Product Standards Committee Report and Recommendations for the Uniform Standards
Currently Subject to Five-Year Review (Phase 8)
Certain Uniform Standards Effective Between January 1, 2012 and December 31, 2012

Substantive Change Items

Substantive change items are proposed amendments to the Uniform Standards that would change or alter the meaning, application or interpretation of the provision. Substantive change items would likely impact not only the Uniform Standards but product filings submitted to the IIPRC and would be the equivalent to a change in an individual state's laws or regulations. When looking at the substantive change items, the scope of review should consider whether circumstances or underlying assumptions have changed since the last time the rule was adopted, amended or reviewed.

List of Substantive Change Items

1. Mix and Match for Disability Income Riders – IIPRC Office; Industry Advisory Committee (IAC)
2. Minimum Benefit Period AND Lump Sum Payment– IAC
3. Redefining Guaranteed Renewable and Noncancellable -- IAC
4. Disability Benefits When Unemployed or Retired -- IAC
5. Partial Disability Triggers -- State Farm; IAC
6. Definition of Preexisting Condition -- Wyoming Department of Insurance (DOI); Idaho DOI; IAC
7. Definition of Total Disability --IAC
8. Reinstatement Requirements – IIPRC Office; IAC
9. Return of Premium Provision -- IAC
10. Suspension of Coverage While Unemployed -- IAC
11. Limitations for Disability Benefits Outside of the United States - IIPRC Office
12. Exclusions and Limitations for Mental Health and Substance Abuse Related Disabilities -- Vermont DOI
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15. Look Back Period for Underwriting Questions -- IAC
16. Minimum Loss Ratio – State Farm
17. Procedures for Review of a Denial of a Claim - IAC

1. MIX AND MATCH FOR DISABILITY INCOME RIDERS

APPLIES: Mix and Match provision of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

Mix and Match: These standards are not available to be used in combination with State Product Components as described in Section 110(b) of the Operating Procedure for the Filing and Approval of Product Filings. These standards are not available to be used in combination with IIPRC-approved or state-approved individual life insurance and annuity forms.

COMMENTS:

Industry Comment: The Industry Advisory Committee (IAC) requested that Mix and Match be permitted for combination filings of individual life and long-term care with Individual Disability Income Insurance (IDI). The request was part of the overall explanation of allowing flexibility for new, more creative product solutions.

IIPRC Office Comments/Observations: The IIPRC Office notes that the group disability income insurance allow the standards to be available for use in combination with state-approved group life insurance policies and annuity contracts, provided that the disability income rider and all the components associated with the disability income rider, e.g. application and rates, are filed and approved in accordance with the applicable uniform standards. A change to allow Mix and Match for state-approved individual life insurance policies and annuity contracts as long as all of the components of the IDI rider are filed and approved with the IIPRC would conform to the group disability income insurance standards. The group disability income standards do not allow Mix and Match with state approved long-term care insurance policies.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC discuss whether they wish to expand Mix and Match to include state approved long-term care insurance policies. The IIPRC office suggests that the PSC consider the following change to the Mix and Match provision in the Standards for Individual Disability Income Insurance Policies:

Mix and Match: These standards are not available to be used in combination with State Product Components as described in Section 11~~0~~1(b) of the Operating Procedure for the Filing and Approval of Product Filing, except that these standards are available to be used in combination with state-approved individual life insurance policies and annuity contracts,

provided that the disability income rider and all the components associated with the disability income rider, e.g. application and rates, are filed and approved in accordance with the applicable uniform standards. ~~These standards are not available to be used in combination with IIPRC-approved or state-approved individual life insurance and annuity forms.~~

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the Oregon Division of Insurance:

If other states approved forms that reduce benefits, mix and match should not be used to reduce consumer protection standards below the compact national designed product standards on Page two of this document. If a state form stated that if Social Security did not approve your disability claim then your individual disability insurance claim was also not approved, this is not a proper use of mix and match. There were many other stated concerns on why disability and long term care should be approved as a suite of products and mix and match not be allowed.

Insurance Compact Office update following the August 29, 2017 PSC Member Call: The PSC discussed the recommended change as well as the comments and noted that the recommended change still required all disability income insurance products (IDI) to be filed through the Compact, so there would not be instances where disability income insurance products are approved at the state level and mixed with Compact approved IDI policies. The Compact Office also notes that as written at this time, IDI riders cannot even be attached to Compact approved life and annuity policies. Although some members noted that their specific states do not permit disability riders with life or annuity policies as a combination product, they concluded that these were administrative requirements not consumer protections. Following discussion, the PSC agreed to recommend the following revision to the Mix and Match provision:

Mix and Match: These standards are not available to be used in combination with State Product Components as described in Section 11~~0~~1(b) of the Operating Procedure for the Filing and Approval of Product Filing, except that these standards are available to be used in combination with state-approved individual life insurance policies and annuity contracts, provided that the disability income rider and all the components associated with the disability income rider, e.g. application and rates, are filed and approved in accordance with the applicable uniform standards. ~~These standards are not available to be used in combination with IIPRC-approved or state-approved individual life insurance and annuity forms.~~

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following comments:

While we agree with the proposed change, we seek clarification on the need to restrict the mix and match to "disability income riders". Some companies may file a rider and some companies may file and issue an IDI policy to accomplish the same mix and match effect.

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The Compact staff explained Section 111(b) of the Operating Procedure for the Filing and Approval of Product Filing, and noted that Mix and Match applies to components of the product, such as the policy form, application, riders and endorsements, not to separate policies. Noting that there is nothing that prohibits a company from marketing a disability income insurance policy with a life insurance policy, the PSC agreed that adding the word "policy" to the Mix and Match provision would be inconsistent with other Uniform Standards as well as with the intent of Mix and Match.

2. MINIMUM BENEFIT PERIOD AND LUMP SUM PAYMENT

APPLIES: §3 B.(2) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

B. DEFINITIONS AND CONCEPTS

(2) "***Benefit Period***" means, subject to satisfaction of all policy terms and conditions by the insured, the length of time for which a *Disabled* insured can be paid periodic (usually monthly) income benefit amounts under the policy. A policy shall provide for at least six consecutive months of periodic income benefits.

COMMENTS:

Industry Comment: The IAC suggests that this definition be modified to allow for products currently available in the marketplace. They suggest changing the minimum benefit period to "at least 3 months" to allow for less than 6 month benefits. The IAC states that availability of 3 month periods is beneficial to consumers who may desire a shorter benefit period, for instance to coordinate an IDI plan with a long-term GDI plan provided by an employer, and is also useful to companies that market IDI as a voluntary benefit through the worksite. The IAC also suggests allowing for lump sum payments.

IIPRC Office Comments/Observations: The IIPRC Office notes that it has received requests for policies with shorter benefit periods and has been unable to accommodate such requests due to this provision.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider whether they wish to allow for the availability of products with a shorter benefit period and options for payments, and if so, to consider the following revisions to the definition of *Benefit Period*:

(2) "***Benefit Period***" means, subject to satisfaction of all policy terms and conditions by the insured, the length of time for which a *Disabled* insured can be paid periodic (usually monthly) or lump sum income benefit amounts under the policy. A policy shall provide for at least ~~six~~ three consecutive months of periodic income benefits or the equivalent lump sum benefit.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

We agree with the proposed change.

Insurance Compact Office update following the September 26, 2017 PSC Member call: Pennsylvania and Texas noted that their state rules do not allow the shorter duration. The Compact office was asked to check the minimum provisions under Model Regulation #171. In response to a question about whether the Consumer Advisory Committee had weighed in on this item, the Compact office responded that their comment letter for the July 12th call itemized some specific concerns within the report, but this was not one of them. The Chair agreed to table this discussion until the Compact office reviewed state requirements and the Model regulation. Members were asked to consider whether they would be opposed to such a revision regardless of individual state requirements and it was suggested that the PSC obtain public feedback on whether a shorter minimum duration could be beneficial to consumers to provide for more affordable options or to fill the gap before group disability benefits commence.

. **Insurance Compact Office update following the October 10, 2017 PSC Member call:**

NAIC Model Regulation #171 contains the following provision:

Section 7. Accident and Sickness Minimum Standards for Benefits

G. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that…

(3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. Section 7F does not apply to those policies providing business buy-out coverage;

The PSC discussed the provision as well as information that at least 18 member states have adopted the Model in whole or substantial part. Several Committee members that have the six month provision in their regulations indicated that they would like to hear further comment on whether a change to three months would provide additional benefits for consumers.

The PSC seeks comment on consumer benefits and/or any concerns with allowing individual disability income insurance products with a three month minimum benefit period.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following comments:

One company has a 3 months benefit period approved in 2015 in all compacting states except: ID, NH, NJ, PA. The following states approved: AK, AL, AR, AZ, CO, CT, DC, DE, GA, HI, IA, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, NE, NM, NV, OK, TN, TX, UT, VA, WA, WI, WV, WY. For AR, CT, DE, IA, KS, SC, TX, UT, and WA, a statement was required on the policy face page indicating that the policy provides limited benefits for a 3 months benefit period. We would be willing to require such a statement in the IIPRC standards.

Looking back at the last 7 years of this one company's experience, 45% of all issued individual disability policies contain a 3 months benefit period. It is the number 1 seller of all benefit periods and equates to 35% of premium for the company. Based on this information there is a significant and consistent customer demand for 3 months benefit periods.

The company advises that the 3 months benefit periods are preferred by those in lower middle class to middle class income levels (blue collar workers) and to these folks the traditional product with longer benefit periods is a tough sell, whereas the 3 months benefit period fills their need at the right price. Some of these consumers buy a 3 months benefit period to fill in until their Employer paid short term disability benefits kicks in.

During the Public Call, the Consumer Advisory Committee representatives spoke against such a decrease in benefit period without having a full discussion through the NAIC and consideration of changes to NAIC Model #171. They indicated a need for disclosure at the time of sale, and information on commission rates paid for limited duration benefit policies, loss ratio information and consumer complaint information. In response to a question asking whether the information regarding the experience of one company meant only one company offered the product, the companies advised that several companies offer this benefit period and it is approved in 45 states.

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The Insurance Compact staff provided an overview of the comments received from the IAC and the Consumer Advisory Committee (CAC) regarding the suggestion to change the minimum benefit period from 6 months to 3 months. Staff also noted that 13 member

states have adopted the 6 month benefit period contained in Model 171, but several of these states have also approved product filings with a 3 month benefit period option, including some that have done so as long as there is disclosure that the policy provides limited benefits. The Compact office also noted that a preliminary review of SERFF Filing Access uncovered at least 6 different companies that offered policies including an option for a 3 month benefit period and these policies were approved in the states that staff reviewed. It was noted that the benefit period was an option, with greater benefits also available for the same product.

Following discussion, the PSC agreed that they were not opposed to allowing a 3 month minimum benefit period as long as there were disclosure requirements and elimination periods for this minimum benefit periods were shorter than for greater benefit periods. The Compact staff will prepare draft amendments for the Committee's review.

