar ~~policy forms~~[policies][certificates][riders] in this state or any other state in the last 10 years.]
[The company has ~~raised~~increased its premiums ~~rates~~ on this [policy][certificate][rider] ~~form~~ or similar ~~policy forms~~[policies][certificates][riders] in the last 10 years. Following is a summary of the ~~rate~~ increases.]
[Over the past 10 years, the company has increased premiums on this [policy][certificate][rider] or similar [policies][certificates][riders] by __%. A summary of the premium increases in the last 10 years is attached to this worksheet.]

Questions Related to Your Income

You do not have to answer the following questions. They are intended to make sure you have thought about how you'll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?
□ Current income from employment □ Current income from investments □ Other current income □ Savings □ Sell investments □ Sell other assets □ Money from my family
□ Other: _____

Could you afford to keep this [policy][certificate][rider] if your spouse or partner dies first?
□ Yes □ No □ Had not thought about it □ Do not know □ Does not apply

[**What would you do if the premiums went up, for example, by 50%?**
□ Pay the higher premium □ Call the company/producer □ Reduce benefits □ Drop the [policy][certificate][rider] □ Do not know]

~~[□ Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]~~

~~How will you pay each year's premiums?~~
~~□ From my Income □ From my Savings/Investments □ My Family Will Pay~~

~~**Income**~~

What is your household annual income from all sources? (check one) □ [Under $10,000] □ [$10,000-20,000] □ [$20,000-30,000] □ [$30,000-50,000] □ [Over $50,000]

~~How d~~**Do you expect your income to change over the next 10 years?** (check one)
□ No change ——— □ Yes, expect i~~t~~ncrease ——— □ Yes, expect d~~D~~ecrease

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?
□ Yes □ No □ Do not know

~~If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.~~

Will you buy inflation protection: (check one) □ Yes □ No

Inflation may increase the cost of long-term care in the future.
If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?
~~If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?~~

□ From my Income~~—□ -From my Savings/Investments—□ My Family Will Pay~~
□ From my investments □ Sell other assets □ Money from my family □ Other: _____

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What [elimination period][waiting period][cash deductible] are you considering? [Number of days _____ in [elimination period][waiting period]
Approximate cost of care for this period: $_____ ~~for that period of care~~.
($xxx per day times the number of days in [elimination period][waiting period], where "xxx" represents the most recent estimate of the national daily average cost of long-term care)]

[Cash deductible $_____]

How are you planning to pay for your care during the [elimination period][waiting period][deductible period]? (check ~~one~~all that apply)
□ From my Income~~□ From my Savings/Investments□ My Family Will Pay~~ □ From my savings/investments □ My family will pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
□ [Under $20,000] □ [$20,000-$30,000] □ [$30,000-$50,000] □ [Over $50,000]

How do you expect your assets to change over the next 10 years? (check one)
□ Stay about the same □ Increase □ Decrease

~~If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.~~

If you are buying this [policy][certificate][rider] to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

□ The answers to the questions above describe my financial situation. **Or** □ I choose not to complete this information. (Check one.)
□ I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following : I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the information contained in this worksheet~~above disclosures~~. **I understand that the rates for this policy may increase in the future.** (This box must be checked.)

Signed: _____ _____
(Applicant) (Date)

[□ I explained to the applicant the importance of completing this information.]

Signed: _____ _____
(Applicant) (Date)

Producer's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My ~~agent~~ producer has advised me that this [policy][certificate][rider] does not seem to be suitable for me. However, I still want the company to consider my application.~~]~~

Signed: _____ _____
(Applicant) (Date)]

~~The~~Someone from the company may contact you to ~~verify~~discuss your answers and the suitability of this [policy][certificate][rider] for you.

(c) and (d) remain the same.