Insurance Compact Office update following the Nov. 21, 2017 PSC Member Call: The Insurance Compact staff provided an overview of the suggested revisions to the Uniform Standards to allow a 3 month minimum benefit period that includes disclosure requirements and elimination periods that are shorter than for greater benefit periods. The Compact staff also noted that the Industry Advisory Committee (IAC) was also seeking the ability to provide lump sum payment of benefits. The Product Standards Committee (PSC) determined that it was not going to recommend lump sum benefits since the proposal from the IAC did not address timeliness of such payments, what benefit periods would include lump sum payments and how it is determined. The PSC did, however, agree to expose the revisions drafted by the Compact staff to allow for the option of a 3 month benefit period as long as there was notification on the Cover Page and the elimination period was no longer than 45 days. The PSC agreed to the following revisions:

§ 2. GENERAL FORM REQUIREMENTS

A. COVER PAGE

(7) A brief description shall appear in prominent print on the cover page of the policy or is visible without opening the policy. The brief description shall contain at least the following information:

(a) A statement that disability income coverage is being provided;

(b) A statement as to whether the policy is *Conditionally Renewable*, *Guaranteed Renewable*, or *Noncancellable*;

(c) A conspicuous statement as follows: *Preexisting Condition* limitations or exclusions and other limitations or exclusions may apply. Please read your policy carefully;

(d) For a policy with a *Benefit Period* of less than six months, a conspicuous statement indicating that the policy provides a limited duration of benefits and specify the duration.

(~~d~~e) A statement as to any benefit limits or reductions due to the attainment of certain ages; and

(~~e~~f) A statement as to whether the policy is *Participating* or *Non-Participating*.

§3.B. DEFINITIONS AND CONCEPTS

(2) "***Benefit Period***" means, subject to satisfaction of all policy terms and conditions by the insured, the length of time for which a *Disabled* insured can be paid periodic (usually monthly) income benefit amounts under the policy. A policy shall provide for at least ~~six~~ three consecutive months of periodic income benefits, subject to the requirements of § 2.A.(7).

(10) "***Elimination Period***" means, subject to satisfaction of all policy terms and conditions by the insured, the length of time an insured shall wait before periodic income benefit amounts are paid under the policy. Periodic income benefit amounts may or may not accrue during the *Elimination Period* at the option of the company. The length of time required to satisfy the *Elimination Period* may, but need not consist of, consecutive units of time. The trigger for the start of the *Elimination Period* shall be commencement of *Disability* for the insured as defined in the policy. The definition or concept may specify a separate *Elimination Period* for *Injury* and a separate *Elimination Period* for *Sickness*. In policies issued with *Benefit Periods* of less than six months, the application of an *Elimination Period* alone or in conjunction with a qualification period (see definition of *Residual Disability)* cannot result in the postponement of payment of periodic income benefit amounts to a *Disabled* insured in excess of 45 days from the commencement of a *Disability*. In policies issued with *Benefit Periods* of six months to one year ~~or less~~, the application of an *Elimination Period* alone or in conjunction with a qualification period (see definition of *Residual Disability)* cannot result in the postponement of payment of periodic income benefit amounts to a *Disabled* insured in excess of 90 days from the commencement of a *Disability*.

Insurance Compact Office update following the Jan. 23, 2018 PSC Public Call:

The IAC submitted the following comments:

The definition that we had proposed included references to a lump sum benefit, and the latest draft by the PSC proposes to eliminate this type of benefit. We respectfully request reconsideration of the lump sum benefit for the following reasons:

This type of benefit has been approved in 46 states, and the lump sum nature of the benefit was not the cause of disapproval in the other states.

Technically, a lump sum concept negates the need for a Benefit Period definition or concept. However, when we were reviewing the existing definition/concept and we focused on suggesting changes to allow a 3 month benefit period, we noted that the current definition/concept presumed that all benefits would be paid on a periodic basis, usually monthly, and this contradicts the availability of a lump sum payment benefit, so we inserted the lump sum possibility into the Benefit Period definition/concept.

A somewhat catastrophic or long-term disability is an appropriate fit for a lump sum benefit payment. Also, this type of benefit payment would be less expensive than a traditional disability income product and, therefore, more attainable for a person who may not able to afford traditional disability income insurance.

A lump sum payment may be payable when the insured meets the definition of Disability in the policy and that Disability is expected to last at least 365 days, as certified by a Physician. A lump sum payment may also be available for situations where the insured is terminally ill, with a life expectancy of 12 months or less, as certified by a Physician (see Appendix A, page 13, definition of Disability or Disabled, other triggers). The predetermined lump sum amount would be paid as soon as the insured meets the appropriate benefit trigger, so a Benefit Period concept is not really needed. An Elimination Period may be required at the option of the company. Once the determined longevity of the Disability is demonstrated, there is no need for an insured to wait for a benefit payment.

We believe that there is a need for a lump sum payment benefit for catastrophic type Disability benefits that are more affordable and, therefore, more readily available to the general public. This type of a benefit could also play well with the mentality of the millennials who don't typically buy traditional DI products.

David Bolton, Oregon Division of Financial Regulation submitted the following comments:

It is my opinion, as someone who worked on the original individual disability standards with some very experienced regulators that the five year review process should not be used

to lower consumer protections for a fully underwritten unilateral issued individual insurance contract…

2. Product standard changes that provide more limited benefits and duration, should have separate product standards developed, and correctly titled as Short-Term Disability Income/Insurance. Protecting income for most consumers is a long term need and for most, is needed until working is completed at age 65. Product Standards that allow for limited benefits will transfer some of this continuing risk of long term disability from the insurance company to state programs.

3. Less than a six month benefit period with a 90 day waiting period, appears to be an illusionary benefit for a product with the title of long term disability insurance or just disability insurance. This is why it is not allowed under Model 171 and Model 880. This should be titled short-term disability insurance.

4. Lump sum payments in the past, were for long term disability claims that everyone agreed would continue with little hope of recovery. (total disability) The longer the benefit period, the higher the offer for the lump sum benefit, which the person disabled could accept or reject.

5. "A somewhat catastrophic or long term disability" should be allowed under the product standards for only additional coverage only after first meeting the definition of disability and claim benefits approved under the individual disability contract. Not for replacing a standalone long term care trigger (2 or more ADL's) which would cut out most of the disability benefits approved under the current disability product standards. (and why would they need another waiting period on top of that very limited benefit?)

The Consumer Advisory Committee (CAC) submitted the following comments:

1). We continue to oppose a standard that authorizes a benefit period of less than six months, contrary to the NAIC Model 171. If this recommendation is retained we urge you to mitigate the potential for deceptive or unsuitable sales of a short duration benefit period policy. The recommended policy cover page statement is delivered too late in the sale process and ineffectual. We urge you to recommend that the IIPRC:

- Ask the NAIC to review Model 171 and Model 880 to either reaffirm the current 6-month restriction or specifically address suitability and disclosure at time of sale. The gap between IIPRC policy form authority and NAIC and state market conduct regulation should be addressed by coordination, not by leaving consumers abandoned in the hole. We note that this IAC proposal attempts to preempts both the NAIC Model

171 and the regulations in many states without any opportunity for either the NAIC or state regulators to consider how best to regulate this practice if it is permitted.

- Require a separate form included with the application that clearly and prominently discloses the policy limited benefit period and that acknowledges notice and explanation of the policy limited benefits period and must be signed by the applicant.
- Include a note in the standard that failure to provide clear disclosure of the limited benefit period time at time of sale and completion of the application constitutes a misrepresentation under Model 880, the NAIC Model Unfair Trade Practice Act.

2). We support the item 2 recommendation that permits no more than a 45-day elimination period when the benefit is less than six months. This provides some assurance that the benefit will be meaningful.

Insurance Compact Office update following the Feb. 6, 2018 PSC Member Call:

The Compact staff noted the CAC's objections to the three month benefit period. Following discussion it was agreed that the CAC's alternative suggestion if the PSC recommends the limited duration for more disclosure of the 3 month benefit period fall more appropriately under application standards, rather than core standards, so they will be discussed on the next conference call after the discussion about the lump sum benefits. The Compact staff summarized the IAC's response to the Committee's concerns that emphasized that lump sum benefit features would benefit individuals impacted by an extended disability or catastrophic disability which would trigger the lump sum payment. Following Committee discussion, it was agreed to allow an optional lump sum benefit feature that the consumer could opt-in to. The Compact staff will prepare draft language for the Committee's review.

Insurance Compact Office update following the Feb. 20, 2018 PSC Member Call:

In addition to the recommendations documented above under the November 21, 2017 PSC Member Call for revisions to allow for the option of a 3 month benefit period as long as there was notification on the Cover Page and the elimination period was no longer than 45 days, the Committee reviewed draft language prepared by the Compact staff and agreed to the language with the addition of (iii) addressing the value of the lump sum in relation to a present value calculation, using language similar to that in the Additional Standards for Accelerated Death Benefits. The Committee agreed to the following addition to § 3 POLICY PROVISIONS C. REQUIRED PROVISIONS (11) Payment of Claims:

(c) The policy may include a provision that after a specified period of periodic claim payments, the company may offer a lump sum payment in lieu of future periodic payments.

(i) The company shall not require that the insured select the lump sum payment option.

(ii) The policy shall specify the benefit triggers for the optional lump sum payment.

(iii) The value of the lump sum shall not be lower than the present value calculation. The present value may reflect the use of an appropriate mortality table and interest rate. The maximum interest rate shall not exceed the greater of:

(A) The current yield on 90-day treasury bills available on the date of the lump sum payment; or

(B) The current maximum adjustable policy loan interest rate based on the Moody's Corporate Bond Yield Averages – Monthly Average Corporates published by Moody's Investor Service, Inc., or successor thereto, for the calendar month ending two months before the date of the lump sum payment. The policy loan interest rate is that which is permitted under the NAIC Model Policy Loan Interest Rate Bill (#590);

In reference to the CAC comments, the Committee agreed that it is maintaining the recommendation for an optional three month benefit period, but is also recommending the addition of the following language to § 3. APPLICATION SECTIONS L. AGREEMENTS:

(3) If the policy offers a Benefit Period of less than six consecutive months of periodic income benefits, the application shall include a statement that the applicant is aware of and understands the limited duration of the Benefit Period selected.

Insurance Compact Office update following the March 6, 2018 PSC Public Call:

The IAC submitted the following comments:

In C. REQUIRED PROVISIONS, item (11)(c)(iii), it requires that the "lump sum shall not be lower than the present value calculation." We request a clarification of what is meant by "present value calculation"? What calculation is intended?

During the public call, the Compact office responded that the intent of the language was that the lump sum shall not be lower than the present value of the remaining periodic claim payments. They suggested that the following change add clarity:

(iii) The value of the lump sum shall not be lower than the present value of the remaining periodic claim payments. The present value may reflect the use of an appropriate disabled life mortality table and interest rate.

The IAC stated that they had no objection to that change.

Insurance Compact Office update following the March 13, 2018 PSC Member Call: The PSC agreed to the following change:

(iii) The value of the lump sum shall not be lower than the present value of the remaining periodic claim payments. The present value may reflect the use of an appropriate disabled life mortality table and interest rate.

3. REDEFINING GUARANTEED RENEWABLE AND NONCANCELLABLE

APPLIES: §3 B.(11) and (15) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

B. DEFINITIONS AND CONCEPTS

(11) "***Guaranteed Renewable***" means that the insured has the right to continue the policy in force by the timely payment of premiums set forth in the policy until at least age 65, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States. During such period, the company shall not unilaterally make any change in any provision of the policy while the policy is in force, except that the company may make changes in premium rates by classes. This policy may also become *Conditionally Renewable* after age 65 at the option of the company.

Drafting Note: See also Amendments section for renewal provision language that may be added at company discretion concerning changes or clarification in applicable law.

(15) "***Noncancellable*"** means that the insured has the right to continue the policy in force by the timely payment of premiums set forth in the policy until at least age 65, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States. During this period, the company shall not unilaterally make any change in any provision of the policy (including premium rates) while the policy is in force. This policy may also become *Conditionally Renewable* after age 65 at the option of the company.

Drafting Note: See also Amendments section for renewal provision language that may be added at company discretion concerning changes or clarification in applicable law.

COMMENTS:

Industry Comment: The IAC states that companies are exploring alternative language that better fits today's need for creative product solutions. With the change in consumer behavior and the shift in mindsets, younger consumers are seeking more flexibility and have different life milestones with age 65 not as important of a date to them. Changing

this definition will allow more flexibility in product development and pricing to meet these changing consumer needs.

The IAC suggests the following amendments to the definitions for *Guaranteed Renewable* and *Noncancellable*:

"***Guaranteed Renewable***" means that the insured has the right to continue the policy in force by the timely payment of premiums set forth in the policy until ~~at least age 65, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States.~~ The earliest of the following:

(a) The insured attains a specified age (not less than age 50);

(b) The insured's fifth *Policy Anniversary*; or

(c) The insured is receiving retirement benefits under governmental retirement benefits, or other qualified or nonqualified retirement benefits.

During such period, the company shall not unilaterally make any change in any provision of the policy while the policy is in force, except that the company may make changes in premium rates by classes. This policy may also become *Conditionally Renewable* ~~after age 65 at the option of the company~~ at the option of the company after the *Guaranteed Renewable* period ends.

"***Noncancellable***" means that an insured has the right to continue a policy in force by the timely payment of premiums set forth in the policy until ~~at least age 65, or as an alternative, until receipt of retirement benefits under the Social Security Act of the United States~~ the earliest of the following to occur:

(a) The insured attains age a specified (not less than age 50);

(b) The insured's fifth *Policy Anniversary*; or

(c) The insured is receiving retirement benefits under governmental retirement benefits, or other qualified or nonqualified retirement benefits;

During such period, the company shall not unilaterally make any change in any provision of the policy, including premium rates ~~while the policy is in force~~. This policy may also become *Conditionally Renewable* ~~after age 65 at the option of the company~~ at the option of the company after the *Noncancellable* period ends.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any requests from filers to limit the definitions of noncancellable or guaranteed renewable. The IIPRC Office notes that NAIC Model Regulations 171 states "The terms 'noncancellable' or 'noncancellable and guaranteed renewable' may be used only in an individual accident and sickness policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force." Companies seeking to limit renewability or its ability to modify rates have the option to consider filing conditionally renewable policies.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC discuss whether to deviate from language for terms and requirements that are defined in a Model regulation and presumably state law.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

We have had significant discussions on these two definitions/concepts. We are now proposing the following:

"Guaranteed Renewable" means that an insured has the right to continue a policy in force by the timely payment of Premiums set forth in the policy until the termination date stated in the policy's specifications page.

Alternatively, the insured has the right to continue the policy in force by the timely payment of Premium until the date the insured is receiving retirement benefits under governmental retirement benefits, or other qualified or nonqualified retirement benefits.

During the period that the policy remains in force, the company shall not unilaterally make any change in any provision of the policy, except that the company may make changes in Premium rates by classes.

This policy may also become Conditionally Renewable at the option of the company after the Guaranteed Renewable period ends."

"Noncancellable" means that an insured has the right to continue a policy in force by the timely payment of Premiums set forth in the policy until the termination date stated in the policy's specifications page.

Alternatively, the insured has the right to continue the policy in force by the timely payment of Premium until the date the insured is receiving retirement benefits under governmental retirement benefits, or other qualified or nonqualified retirement benefits.

During the period that the policy remains in force, the company shall not unilaterally make any change in any provision of the policy, including Premium rates.

This policy may also become Conditionally Renewable at the option of the company after the Noncancellable period ends."

We believe that the above suggested language is a simplified approach to what we had suggested on March 31.

We also wish to note that under Permissible Limitations/Exclusions, the Insurance With Other Companies and the Other Insurance With This Company standards, which are based on Model #171, there will be situations where both premium and benefits may change. It is our understanding that the definitions/concepts are justified because a person buys a policy with one of these definitions/concepts accepts the fact that the exercise of that definition/concept will result in a change to the benefit and premiums, so therefore the apparent contradictions are OK. However, we seek the PSC's opinion on this issue.

The Consumer Advisory Committee (CAC) provided the following written comments:

Items that are unsupported or that are objectionable include the following:

1) Radical changes to the definitions of non-cancellable and guaranteed renewable that defy consumer expectations and the law of most states.

Insurance Compact Office update following the Nov. 21, 2017 PSC Member Call: The PSC discussed the IAC request to allow any end date specified by the company to be the end date for noncancellable or guaranteed renewable policies. Noting that consumers, whether young or old, would want disability coverage for their productive work life and that such a change would nullify the meaning of these terms, the PSC determined that such a change is beyond the discussion for a Five Year Review, and was a major policy decision

requiring substantial public debate. The PSC concluded that allowing flexibility for coverage should not be achieved by whittling away at any value to the policy and potentially creating a product that terminates only to be rewritten at a higher rate. There was no support for recommending this change.

Insurance Compact Office update following the Jan. 23, 2018 PSC Public Call:

The IAC withdrew the comments they submitted on January 19, 2018

The Consumer Advisory Committee (CAC) submitted the following comments:

3). We support the item 3 recommendation to reject the IAC proposed changes to the definitions of non-cancellable and guaranteed renewable.

4. DISABILITY BENEFITS WHEN UNEMPLOYED OR RETIRED

APPLIES: §3 B. of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

B. DEFINITIONS AND CONCEPTS

(17) "Occupation" means a position or professional calling for which a person receives or can receive remuneration.

The current standards do not have definitions for "job" or "specialty."

COMMENTS:

Industry Comment: The IAC requested adding similar definitions for "job" or "specialty" as found in the group disability income insurance standards, revising the definition of "occupation" to conform with the definition found in the group disability income insurance standards, and adding provisions to all of these terms to address situations in which the insured is unemployed or retired when the *Disability* begins. The IAC included this proposal under their blanket explanation that such changes would allow more flexibility in product development and pricing to meet changing consumer needs. The following is the language suggested by the IAC:

"Job" means the performance of *Substantial and Material Duties* routinely performed for wage or profit.

If the insured is *Unemployed* at the time *Disability* begins, the term will be deemed to mean:

(a) The last *Job* in which the insured worked within a specified period of time, such as twelve (12) months; or

(b) Any *Job* which the insured was able to perform based on his or her education, training or experience.

"*Unemployed*" as used in this item means that an insured is not actively working in any capacity for pay or profit at the time *Disability* begins, and is not eligible for governmental retirement benefits, or other qualified or nonqualified retirement benefits.

If the insured is *Retired* at the time *Disability* begins, the term will be deemed to mean:

(a) The last *Job* in which the insured worked within a specified period of time, such as twelve (12) months;

(b) Any *Job* which the insured was able to perform based on his or her education, training or experience; or

(c) Inability to perform any of the normal activities of a retired person in good health and of like age.

"*Retired*" as used in this item means that the insured is not actively working in any capacity for pay or profit at the time *Disability* begins, and is eligible for governmental retirement benefits, or other qualified or nonqualified retirement benefits.

(17) "Occupation" means a ~~position or professional calling for which a person receives or can receive remuneration~~. group of *Jobs* or related *Jobs* in the national economy or marketplace, as appropriate, in which a common list of tasks is performed, or which are related in terms of similar objectives or methodologies and which may be related in terms of materials, products, work actions or worker characteristics

If the insured is *Unemployed* at the time *Disability* begins, the term will be deemed to mean:

(a) The last *Occupation* in which the insured worked within a specified period of time, such as twelve (12) months; or

(b) Any *Occupation* which the insured was able to perform based on his or her education, training or experience.

"*Unemployed*" as used in this item means that an insured is not actively working in any capacity for pay or profit at the time *Disability* begins, and is not eligible for governmental retirement benefits, or other qualified or nonqualified retirement benefits.

If the insured is *Retired* at the time *Disability* begins, the term will be deemed to mean:

(a) The last *Occupation* in which the insured worked within a specified period of time, such as twelve (12) months;

(b) Any *Occupation* which the insured was able to perform based on his or her education, training or experience; or

(c) Inability to perform any of the normal activities of a retired person in good health and of like age.

"*Retired*" as used in this item means that the insured is not actively working in any capacity for pay or profit at the time *Disability* begins, and is eligible for governmental retirement benefits, or other qualified or nonqualified retirement benefits.

"Specialty" means a general specialty or sub-specialty recognized by the American Board of Medical Specialties, the American Bar Association, the state where an insured's policy is issued for delivery, or any other state, as applicable/appropriate.

If the insured is *Unemployed* at the time *Disability* begins, the term will be deemed to mean:

(a) The last *Specialty* in which the insured worked within a specified period of time, such as twelve (12) months; or

(b) Any *Specialty* which the insured was able to perform based on his or her education, training or experience.

"*Unemployed*" as used in this item means that an insured is not actively working in any capacity for pay or profit at the time *Disability* begins, and is not eligible for governmental retirement benefits, or other qualified or nonqualified retirement benefits.

If the insured is *Retired* at the time *Disability* begins, the term will be deemed to mean:

(a) The last *Specialty* in which the insured worked within a specified period of time, such as twelve (12) months;

(b) Any *Specialty* which the insured was able to perform based on his or her education, training or experience; or

(c) Inability to perform any of the normal activities of a retired person in good health and of like age.

"*Retired*" as used in this item means that the insured is not actively working in any capacity for pay or profit at the time *Disability* begins, and is eligible for governmental retirement benefits, or other qualified or nonqualified retirement benefits.

IIPRC Office Comments/Observations: The IIPRC Office is aware that some companies are filing disability products that may provide benefits for retired or unemployed individuals. The IIPRC Office has not been provided evidence that the existing definitions within these standards prohibit a definition of "occupation" from including activities when an insured is unemployed or retired. The IAC has not explained the specific use of the requested additional terms or the types of benefits that would be provided to consumers. The IIPRC Office notes that the definitions in the group disability standards for "job" and "specialty" are primarily used in further defining other terms, such as "regular specialty," "actively at work," and "total disability."

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC determine the extent of rewriting of the Standards for Individual Disability Income Insurance Policies to include all of the group disability income insurance terms and concepts and to address definitions for all potential new product offerings. The IIPRC Office also suggests that if the PSC wishes to consider these suggestions, that they ask the IAC to more specifically explain the reasons for such additions, the benefits to insureds, and where such terms would be included within the Standards.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

We are now advising that contrary to what we suggested on March 31, "Occupation" need not include the retirement and unemployment language because as we are suggesting that this term be defined to mean "a group of Jobs or related Jobs…" and the definition/concept of Job will include the unemployment/retirement language. The unemployed/retired language was added to clarify how a policy will define duties when there are such changes in employment status.
In the definition/concept of "Specialty", after the "American Board of Medical Specialties", we suggest adding: "the American Osteopathic Association Bureau of Osteopathic Specialist, the American Dental Association or". The companies advise that they prefer a broader definition/concept and they currently have this language approved in the states.

Insurance Compact Office update following the Nov. 21, 2017 PSC Member Call: The PSC concluded that the IAC did not justify the need for adding the definitions listed in this item as well as including information related to being unemployed or disabled. It was noted that it is not clear that the current definitions within these standards would prohibit a

definition of "occupation" from including activities when an insured is unemployed or retired, and no identification of how circumstances or underlying assumptions had change to require this revision had been presented by the IAC. There was no support for recommending this change.