(e) LTC Form E Claims Denial Reporting Form

LTC FORM E
Claims Denial Reporting Form
Long-Term Care Insurance

For the State of Montana
For the Reporting Year of _____

Company Name : _____ Due: June 30 annually
Company Address: _____
Company NAIC: _____ Number: _____
Contact Person: _____ Phone Number: _____
Line of Business: Individual Group

Instructions:

The purposes of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:
□ Per Claimant – counts each individual who makes one or a series of claim requests.
□ Per Transaction – counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

Inforce Data

	State Data	Nationwide Data[1]
Total Number of Inforce Policies [Certificates] as of December 31st		

Claim & Denial Data

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting		

	Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided by Line 1)		
7	Number of Long-Term Care Claims Denied due to:		
8	▪ Long-Term Care Services[2]		
9	▪ Provider/Facility Not Qualified under the Policy[3]		
10	▪ Benefit Eligibility Criteria Not Met[4]		
11	▪ Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

(f) LTC Form F Potential ~~Rate~~ Premium Increase Reporting Form

LTC Form F

Instructions: *Insurers shall provide all of the following information to the applicant regarding premium, premium adjustments, potential premium increases, and policyholder options in the event of a premium increase except as noted below. This form does not need to be provided in the event the policy does not reserve the right to increase rates.*

As used in this form:
"Policy" shall mean policy, certificate, or rider, as applicable.
"Premium" shall include premium schedules, as applicable.
Companies may substitute whichever term is appropriate to reflect the long-term care insurance for which the applicant is applying.
~~This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policy holder options in the event of a rate increase.~~

~~**Insurers shall provide all of the following information to the applicant:**~~

Long-Term Care Insurance
Potential ~~Rate~~Premium Increase Disclosure Form

Important Notice: Your long-term care insurance company **may** increase the premium for your policy **every year**. You have certain rights and it is important that you understand them before you buy a long-term care insurance policy. Please read this information and be sure you understand it before you buy a policy.

This policy is guaranteed renewable*. Companies can increase the premiums for guaranteed renewable policies in the future. The company cannot increase your premiums because you are older or your health declines. It can increase premiums based on the experience of all individuals with a policy like yours.*

1. What Is Your Premium?

The producer has quoted you a premium of $[__] for this policy. This is **not** a final premium. The premium might change during the underwriting process or if you choose different benefits. The premium you will be required to pay for your policy will be [shown on the schedule page of][attached to] your policy.

2. How Will I Know If My Premium Is Changing?

The company will send you a notice. The notice will include the new premium and when you will start paying it. It also will give you ways you could avoid paying a higher premium. One likely choice will be to keep your insurance policy, but with fewer or lower benefits than you bought. Another choice may be to stop paying premiums and have a "paid-up" policy with fewer or lower benefits than the policy you bought. You may have other choices.

~~**[Premium Rate][Premium Rate Schedules]**: [Premium rate][Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are][on the application][$_____]~~

~~1. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.~~

~~2. **Rate Schedule Adjustments:**~~

~~The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.~~

~~3. **Potential Rate Revisions:**~~

~~**This policy is Guaranteed Renewable**. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.~~

~~**If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:**~~

~~$ Pay the increased premium and continue your policy in force as is.~~
~~$ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)~~
~~$ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)~~
~~$ Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)~~
~~$~~

Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

~~$~~● Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

~~$~~● You lapse (do not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

~~$~~● You bought the policy at age 65 and paid the $1,000 annual premium for 10

years, so you have paid a total of $10,000 in premium.

~~$~~● In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums.)

~~$~~● Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%

83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which ARM 6.6.3119(4)(c) and (e) of the regulation are applicable].

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; and

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

(g) remains the same.

(h) LTC Form H Guidelines for Long-Term Care Independent Review Entities

LTC FORM H

Guidelines for Long-Term Care Independent Review Entities

In order for an organization to qualify as an independent review organization for long-term care insurance benefit trigger decisions, it shall comply with all of the following:

a. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews hold a current unrestricted license or certification to practice a health care profession in the United States.

b. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

c. The independent review organization shall ensure that any health care professional on its staff and with whom it contracts to provide benefit trigger determination reviews who is not a physician holds the current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive

impairment.

d. The independent review organization shall ensure that all health care professionals on its staff and with whom it contracts to provide benefit trigger determination reviews have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

e. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals it utilizes for benefit trigger determination reviews receives compensation of any type that is dependent on the outcome of the review.

f. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed healthcare professionals it utilizes for benefit trigger determination reviews are in any manner related to, employed by, or affiliated with the insurer, insured, or with a person who previously provided medical care or long-term care services to the insured.