5. PARTIAL DISABILITY TRIGGERS

APPLIES: §3 B.(18) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISIONS:

B. DEFINITIONS AND CONCEPTS

(18) "***Partial Disability***" means that a company may use a *Partial Disability* benefit trigger that states that, due to *Injury* or *Sickness*, the insured has the inability to perform some of the substantial and material duties of an *Occupation* for which he or she is qualified by reason of education, training or experience or the inability to perform all of the substantial and material duties of an *Occupation* for which he or she is qualified by reason of education training or experience for as long as usually required. A company shall use a *Partial Disability* benefit trigger (using either a time worked or *Earnings* measurement) which indicates that, due to *Injury* or *Sickness*, an insured shall be working at least 20% but no more than 80% of the time worked (expressed as hours per week or otherwise) just before a *Disability* began, or an insured shall be earning at least 20% but no more than 80% of *Prior Earnings*. *Partial Disability* benefit triggers shall be met for an insured to be paid *Partial Disability* benefits subject to satisfaction of all policy terms and conditions by the insured. The term *Partial Disability* shall be used (except as otherwise specified in this definition or concept) in reference to paying a stated percentage of the *Total Disability* periodic income benefit amounts, and the stated percentage of the *Total Disability* periodic income benefit amount shall be no less than 20% and no greater than 80%. An insured working longer than 80% of time worked just before a *Disability* began, or earning more than 80% of *Prior Earnings* may be deemed ineligible for *Partial Disability* benefits. An insured working less than 20% of time worked just before a *Disability* began or earning less than 20% of *Prior Earnings* shall be eligible for the *Total Disability* benefit under the policy subject to satisfaction of all policy terms and conditions by the insured. A company may require care by a *Physician*. Alternatively, standards as described in the *Residual Disability* definition or concept are acceptable, and, when this alternative is followed, the term *Partial Disability* may be used instead of the term *Residual Disability*.

Drafting Note: 80% may be reduced to as low as 50% if the company gives prominent notice of the lower threshold.

COMMENTS:

Industry Comment: An Industry commenter suggested that the definition for *Partial Disability* be amended to permit a period of *Total Disability* before *Partial Disability*

benefits are payable. The commenter stated that the majority of states including many of the participating Compacting States permit this requirement. It was noted that the ability to require a period of *Total Disability* before a period of *Partial Disability* is included in the Compact's standards for *Residual Disability*. Although the benefit provided by *Residual Disability* could potentially be lower, the administration expense for claims under the *Residual Disability* standard is expected to be higher due to the need to periodically collect and review earnings information, determine the percentage reduction of the insured's prior earnings, and adjust the claim payment accordingly. Administering a claim based on *Partial Disability* alone may also be viewed as an additional expense since it is not the primary intent of a Disability Income policy.

The commenter concluded that including the requested option would allow more companies to include *Partial Disability* benefits, particularly for more short-term and simplified disability products and benefit policyholders. Without such a change, the administrative expense may discourage companies from including any *Partial Disability* benefit, and companies may opt to pursue a state by state filing, where such an option is permitted, rather than file with the Compact.

Industry Advisory Committee Comment: The Industry Advisory Committee (IAC) suggested that the PSC consider the approach taken under the Group Disability Income Insurance Policy and Certificate Uniform Standards for Employer Groups with some modifications. Making this revision would achieve the objective requested by the company filer to allow a period of *Total Disability* before *Partial Disability* benefits. With such a revision, *Partial Disability* and *Residual Disability* would have the same definition as follows:

> "*Partial Disability*" or "*Residual Disability*": means that, due to an *Injury* or *Sickness*, a *Covered Person*:
>
> (a) Is not *Totally Disabled*; and
>
> (b) Is able to perform one or more but not all the *Substantial and Material Duties* of the work-related tests prescribed in the terms/concepts of *Regular Job*, *Regular Occupation*, *Regular Specialty*, or any other *Occupation* for which the insured is qualified by reason of education, training or experience, as applicable; or
>
> (c) Is able to perform all of the *Substantial and Material Duties* of his or her *Regular Job*, *Regular Occupation*, *Regular Specialty*, or any *Occupation* for

which the insured is qualified by reason of education, training or experience, but not for the time usually required; and

(d) Is in fact engaged in work for wage or profit at his or her maximum capacity, as determined by a *Physician*.

The policy may require the *Covered Person* to satisfy a specified earnings loss related test, based on a percentage of the *Covered Person's Pre-Disability Earnings* and/or a work hour related test. Such tests may be in addition to items (a) through (d) above, or may be alternatives to item (b) or (c) above.

The policy may require the *Covered Person* to be *Totally Disabled* for a specified period of time before the *Covered Person* may be considered *Partially Disabled* or *Residually Disabled* under the terms of the certificate. The specified period of time may be less than, equal to or greater than the *Elimination Period*.

IIPRC Office Comments/Observations: The IIPRC Office often issues objections regarding the definition of partial disability. The current definition for *Residual Disability* allows for a qualification period in which the insured is *Totally Disabled* before *Residual Disability*. When the group disability income insurance uniform standards were developed, the definition for *Partial Disability* included *Residual Disability*. The IIPRC office notes that a recommendation for revisions to Residual Disability was made under Clarification Item #1.

IIPRC Office Recommendation: The IIPRC Office suggests that to avoid encouraging state by state filings, the PSC consider either adding the ability for insurers to require *Total Disability* before eligibility for *Partial Disability*, or to combine the definitions for *Partial Disability* and *Residual Disability* for consistency with the group disability income insurance uniform standards. The use of a combined definition would include allowing insurers the option to require total disability before eligibility for *Partial* or *Residual Disability*.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

On page 14, in the last sentence of the paragraph following item (d), we need to correct the item references as follows: "Such tests may be in addition to items (b), (c) and (d), or may be alternatives to item (b) or (c) above." We agree with using the GDI approach to these definitions.

Insurance Compact Office update following the September 12, 2017 PSC Member Call: The PSC received an overview of State Farm's request to amend the definition for Partial Disability to permit a period of Total Disability before Partial Disability benefits are payable similar to requirements for Residual Disability, as well as the Industry Advisory Committee (IAC) request to combine the definitions of Partial Disability and Residual Disability, using an approach like in the Group Disability Income Insurance Uniform Standards. The Compact Office noted that they regularly see companies require total disability prior to partial disability in filings, resulting in objections requiring removal. Following discussion, the Committee agreed to request that the Compact Office draft two definitions for review – the first would focus on revisions to the current Partial Disability definition to include a requirement for Total Disability and the second would be to combine the definitions of Partial Disability and Residual Disability as defined in the individual standards, not group, since the PSC was not inclined to totally rewrite these standards to conform to group standards. The Compact Office will provide these draft definitions for further discussion.

Insurance Compact Office update following the October 10, 2017 PSC Member Call:

The PSC reviewed proposals developed by the Compact office for two definitions for review. The first focused on revisions to the current *Partial Disability* definition to include a requirement for *Total Disability* and the second would be to combine the definitions of *Partial Disability* and *Residual Disability* as defined in the individual standard, not the group standards. Both drafts included revisions agreed to with clarification items 1 and 2 as well. Following discussion, the PSC agreed to expose the following combined definition for public comment. The definition includes the option that a company can require a period of *total disability* before an individual is eligible for *partial disability* benefits.

***Partial Disability*" *or "Residual Disability*" means that, due to an *Injury or Sickness*, the insured is unable to perform one or more, but not all of the substantial and material duties of an *Occupation* for which he or she is qualified by reason of education, training or experience, or the inability to perform all of the substantial and material duties of an *Occupation* for which he or she is qualified by reason of education training or experience for as long as usually required.

(a) The benefit trigger may be described in terms of a reasonable reduction in the insured's time worked expressed as hours per week or otherwise due to *Disability*.

(i) In order to trigger benefits, an insured shall be working at least 20% but no more than 80% of the time worked just before a *Disability* began.

(ii) The benefit may be stated in terms of paying a stated percentage of the *Total Disability* periodic income benefit amounts, and the stated percentage of the *Total Disability* periodic income benefit amount shall be no less than 20% and no greater than 80%.

(iii) An insured working longer than 80% of time worked just before a *Disability* began may be deemed ineligible for *Partial Disability* benefits.

(iv) An insured working less than 20% of time worked just before a *Disability* began or earning less than 20% of *Prior Earnings* shall be considered working 0% or a 100% reduction in average *Prior Earnings* for the claim time period, subject to satisfaction of all policy terms and conditions by the insured.

Drafting Note: 80% may be reduced to as low as 50% if the company gives prominent notice of the lower threshold.

(b) Alternatively, the benefit trigger may be described in terms of a reasonable reduction in the insured's *Earnings* due to *Disability*.

(i) An insured shall be earning at least 20% but no more than 80% of *Prior Earnings*.

(A) The benefit may be stated in terms of paying a stated percentage of the *Total Disability* periodic income benefit amounts, and the stated percentage of the *Total Disability* periodic income benefit amount shall be no less than 20% and no greater than 80%.

(B) If the reduction in *Earnings* of an insured for a claim time period (usually monthly) equals or exceeds 80% of average *Prior Earnings* (calculated for a comparable time period), then the insured's reduction of average *Prior Earnings* shall be considered a 100% reduction in average *Prior Earnings* for the claim time period subject to satisfaction of all policy terms and conditions by the insured.

(C) If the reduction in *Earnings* of an insured for a claim time period (usually monthly) is less than 20% of average *Prior Earnings* (calculated for a comparable time period) may result in no benefits being paid.

Drafting Note: 80% may be reduced to as low as 50% if the company gives prominent notice of the lower threshold.

(ii) The reduction in *Earnings* of an insured shall be measured by comparing *Earnings* for a claim time period (usually monthly) to average *Prior Earnings* (calculated for a comparable time period).

(A) The percentage of the *Total Disability* periodic income benefit amounts paid shall be calculated by subtracting current *Earnings* for a claim time period (usually monthly) from average *Prior Earnings* (calculated for a comparable period of time), and placing this difference as the numerator over average *Prior Earnings* (calculated for a comparable time period) as the denominator. This fraction shall be converted to a percentage, and the percentage multiplied by the *Total Disability* periodic income benefit amounts to arrive at the *Partial* or *Residual Disability* benefit paid for a claim time period.

(B) Alternatively, this can be expressed as a formula, such as: the difference between *Prior Earnings* and current *Earnings* OVER *Prior Earnings*, multiplied by the *Total Disability* periodic income benefit amounts.

(c) *Partial or Residual Disability* benefits may be predicated upon a qualification period during which the insured shall be *Totally Disabled* before *Partial* or *Residual Disability* benefits are paid. The qualification period may be in lieu of the *Elimination Period* or in addition to the *Elimination Period* but may not exceed six months due to use of a qualification period alone or in conjunction with an *Elimination Period*. A company may require care by a *Physician*.

Drafting Note: Benefits may be predicated on the insured being *Totally Disabled*, not on receipt of *Total Disability* benefits. In no event shall the qualification period result in the postponement of payment of *Partial or Residual Disability* benefits for a time period in excess of six months from commencement of the insured being *Totally Disabled*.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following comments:

We had previously recommended using the Group DI approach for clarity and better organization and progression of information provided. We find the rewrite of the current IDI standards somewhat disjointed with other changes that are still under consideration, such as:

- On Page 12, a reference to "Substantial and Material Duties is proposed in lower case so not clear if this is to be a Definition/Concept.

- On Page 12, there are references to "Occupation" and it is not clear if the Definitions/Concept we proposed for "Occupation", "Regular Occupation", "Regular Job" and "Regular Specialty" are still under consideration for this Item #5.

- On Page 12, the Report has elected to use the term "Prior Earnings". In Group DI, instead of equating "Prior Earnings" and "Pre-Disability Earnings" and using these one or

both of these in the standards for benefit provisions, we elected to settle with "Pre-Disability Earnings" for clarity since "Prior Earnings" is not as specific as "Pre-Disability Earnings" and we only need one of these. Accordingly, we suggest that we do the same for IDI – in the current IDI standards, the Definitions/Concepts section includes both "Prior Earnings" and "Pre-Disability Earnings" and the Report proposes to refer to "Prior Earnings". We should select one term and be consistent, and if "Pre-Disability Earnings" was acceptable for Group DI, it should be acceptable for IDI. Companies have the option to substitute "Prior Earnings" or any other term as long as it is used consistently, so electing one consistent approach would not eliminate this flexibility for the companies.

- The references to "periodic income benefits are not consistent with the proposed "Benefit Period" language which is intended to clarify "periodic (usually monthly) or lump sum".

- On Page 13, there is a reference to "current Earnings". The current IDI Definition/Concept states that "Earnings" means the amount of income received by an insured". It is not clear what the intention is to add "current" – is the intent to refer to Earnings while Partially/Residually Disabled?

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The Chair suggested that the Committee defer discussion of the IAC comments on this item until the Committee had completed its review of all the suggested additions for other definitions that were made by the IAC. The Committee members agreed.

Insurance Compact Office update following the Dec. 19, 2017 PSC Member Call: In response to the IAC questions, the PSC notes the following:

Per the updated Appendix A (see page 3), the PSC is suggesting defining "Substantial and Material Duties," so this term will be capitalized in the revised definition.

The PSC is not adding definitions for "Regular Occupation," "Regular Job" and "Regular Specialty" (See Page 3 of revised Appendix A)

The definition or "Prior Earnings in IDI states is applies to "Prior Earnings or Pre-Disability Earnings" and both terms are acceptable. There is no reason to change.

The PSC is not recommending the addition of an option for lump sum disability benefits for the reasons stated under Substantive Item #2.

References to "current Earnings" are already in the current definition of "Residual Disability" and are repeated here since the proposal is to combine the definitions of

"Partial Disability" and "Residual Disability" as defined in the individual standard, not the group standards.

Insurance Compact Office update following the Jan. 23, 2018 PSC Public Call: The IAC submitted the following comments:

With regard to the proposed rewrite of these definitions/concepts, we wish to point out that depending on what decision is made regarding lump sum payment benefits, the references

to "periodic income benefits" are not consistent with the lump sum payment benefit.

Elimination Period and Qualification Period Issues:

The companies had suggested that the definition/concept of Partial/Residual Disability allow an option to require Total Disability prior to a period of a Partial Disability. The current PSC draft does not allow for this option under Partial Disability, but it does under Residual Disability. Companies want a Partial Disability benefit as a less expensive alternative to Residual (which requires an earnings test to determine benefits), and they further want to be able to require Total Disability first, for some period of time, and still extend the option of Partial Disability benefits following that period of Total Disability. On Report page 25, there is the following suggested language: "(C)*Partial or Residual Disability* benefits may be predicated upon a qualification period during which the insured shall be *Totally Disabled* before *Partial* or *Residual Disability* benefits are paid. The qualification period may be in lieu of the *Elimination Period* or in addition to the *Elimination Period* but may not exceed six months due to use of a qualification period alone or in conjunction with an *Elimination Period*. A company may require care by a *Physician*. **Drafting Note:** Benefits may be predicated on the insured being *Totally Disabled*, not on receipt of *Total Disability* benefits. In no event shall the qualification period result in the postponement of payment of *Partial or Residual Disability* benefits for a time period in excess of six months from commencement of the insured being *Totally Disabled."*

If a person purchases an IDI policy with a 365 day Elimination Period for Total Disability, in order to keep expenses low, that policy, according to the PSC proposed language above, would have to provide for Partial Disability benefits starting at 180 days from the date of Disability. The Drafting Note language is a bit confusing. It's fine to say that the insured has to be Totally Disabled during the qualifying period (not necessarily collecting benefits); however, the second sentence seems to indicate that the Partial Disability benefits would have to start prior to the end of the policy Elimination Period of 365 days in our example. The Elimination Periods for Total Disability and Partial/Residual Disability

are the same. The PSC may not have considered the possibility of a policy with a longer Elimination Period for Total Disability, such as 365 days, when they included their suggested language. It is not common for IDI policies to have extra-long Elimination Periods, but they are available and they are purchased for various reasons, including cost savings.

The companies question why the PSC would prescribe a lesser maximum qualification period for a secondary/optional Disability benefit when most member compacting states do not have this requirement. The intent of this requirement seems to be so that companies do not market an IDI policy with an unreasonably long qualification period in addition to a lengthy elimination period (e.g. a 1 year elimination period plus a 2 year qualification period is of questionable benefit to an insured). Most states have a 365 or 730 day maximum Elimination Period for Total Disability, so a ceiling at least that high would make more sense. Alternatively, a maximum qualification period in addition to an Elimination Period either in total number of days or relative to the Elimination Period would make more sense.

Insurance Compact Office update following the Feb. 6, 2018 PSC Member Call:

After discussion, the PSC agreed to the following revision to (c) and the Drafting Note in response to concerns regarding the potential for a lesser maximum qualification period for Partial or Residual Disability:

(c) Partial or Residual Disability benefits may be predicated upon a qualification period during which the insured shall be *Totally Disabled* before *Partial* or *Residual Disability* benefits are paid. The qualification period may be in lieu of the *Elimination Period* or in addition to the *Elimination Period* but ~~may not exceed six months due to use of a qualification period alone or in conjunction with an Elimination Period~~ the combined *Elimination Period* and qualification period, if any, for *Partial/Residual Disability* benefits cannot exceed that for *Total Disability*. A company may require care by a Physician.

Drafting Note: Benefits may be predicated on the insured being *Totally Disabled*, not on receipt of *Total Disability* benefits. In no event shall the combined *Elimination Period* and qualification period, if any, for *Partial/Residual Disability* benefits exceed that for *Total Disability*.

6. DEFINITION OF PREEXISTING CONDITION

APPLIES: §3.B.(21) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISION:

§ 3. B. DEFINITIONS AND CONCEPTS

(21) "Preexisting Condition" means a condition for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a one-year period preceding the effective date of the coverage of the insured, or for which medical advice or treatment was recommended by a Physician or received from a Physician within a two-year period preceding the effective date of the coverage of the insured. The term "coverage of the insured" as used in this definition or concept refers to initial coverage amounts when a policy is first issued, and it may, at company discretion, also refer to coverage increase amounts which are issued after the policy is first made effective when those coverage increase amounts are subject to evidence of medical insurability. In the case of coverage increase amounts subject to evidence of medical insurability, the time periods in this definition or concept run anew from the effective dates of the increased coverage amounts and apply anew only to the coverage increases.

COMMENTS:

Regulator Comments: The Wyoming Insurance Department and the Idaho Department of Insurance submitted comments regarding the definition of preexisting condition. Wyoming notes that the Compact standard allows for "prudent person" language, which is not allowed in Wyoming, where preexisting conditions can only relate to conditions for which medical advice, diagnosis, care or treatment was recommended. Wyoming's look back period is for 6 months, regardless of how a person received advice or treatment. Wyoming also notes that the Compact standard allows no limit for how long coverage can be limited or excluded for a preexisting condition, while Wyoming law caps such a limitation or exclusion at 12 months after the effective date.

Idaho notes that their rules state that a preexisting condition provision cannot be more restrictive than a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage. Like Wyoming, they also cap the time period to

limit or exclude preexisting condition coverage to 12 months from the effective date of coverage.

Both states request that the Insurance Compact review the preexisting condition language to provide greater consumer protection and limit its application.

Industry Comment: The Industry Advisory Committee (IAC) suggests combining some provisions currently in the IDI uniform standards with those found in the Group Disability Income Insurance Policy and Certificate Standards, and allowing any time period for when symptoms existed or medical advice sought, recommended or received as long as the timeframe does not exceed 24 months. The IAC suggests the following language:

"***Preexisting Condition***" means:

(a) A condition for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a specified period of time (such as 1 to 12 months, but not to exceed 24 months) preceding the insured's effective date of the coverage;

(b) A condition, whether diagnosed or not, for which medical advice or treatment was recommended by a *Physician* or received from a *Physician* within a specified period of time (such as 1 to 12 months, but not to exceed 24 months) preceding the insured's effective date of the coverage; or

(c) A condition, whether diagnosed or not, for which an insured received medical advice, consultation, diagnostic testing or treatment, or took or was prescribed drugs or medications within a specified period of time (such as 1 to 12 months, but not to exceed 24 months) preceding the insured's effective date of the coverage.

The term "insured's coverage" as used in this definition or concept refers to initial coverage amounts and it may also refer to coverage increase amounts. In the case of coverage increase amounts, the time periods in this definition or concept run anew from the effective dates of the increased coverage amounts and apply anew only to the coverage increases.

IIPRC Office Comments/Observations: The IIPRC Office notes that the current NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (Model Regulation #171) which includes Disability Income Insurance states

"'Preexisting condition' shall not be defined more restrictively than the following: 'Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two year period preceding the effective date of the coverage of the insured person.' " Section 6 of the Model Regulation limits exclusions or limitations after twelve (12) months only for any preexisting condition not specifically excluded from coverage by terms of the policy. At the time the standards were originally proposed, the Product Standards Committee (PSC) recommended amending the "ordinarily prudent person" language to a one year look back period, based on comments received from a member state.

The Compact's Group Disability Income Insurance standards cap the look back period at two years, but allow for a lesser time period. The definition is not completely identical to the language listed in the individual standards. Like the individual standards, there is no cap on how long a preexisting condition limitation or exclusion is permitted.

IIPRC Office Recommendation: The IIPRC Office notes that the existing standards are consistent with the NAIC Model, but suggests that the PSC review whether more member states require shorter look back periods and/or timeframes for which coverage for preexisting conditions may be limited or excluded or if the members wish further changes to the definition for consistency with the group disability income standards.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

The vast majority of states allow 24 months/24 months preexisting conditions timeframes and the use of these timeframes is common in the IDI industry. Only three states (ID, VA, WY) limit both the timeframe prior to the issue date and after the issue date. Two more states (IL, NV) limit only the timeframe prior to the issue date (IL only does this for the "prudent person" provision).

The Consumer Advisory Committee (CAC) provided the following written comments:

Items that are unsupported or that are objectionable include the following:

An overreaching definition of pre-existing condition that defies any reasonable anti-risk selection purpose for this underwritten product. As proposed an insured who had symptoms diagnosed by a physician as a common cold would be excluded from coverage when the symptoms proved to precede a stroke.

Insurance Compact Office update following the September 12, 2017 PSC Member Call: It was noted that the "ordinarily prudent person" language is found in NAIC Model #171 as well as in the group disability income insurance uniform standards. Model #171 has a look back period of two years for both symptoms and treatment although the two years is bracketed in the Model while the current Uniform Standard is a one year look back for symptoms and two years for receiving medical advice or treatment by a physician. Model #171 contains a provision that a policy shall not exclude coverage for a preexisting condition for a period greater than twelve months following issuance of the policy if the application doesn't ask about prior medical history and the preexisting condition is not specifically excluded, similar to language suggested in the written comments from Idaho.

The PSC decided that there was no clear change in circumstances justifying the need to change the look back period from what was decided initially and more consistent with the NAIC Model. The PSC was disinclined to change the definition to the one found in the GDI standards, as suggested by the IAC, since it would limit the protections currently provided in the standards. The Committee did agree, however, that it would be prudent and an enhanced consumer protection to add language similar to the Model to address the length of time a company can apply a preexisting condition. The Insurance Compact Office will draft language for further discussion.

Insurance Compact Office update following the October 10, 2017 PSC Member Call: The PSC reviewed the language in Model 171 that a policy shall not exclude coverage for a preexisting condition for a period greater than twelve months following issuance of the policy if the application doesn't ask about prior medical history and the preexisting condition is not specifically excluded, as well as suggested draft language under § 3 F.(13) Permissible Limitations or Exclusions. The PSC agreed that the following addition would add clarity:

§3 F. PERMISSIBLE LIMITATIONS OR EXCLUSIONS

(13) **Preexisting Conditions**.