g. The independent review organization shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewer's current and past employment history, practice affiliations, and a description of past experience with decisions relating to long-term care, functional capacity, dependency in activities of daily living, or in assessing cognitive impairment. Specifically, with regard to reviews of tax qualified long-term care insurance contracts, it must demonstrate the ability to assess the severity of cognitive impairment requiring substantial supervision to protect the individual from harm, or with assessing deficits in the ability to perform without substantial assistance from another person at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.

h. The independent review organization shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately licensed, registered, or certified; trained in the principles, procedures, and standards of the independent review organization; and knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment, which is the subject of the independent review.

i. The independent review organization shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

j. The independent review organization shall provide a description of the policies and procedures employed to protect confidentiality of protected health information, in accordance with federal and state law.

k. The independent review organization shall provide a description of its quality assurance program.

l. The independent review organization shall provide the names of all corporations and organizations owned or controlled by the independent review organization or which own or control the organization, and the nature and extent of any ownership or control. The independent review organization shall ensure that neither it, nor any of its employees, agents, or licensed health care professionals utilized are not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insured is a member.

m. The independent review organization shall provide the names and resumes of all directors, officers, and executives of the independent review organization.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The changes and additions are meant to modernize the rule consistent with the language contained in the latest version of NAIC model regulation 641.

6.6.3121 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS (1) through (5) remain the same.

(6) A premium increase notice required by (5) shall include:

(a) an offer to reduce policy benefits provided by the current coverage consistent with the requirements of ARM 6.6.3129;

(b) a disclosure stating that all options available to the policyholder may not be of equal value; and

(c) in the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The additional language is meant to modernize the rule consistent with the language contained in the latest version of NAIC model regulation 641.

6.6.3122 INITIAL FILING REQUIREMENTS (1) through (2)(b)(iv) remain the same.

(v) a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; ~~or~~ and

(vi) through (3) remain the same.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The change to (2)(b)(v) is meant to correct an inadvertent drafting error in the original rule.

6.6.3129 RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS

(1) Every long-term care insurance policy shall include~~:~~

~~(a)~~ a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy premium in at least one of the following ways:

~~(i)~~(a) reducing the maximum benefit; or

~~(ii)~~(b) reducing the daily, weekly, or monthly benefit amount.

~~(b)~~(2) In addition to (1), the issuer may also offer other reduction options that are consistent with the policy design or the carrier's administrative processes.

(3) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the issuer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

~~(2)~~(4) The provision required by (1) shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

~~(3)~~(5) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force and shall be consistent with the approved rate table.

~~(4)~~(6) The issuer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

~~(5)~~(7) If a policy is about to lapse, the issuer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by ARM 6.6.3104A(1)(c).

~~(6)~~(8) This rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

~~(7)~~(9) This rule applies to any long-term care policy issued in Montana on or after January 1, 2009.

AUTH: 33-1-313, 33-22-1121, MCA
IMP: 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

REASON: The additional language is to modernize the rule consistent with the language contained in the latest version of NAIC model regulation 641.

5. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Mike Winsor, Attorney, Office of the Montana State Auditor, 840 Helena Avenue, Helena, Montana, 59601; telephone (406) 444-2004; fax (406) 444-3497; or e-mail mwinsor@mt.gov, and must be received no later than 5:00 p.m., December 19, 2018.

6. Mike Winsor, Attorney, will preside over and conduct this hearing.

7. The CSI maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list may sign up by clicking on the blue button on the CSI's website at: http://csimt.gov/laws-rules/ and may specify the subject matter they are interested in. Notices will be sent by e-mail unless a mailing preference is noted in the request. Requests may also be sent to the CSI in writing. Such written request may be mailed or delivered to the contact information in 2 above or may be made by completing a request form at any rules hearing held by the CSI.

8. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

9. With regard to the requirements of 2-4-111, MCA, the department has determined that the adoption and amendment of these rules will significantly and directly impact small businesses.

/s/ Michael A. Kakuk	/s/ Kristin Hansen
Michael A. Kakuk	Kristin Hansen
Rule Reviewer	Chief Legal Counsel

Certified to the Secretary of State October 23, 2018.