(a) Any provision included in a policy limiting or excluding coverage for losses incurred or disabilities arising from *Preexisting Condition*s shall clearly define the limitation or exclusion and disclose such limitation or exclusion in the policy. The policy shall not exclude or limit coverage for a loss due to a preexisting condition for a period greater than twelve months following issuance of the policy where the application for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically limited or excluded by the terms of the policy.

(b) For a disease or physical condition that has not been excluded from coverage by name or specific description effective on the date of loss, losses incurred or disabilities commencing on or after the coverage effective date due to that disease or physical condition shall be covered immediately when:

(i) The disease or physical condition is an *Injury* or *Sickness* as described in the Definitions and Concepts section and is not a *Preexisting Condition* as described in the Definitions and Concepts section; or

(ii) The disease or physical condition is disclosed in the application, but the company has taken no express underwriting action for the disease or physical condition.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following comments:

We can accept the current IDI Definition/Concept for preexisting conditions if we are able to change "or for which medical advice or treatment was recommended by a *Physician* or received from a *Physician*" to say "or for which medical advice, consultation, diagnostic testing or treatment was recommended by a *Physician* or received from a *Physician*, or for which the insured took or was prescribed drugs or medications…."

We had and continue to have concerns with relying on "treatment" to include consultation, diagnostic testing, prescribing drugs and medications or taking drugs and medications. Too many times a company may miss a preexisting condition such as a slow degenerative disease or mental /nervous disorders because an applicant has not been "treated" recently and yet they are taking drugs or medications. The Group DI Definition/Concept allows a more detailed question, even though Model #171 was not as specific, and so we believe a more detailed question should also be allowed for IDI.

In the example of "overreach" provided at the bottom of Page 16 of the Report, it is argued that "symptoms diagnosed by a Physician as a common cold would be excluded from coverage when the symptom proved to precede a stroke." We believe this conclusion is mistaken – the language clearly requires that an insured would have had to receive medical advice, consultation, diagnostic testing or treatment, or had taken or was prescribed to take drugs or medications for the stroke.

With regard to the language proposed for Section 3F. PERMISSIBLE LIMITATIONS OR EXCLUSIONS, as shown at the bottom of Page 17 of the Report, we suggest making a change to better clarify that if a disability due to a preexisting condition begins in the first 12 months following a policy effective date, such disability will not be covered under the policy. We propose the following change:

"The policy shall not limit or exclude coverage for a loss due to a *Preexisting Condition* that begins after twelve (12) months following the issuance of the policy where the application for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care or treatment and the *Preexisting Condition* is not specifically limited or excluded by the terms of the policy."

The Consumer Advocates Committee in their comments for Substantive Issue #9 complained that the IDI products are "already expensive products." We have made several suggestions in the definitions of Total Disability (Substantive Change Item #7), Rehabilitation, and in this Substantive Issue #6 and other provisions to make the product more affordable, and in some cases have met PSC resistance to this. In our arguments to allow better language in this Substantive Issue #6, we are told that what we suggested was too restrictive; however; if an underwriter cannot have better tools to asses a risk for a pre-existing condition, rates may have to be higher.

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The Committee first discussed the IAC request to amend the definition of Preexisting Condition to include consultation, diagnostic testing and taking or being prescribed drugs within two years preceding the effective date of coverage. Some members expressed reservations about the term "consultation," indicating that it could be interpreted more broadly than seeking medical advice regarding a medical condition and noting that it is not a term used in most state definitions for preexisting conditions. The Committee agreed to the following revision to the current definition of preexisting condition:

"Preexisting Condition" means a condition for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a one-year period preceding the effective date of the coverage of the insured, or for which medical advice, diagnostic testing or treatment was recommended by a *Physician* or received from a Physician or for which the insured took or was prescribed drugs or medications within a two-year period preceding the effective date of the coverage of the insured. The term "coverage of the insured" as used in this definition or concept refers to initial coverage amounts when a policy is first issued, and it may, at company discretion, also refer to coverage increase amounts which are issued after the policy is first made effective when those coverage increase amounts are subject to evidence of medical insurability. In the case of coverage increase amounts subject to evidence of medical insurability, the time periods in this definition or concept run anew from the effective dates of the increased coverage amounts and apply anew only to the coverage increases.

The PSC then reviewed the IAC request to clarify the language proposed by the PSC and noted that the language proposed could be interpreted to limit the period of time the preexisting condition can be limited or excluded, or that it possibly could be read to allow new conditions to

be limited or excluded if they develop after the first twelve months of the policy. Following discussion, the PSC agreed to the following revision:

§3 F. PERMISSIBLE LIMITATIONS OR EXCLUSIONS

(13) **Preexisting Conditions**.

(a) Any provision included in a policy limiting or excluding coverage for losses incurred or disabilities arising from *Preexisting Condition*s shall clearly define the limitation or exclusion and disclose such limitation or exclusion in the policy. Beginning no more than twelve months following the effective date of the policy, the policy shall not limit or exclude coverage for a loss due to a *Preexisting Condition* if the application for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically limited or excluded by the terms of the policy.

Insurance Compact Office update following the Jan. 23, 2018 PSC Public Call: The Consumer Advisory Committee (CAC) submitted the following comments:

4). We support the item 6 recommendation regarding pre-existing g condition exclusions. However we suggest the phrase "for which the insured took or was prescribed drugs or medications" should be revised to " for which a qualified health professional prescribed drugs or medication."

Insurance Compact Office update following the Feb. 6, 2018 PSC Member Call: The Committee approved the following revisions suggested by the CAC:

"Preexisting Condition" means a condition for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a one-year period preceding the effective date of the coverage of the insured, or for which medical advice, diagnostic testing or treatment was recommended by a *Physician* or received from a Physician or for which ~~the insured took or was~~ a qualified health professional prescribed drugs or medications within a two-year period preceding the effective date of the coverage of the insured. The term "coverage of the insured" as used in this definition or concept refers to initial coverage amounts when a policy is first issued, and it may, at company discretion, also refer to coverage increase amounts which are issued after the policy is first made effective when those coverage increase amounts are subject to evidence of medical insurability. In the case of coverage increase amounts subject to evidence of medical insurability, the time periods in this definition or concept run anew from the effective dates of the increased coverage amounts and apply anew only to the coverage increases.

7. DEFINITION OF TOTAL DISABILITY

APPLIES: §3 B.(28) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

B. DEFINITIONS AND CONCEPTS

(28) "***Total Disability***" means a definition of *Total Disability* no more restrictive than indicating that during the first 12 months of a *Total Disability*, excluding the *Elimination Period*, an insured is unable to perform the substantial and material duties of the insured's own *Occupation* and is not in fact engaged in any job or *Occupation* for wage or profit.

The policy may provide that after the first 12 months of *Total Disability* the company may predicate the continuance of benefits on the insured's inability to perform the substantial and material duties of any work or *Occupation* for which he or she is qualified by reason of education, training or experience. The policy may also provide that a company may require an insured to have an inability to perform the substantial and material duties of his or her own *Occupation* after the first 12 months of a *Total Disability*.

An insured shall not be required to be unable to perform "any *Occupation* whatsoever, "any occupational duty," or "each and every duty of his or her *Occupation*" or words of similar import.

A company may require care by a *Physician*. If it can be shown that the insured has reached his or her maximum point of recovery, yet is still *Totally Disabled* under the terms of the policy, the care and attendance of a *Physician* on a regular basis is not required.

COMMENTS:

Industry Comment: The IAC suggests that the definition of Total Disability be amended to be more like the definition found in the Group Disability Insurance Policy and Certificate Standards, but be further revised to require that the insured be unable to perform <u>all</u> the Substantial and Material Duties of his or her Job, Occupation or Specialty (adding definitions for all of those terms) or any gainful Job, Occupation or Specialty for which the

insured is qualified by reason of education, training or experience as applicable and is not in fact working for wage or profit.

The IAC's comments contained a global explanation for all suggested changes that the standards need to be flexible enough to not only to support new, more creative product solutions, but foster their development. The companies need to have the ability to create affordable products for those who truly cannot afford traditional type coverage but are in much need of income protection, especially in the event of a long-term or serious disability.

IIPRC Office Comments/Observations: The IIPRC Office notes that it has issued objections to companies that have filed products that define total disability in a manner that may be considered more restrictive than the standards.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC ask the IAC to provide further explanation for the need for this change and an explanation of why such a change would not have a detrimental impact on the insured.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

There is a definite need in the marketplace to be able to create affordable policies that meet the needs of a vast number of the under-served population, particularly in the blue/gray collar market. Policies with limited benefit periods or that pay a lump sum upon a qualifying disability could be priced to be attainable and offer value to those who cannot afford traditional products. These types of products are eliminated or completely negated if companies must adhere to an initial period of "own occupation" definition of disability. While the companies are not suggesting that we do away with the option to purchase "own occupation" coverage, this "any occupation" choice could provide a viable benefit option for many. Also, by allowing additional benefit triggers within a policy, a person could collect benefits for reasons other than "total" disability.

The Consumer Advisory Committee (CAC) provided the following written comments:

Items that are unsupported or that are objectionable include the following:

A definition of "Total Disability" that is more restrictive than that found in the group standards and that is inherently misleading: A disabled insured will be surprised to learn there are no benefits because the insured can perform one, but not all the rest of the

"substantial and material" job duties. Note this proposal is contrary to NAIC Model 171 Section 5 N.

Insurance Compact Office update following the Nov. 21, 2017 PSC Member Call: The PSC noted that there was no clear indication of a need to conform GDI and IDI definitions in this instance, and doing so would take away a consumer benefit that is currently in the IDI standards. They also noted that the IAC wanted to further amend the IDI standards to be even more restrictive than the GDI definition. The PSC agreed with the comments from the Consumer Advisory Committee and is not recommending this proposed change.

Insurance Compact Office update following the Jan. 23, 2018 PSC Public Call:

The IAC submitted the following comments:

The companies did not intend to make the definition more stringent than the definition in Group DI – and we believe the problem is with our request to use the word "all" in connection with the inability to perform Material and Substantial Duties. We are agreeable to delete the word "all".

We do, however, respectfully request that the PSC give further consideration to discontinuing the initial 12-month "own occupation" requirement and allowing an "any occupation for which the insured is qualified by reason of education, training, and experience" definition of disability from day one, as an option.

Additionally, further consideration should also be given to allowing for other disability benefit triggers (see Appendix A, page 13, definition of Disability or Disabled, other triggers) to follow a period (possibly two years) of occupational disability, such as own or any occupation.

The requested considerations are consistent with what is offered in the GDI standards, but more importantly, these options and triggers would certainly give companies a much better chance to offer affordable options to the under-served population that cannot afford high-end disability policies. Our previous comments still stand on this particular topic.

David Bolton, Oregon Division of Financial Regulation submitted the following comment:

1. Individual Disability Insurance is not the same as group disability insurance. My own Individual disability insurance required full occupational and medical underwriting. It contains a three year true own occupation definition of disability and very limited exclusions and limitations. I pay the premium for both individual and group long tern disability insurance. Group Long Term Disability Insurance can change every open

enrollment and with every IIPRC five year review of the product standards. Why would fully underwritten products also require a long waiting period. This is usually for group disability that is issued without full underwriting. An individual long term disability contract should continue to require at least a 12 month own occupation definition.

Insurance Compact Office update following the Feb. 6, 2018 PSC Member Call: The Committee discussed the IAC's request for reconsideration and raised concern over reasonable consumer expectations of coverage related to one's own occupation vs. any occupation. The Committee's decision was not to accept the IAC's proposal and leave the language as is.

Insurance Compact Office update following the March 6, 2018 PSC Public Call:

The IAC submitted the following comments:

We are at a loss as to how only 3 states have a 12-month "own occupation" requirement (FL, MD, and NJ) and yet the PSC chooses to hold on to a minority view regarding the perceived "need" for some period of "own occupation" coverage to be applied to every compacting state. In an age where people are beginning to purchase everything over the Internet, instantaneously, the ability to offer "any occupation" coverage with limited underwriting becomes an important option for companies. This also plays into the mentality of the younger working generation, who seemingly struggle to see the need to purchase disability income coverage, but may be enticed by affordable and easily attainable disability income coverage. The consumer who has a sedentary job, sitting in an office or at a desk all day, has little, if any, use for an "own occupation" definition of disability. If that person can't do a desk job due to a disability, what else will that person be able to do? So, to pay for "own occupation" is likely to pay for more coverage than is necessary. For the consumer who has a manual type occupation, from which it is easier to become disabled, "own occupation" coverage is more expensive, and frequently too expensive, and so this person may not be able to afford any coverage, where he/she may have purchased "any occupation" coverage, which would have provided coverage in the event he/she can't do a sedentary job, as well. The companies know they have a huge, under-served population that cannot afford what is considered "traditional" disability insurance with all the bells and whistles, but who need some type of coverage, possibly more than anyone else. We also live in a time where people purchase things in a different way than they did 10, 20 years ago. If we continue to think old-school, under the guise of protecting the consumer from their own choices, then we will become obsolete.

Insurance Compact Office update following the March 613, 2018 PSC Member Call: The Committee did not note any new reasons for reconsideration and decided to leave the initial 12-month "own occupation" requirement unchanged.

8. REINSTATEMENT REQUIREMENTS

APPLIES: § 3 C. REQUIRED PROVISIONS (15) Reinstatement of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISION:

(15) **Reinstatement**. The policy shall include a reinstatement provision describing the company procedures when a renewal premium is not timely paid by an owner.

(a) When the owner does not timely pay a renewal premium and the company or its producer subsequently accepts payment of the renewal premium without an application, this provision shall state the policy is reinstated in such case as though a policy lapse had not occurred.

(b) When the owner does not timely pay a renewal premium and the company or its producer requires an application for reinstatement and issues a conditional receipt or interim insurance agreement for the premium tendered for reinstatement of the policy by the owner, this provision shall state that the policy is reinstated upon approval of the application by the company; or, if the company does not act to approve the application, the policy is reinstated on the 45th day following the date of the conditional receipt or interim insurance agreement unless the company has given notice to the owner of company disapproval of the application previous to the expiration of the 45 day time limit.

(c) This provision shall state that the reinstated policy shall cover loss resulting from accidental injury sustained on or after the date of reinstatement and loss due to sickness as may begin on or after the date of reinstatement. The company may add riders, amendments or endorsements to the reinstated policy complying with these standards..

(d) Any premium accepted with a reinstatement shall be applied to a period for which the owner did not previously pay premium, but not to any period more than 60 days prior to the date of reinstatement. (The last sentence may be omitted from any policy which the owner has the right to continue in force subject to its terms by timely premium payment until at least the

insured's age 50 or, in the case of a policy issued after the insured's age 44, for at least five years from its date of issue.)

(e) Misstatements in the application for reinstatement are subject to the same standards for misstatements in the original application. The company may impose a reasonable time limit to apply for reinstatement, but in no event less than six months from the termination date of the policy.

COMMENTS:

Industry Comment: The IAC suggests that the PSC consider the life insurance standards for reinstatement, but did not explain why they made this request. They also suggested an addition to the reinstatement provision to say that if the policy includes a Return of Premium (see Substantive Item #11 for this suggested addition) benefit and the company has paid such benefit, the policy may contain a provision that the policy terminates at such payment and may not be reinstated.

IIPRC Office Comments/Observations: The IIPRC Office often issues objections to filers because they routinely include a provision requiring an application for reinstatement when a policy lapses. This requirement is not permitted under § 3C.(15)(a) if the company or producer accepts payment of a renewal premium without a reinstatement application. Filers have commented that current procedures do not include acceptance of a renewal premium on a lapsed policy without a reinstatement application. The IIPRC Office notes that this provision is different from requirements found in the group disability income insurance uniform standards and life insurance uniform standards, but is similar to the requirements found in the long-term care insurance standards.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC review state filing requirements for reinstatement and discuss whether a requirement that the reinstatement provisions clearly state whether a company may require or shall not require a reinstatement application if it accepts a renewal premium after the grace period should be mandatory, optional or eliminated.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the Industry Advisory Committee (IAC):

We suggested the life insurance standard for consistency since DI and Life may be sold in combination.

Current IDI standard Item (15)(a) addresses situations where a company or a producer accepts a renewal premium without requiring a reinstatement application. By the end of a grace period, the owner/insured receives a letter advising him/her of the grace period due to reinstate the policy. Current industry practice varies from company to company, but each company has a short window of time, such as 10-15 days after the letter is sent, during which it will accept a premium and not require an application to reinstate the policy. Contrary to what is stated in (15)(a), the companies have language filed and approved in all states that allows them to accept the premium and ***reinstate the policy as of the date they received the premium***, ***not as of the date of lapse***. The reason for doing so is to avoid anti-selection (buying a claim). If an injury or sickness began during the "gap" period of time between date of lapse and date the premium was received, disabilities caused by such injury or sickness will not be covered under the reinstated policy.

Current IDI standard item (15)(b) states that when premium is received with a reinstatement application, and the application is approved by the company, the policy will be reinstated on the date of such approval, provided the company approves the application within 45 days of its receipt. If the company does not approve or decline the application and does not notify the applicant of its decision by the end of the 45 day period, the policy is reinstated at the end of the 45 day period. In either case of an approval or no action taken by the company by the end of the 45 day period, if an injury or sickness began during the "gap" period of time between date of lapse and date the policy is reinstated, disabilities caused by such injury or sickness will not be covered under the reinstated policy.

With regard to the conditional receipt language in the current IDI standards, a conditional receipt only provides coverage while a policy is in underwriting and premium has been collected. Since a reinstated policy will only provide coverage for loss that occurs "on or after the date of reinstatement", a conditional receipt concept makes no sense since there will never be coverage provided under a conditional receipt.

The Consumer Advisory Committee (CAC) provided the following written comments:

Items that are unsupported or that are objectionable include the following:

Allowing an insurer to terminate coverage after it has accepted a late premium payment without condition. Insurers unwilling to accept late payments should have the responsibility to promptly reject the payment or to promptly alert the insured to possible termination of coverage by issuing a conditional receipt. Note this proposal is contrary to NAIC Model 180 Section A (5).

Insurance Compact Office update following the August 29, 2017 PSC Member Call: The Compact office clarified that the issue that filers have raised, which is different from the comments submitted by the IAC, is that as currently written it appears the standard could apply to situations where payment is made to a lock box and the company has no control over a requirement for an application. The IAC raised two different issues, one requesting reinstatement as of the date of receipt of premium and the other questioning the language in §3 C.(15)(b) about conditional receipts. Following discussion, the PSC agreed that adding the word "requiring" an application would provide clarity and be consistent with the language in the long-term care insurance uniform standards, and that states generally allow the reinstatement to be from receipt of premium payment, not to be retroactive to the lapse date. The PSC also agreed to eliminate reference to conditional receipts. The following revisions are suggested for recommended amendments, including noting that the producer must be authorized to accept premium:

(15) **Reinstatement**. The policy shall include a reinstatement provision describing the company procedures when a renewal premium is not timely paid by an owner.

(a) When the owner does not timely pay a renewal premium and the company or ~~its~~ an ~~producer~~ agent duly authorized to accept premium payment subsequently accepts payment of the renewal premium without requiring an application, this provision shall state the policy is reinstated ~~in such case as though a policy lapse had not occurred~~ as of the date of receipt of the renewal premium.

(b) When the owner does not timely pay a renewal premium and the company or its producer requires an application for reinstatement ~~and issues a conditional receipt or interim insurance agreement for the premium tendered for reinstatement of the policy by the owner~~, this provision shall state that the policy is reinstated upon approval of the application by the company; or, if the company does not act to approve the application, the policy is reinstated on the 45th day following the date of ~~the conditional~~ receipt ~~or interim insurance agreement~~ of the application for reinstatement unless the company has given notice to the owner of company disapproval of the application previous to the expiration of the 45 day time limit.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following comments:

The term "producer" should be changed to say "agent" for consistency with IIPRC standards.

We seek clarification if the Item (15) preamble as shown on Page 22 of the Report would allow a company to include the right to require evidence of insurability if a previous insured wants to reinstate after the 60 days reinstatement period. If the answer is no, then we respectfully request a justification for not allowing this – for anti-selection purposes, this is the one of the critical components of an application for reinstatement.

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The Chair noted that the reference to producer in (15)(b) was an oversight and would be corrected. The Compact Office advised members that other Uniform Standards with Reinstatement provisions specifically state whether evidence of insurability may be required. The Committee agreed that certain sections of this provision, such as when payment if accepted without requiring an application, would not permit evidence of insurability. The PSC agreed to add a sentence to (b) addressing evidence of insurability.

(15) **Reinstatement**. The policy shall include a reinstatement provision describing the company procedures when a renewal premium is not timely paid by an owner.

(a) When the owner does not timely pay a renewal premium and the company or ~~its~~ an ~~producer~~ agent duly authorized to accept premium payment subsequently accepts payment of the renewal premium without requiring an application, this provision shall state the policy is reinstated ~~in such case as though a policy lapse had not occurred~~ as of the date of receipt of the renewal premium.

(b) When the owner does not timely pay a renewal premium and the company or its ~~producer~~ agent requires an application for reinstatement ~~and issues a conditional receipt or interim insurance agreement for the premium tendered for reinstatement of the policy by the owner~~, this provision shall state that the policy is reinstated upon approval of the application by the company; or, if the company does not act to approve the application, the policy is reinstated on the 45th day following the date of ~~the conditional~~ receipt ~~or interim insurance agreement~~ of the application for reinstatement unless the company has given notice to the owner of company disapproval of the application previous to the expiration of the 45 day time limit. Evidence of insurability may be required.

9. RETURN OF PREMIUM PROVISION

APPLIES: §3.D. OPTIONAL PROVISIONS of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

There is no current standard for a Return of Premium Benefit

COMMENTS:

Industry Comment: The IAC requested adding a Return of Premium Benefit to the Optional Provisions. The IAC did not provide a specific reason for the addition beyond the blanket explanation that such changes would allow more flexibility in product development and pricing to meet changing consumer needs. The following is the language suggested by the IAC:

RETURN OF *PREMIUM* BENEFIT

(1) A policy may include a Return of *Premium* Benefit. If the policy includes such a benefit, the policy shall state that the amount of the benefit will equal:

(a) The total of all *Premiums* paid for the policy multiplied by the appropriate percentage in the Table of Return of *Premium* Percentages, as shown in the specifications page of the policy; minus

(b) The total of all *Disability* benefits paid under the policy.

(2) The policy shall state that the benefit is payable on the date any of the following events occur:

(a) Upon the owner's written request at any time;

(b) When the company receives proof of the insured's death;

(c) When the policy lapses; or

(d) When the policy ends.

(3) In lieu of ending the policy and receiving the Return of *Premium* Benefit when an insured reaches the age at which the Return of *Premium* Percentage equals 100 percent, the owner may continue the policy in force until the policy's expiration

date. In this case, the following conditions apply:

(a) The company will maintain the Return of Premium Benefit amount on deposit and credit interest at the rate paid by the company for funds left on deposit

(b) The company will adjust the policy *Premium* to remove the *Premium* paid for the Return of *Premium* benefit; and

(c) The owner may terminate the policy at any time and collect the Return of *Premium* Benefit less the total of all *Disability* benefits paid under the policy.

(4) If the policy has a Waiver of *Premium* Benefit, the policy shall state that any *Premium* waived under such benefit will be considered paid *Premium* when computing the amount in Paragraph (1)(a), and will be considered a benefit paid when computing the amount in Paragraph (1)(b).

(5) The policy shall state that the policy will end on the date the company computes the Return of *Premium* Benefit. After such date, the policy may not be reinstated. If any *Disability* benefits accrue under the policy after the Return of *Premium* benefit amount has been paid, the company will only pay *Disability* benefits that exceed the amount of Return of *Premium* benefit that has been paid.

IIPRC Office Comments/Observations: The IIPRC Office is aware that some companies offer a return of premium rider in which for an additional premium, the insured receives a refund of all monthly premiums if the insured does not become disabled during the duration of the policy. Other riders include a return of a portion of the premium paid minus disability benefits paid during the term of the policy. To date, the IIPRC Office has not received submissions of filings with this benefit feature.

IIPRC Office Recommendation: The IIPRC Office suggests that before consideration of this request, that the PSC request that the IAC provide more information about why they are requesting the addition of this provision, how many companies offer these riders, and how many states permit the sale of these riders.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the Industry Advisory Committee (IAC):

The benefit was filed in 2010-2011 as an IDI benefit and approved in 36 IIPRC member jurisdictions. It was exempt from filing in AZ and TX. It was not filed in CT or VT. It was not filed in AK and HI because the filer was not licensed there. GA approved after requiring that a notice state that the benefit may only be issued with cancer expense, long-term care or disability income policy. MA objected on the basis that returning a part of the premium constitutes rebating, and allowing accrual of interest on paid premium held on deposit to be a form of cash value - the state would have approved a return of premium for the total amount of premium paid.

One company is currently marketing this benefit, but other companies agreed that it should be included as a standard. We cannot definitely say what companies' future plans will be.

The following written comments were received from the Consumer Advisory Committee (CAC):

Return of premium rider. We urge you to consider whether this invites sale of an expensive feature that covers no risk attached to an already expensive product.

Insurance Compact Office update following the September 26, 2017 PSC Member Call: The Committee discussed the proposal and noted that the IAC provided only a vague rationale for the benefit of such a provision to consumers and only indicated one company offered this provision. They also noted that there was no indication of how such a provision impacts rates. Members also expressed reservation about the proposed language and a reference to "the appropriate percentage in the Table of Return of Premium Percentages" as a multiplier for the actual return of premium. The Committee was disinclined to pursue adding this benefit without documentation from insurers providing 1.) some framework for the variability of percentages in the referenced Table of Return of Premium Percentages; 2) an explanation of how circumstances or underlying assumptions have changed since the standards were adopted to justify a need to add such a benefit feature; 3) an indication of the impact on rates for such a feature, and 4) a response to the CAC concern that this provision "invites sale of an expensive feature that covers no risk attached to an already expensive product."

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following comments:

We withdraw our request to include this benefit.

10. SUSPENSION OF COVERAGE WHEN UNEMPLOYED

APPLIES: §3.D. OPTIONAL PROVISIONS of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

There is no current standard for Suspension of Coverage While Insured is Unemployed

COMMENTS:

Industry Comment: The IAC requested adding a Suspension of Coverage While Insured is Unemployed to the Optional Provisions. The IAC did not provide a specific reason for the addition beyond the blanket explanation that such changes would allow more flexibility in product development and pricing to meet changing consumer needs. The following is the language suggested by the IAC:

SUSPENSION OF COVERAGE WHILE INSURED IS UNEMPLOYED

(1) If an insured has been covered for *Disability* benefits under the policy for at least one (1) year and then becomes unemployed and receives eight (8) weeks of government unemployment benefits, the company may allow the insured to suspend coverage under the policy upon receipt of written request from the insured for such suspension and the insured's certification that he or she is unemployed and has received eight (8) weeks government unemployment benefits. The suspension will begin on the date that the company receives the written request and certification. *Premiums* must be paid up to the date of suspension.

(2) During any policy suspension, the company will not accept *Premiums* and benefits or options previously available under the policy, as well as any attached riders, endorsements or amendments, may not be exercised.

(3) If any *Premiums* were paid for a period beyond the date of suspension, the company shall refund such *Premiums* on a pro-rata basis.

(4) The suspension will end on the date any of the following events occur:

(a) The date the insured dies;

(b) The end of a period not exceeding twelve (12) months following the date of suspension; or

(c) The date the company receives the insured's written request to end the suspension and evidence satisfactory to the company that the insured is gainfully employed;

(5) If suspension ends under (4)(b) above, the company will notify the insured that the policy will be back in force if the insured resumes *Premium* payments.

(6) When the policy is again in-force, the insured will have the same rights under the policy as he or she had prior to suspension. However, the policy will not pay *Disability* benefits for *Disability* due to:

(a) *Injury* that occurred while the policy was suspended; or

(b) *Sickness* which first manifested itself while the policy was suspended.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any product filings in the past that contain this type of provision.

IIPRC Office Recommendation: The IIPRC Office suggests that before consideration of this request, that the PSC request that the IAC provide more information about why they are requesting the addition of this provision, how many companies offer or would like to offer this option, whether the specific detail proposed (for example requiring receipt of eight weeks of unemployment benefits) is consistent with the requirements of most Insurance Compact filing companies, and whether products containing such a provision are approved in the states.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the Industry Advisory Committee (IAC):

The provision was filed as part of an IDI filing in 2010 and was approved in 41 IIPRC member jurisdictions. MD approved a variation. Filing was not made in AK and HI because the filer is not licensed there. Another company filed the provision and received approvals in all states except MD and MN. Another company filed this provision and has approval in all states.

Three companies are currently using this provision, but others agreed that it should be included as a standard. The provision is a consumer benefit, allowing a person to suspend the policy while unemployed, versus facing the loss of the policy because the premiums are a temporary hardship. We cannot definitely say what companies' future plans will be.

Insurance Compact Office update following the September 26, 2017 PSC Member Call: The PSC agreed in principle with the concept of adding a provision for suspension of coverage while unemployed. They were inclined to add language less prescriptive than the draft language offered by the IAC since such specific detail as requiring 8 weeks of government unemployment benefits and limiting the benefits to 12 months would tend to constrict an insurer's ability to offer benefits that fit consumer need as well as allow for future change. The Compact staff will work on potential revisions to the proposed language and the PSC will seek comment on specifically why the IAC would require such prescriptive standards in this optional benefit provision.

Insurance Compact Office update following the October 10, 2017 PSC Member Call:

The PSC discussed the Compact office draft revisions to the proposed language offered by the IAC, and noted that it does address the concern that some language in the IAC draft may be too prescriptive. Following some edits, the PSC agreed to seek comment on the following recommendation for a new optional provision for Suspension of Coverage while the insured is unemployed:

SUSPENSION OF COVERAGE WHILE INSURED IS UNEMPLOYED

(1) If an insured has been covered for *Disability* benefits under the policy for ~~at least one (1) year~~ the time period specified in the policy and ~~then~~ becomes unemployed, ~~and receives eight (8) weeks of government unemployment benefits~~, the company may allow the insured to suspend coverage under the policy.

(2) Any minimum period of unemployment, requirements for ~~upon receipt of~~ a written request from the insured for such suspension and the insured's certification that he or she is unemployed, and required evidence of unemployment shall be specified in the policy ~~and has received eight (8) weeks government unemployment benefits~~. The suspension will begin on the date that the company receives the ~~written request. and certification~~ documentation specified in the policy. *Premiums* must be paid up to the date of suspension.

(~~2~~3) During any policy suspension, the company will not accept *Premiums* and benefits or options previously available under the policy, as well as any attached riders, endorsements or amendments may not be exercised.

(~~3~~4) If any *Premiums* were paid for a period beyond the date of suspension, the company shall refund such *Premiums* on a pro-rata basis.

(5) The policy shall specify the maximum period for which the policy may be suspended;

(~~4~~6) The suspension will end on the date any of the following events occur:

(a) The date the insured dies;

(b) The maximum period of suspension permitted under the policy ~~end of a period not exceeding twelve (12) months following the date of suspension~~; or

(c) The date the company receives the insured's written request to end the suspension and evidence satisfactory to the company that the insured is gainfully employed;

(~~5~~7) ~~If suspension ends under (46)(b) above, the company will notify the insured that the policy will be back in force if the insured resumes~~ Reinstatement of the policy following a period of suspension may be contingent upon payment of *Premium*.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following comments:

The proposed changes are acceptable to us.

11. LIMITATION FOR DISABILITY BENEFITS OUTSIDE OF THE UNITED STATES

APPLIES: §3 F. of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISIONS:

There is currently no exclusion or limitation for disability benefits outside of the United States.

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office often issues objections to filers because the form contains a limitation on benefits when the insured is outside of the United States. Filers have indicated that such a limitation is a common exclusion in individual DI policies and may have been inadvertently not included. Filers have indicated it is important to their ability to effectively manage claims and determine eligibility for benefits. It can be difficult to obtain needed documentation and medical records, investigate claims and order independent medical exams when the insured is outside of the United States or Canada. The companies have noted that both the group disability income insurance uniform standards and the long term care insurance standards contain such a limitation, and the companies are unaware of any state prohibiting this restriction.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following addition, similar to the limitation found in the Group Disability Income Insurance Policy and Certificate Uniform Standards, to § 3 F. PERMISSIBLE LIMITATIONS OR EXCLUSIONS:

DISABLED **INSURED RESIDING OUTSIDE THE UNITED STATES, TERRITORIES OR POSSESSIONS OF THE UNITED STATES OR CANADA, AS APPLICABLE (the "Specified Area")**

(1) If a *Disabled* insured is determined to be residing outside the Specified Area, benefits for such *Disability* may be limited, suspended or excluded. The limitation, suspension or exclusion may apply whether or not the *Disability* began while the insured was residing outside the specified area. For a suspension, the policy shall state that upon return to the specified area, a *Disabled* insured may re-apply for benefits under the policy.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the Industry Advisory Committee (IAC):

We are recommending additional changes to the exclusion/limitation we requested on March 31:

(1) If a *Disabled* insured is determined to be residing, working or travelling outside the Specified Area, benefits for such *Disability* may be limited, suspended or excluded. For a suspension, a policy shall state that upon return to the Specified Area, a *Disabled* insured may re-apply for benefits under the policy.

The companies noted that persons may be disabled and residing, working or travelling abroad, or may become disabled while residing, working or travelling abroad, and that both situations should be allowed to be excluded or limited, as appropriate.

Insurance Compact Office update following the August 29, 2017 PSC Member Call: The PSC noted that the limitation for residing outside the United States or Canada is a common one in individual disability income insurance policies approved in the states, and it appears this limitation was overlooked, not specifically excluded when the standards were initially drafted and adopted. They noted that the additional language requested by the IAC to include "working or travelling" is not contained in the group disability income uniform standards and filings received by the Insurance Compact that initially contained a limitation when the insured was outside of the United States that resulted in issuance of an objection were not as restrictive as the IAC requested change. Following discussion, the PSC agreed that in this case the language should be consistent with the group disability standards and they agreed to the language recommended by the Compact office:

***DISABLED* INSURED RESIDING OUTSIDE THE UNITED STATES, TERRITORIES OR POSSESSIONS OF THE UNITED STATES OR CANADA, AS APPLICABLE (the "Specified Area")**

(1) If a *Disabled* insured is determined to be residing outside the Specified Area, benefits for such *Disability* may be limited, suspended or excluded. The limitation, suspension or exclusion may apply whether or not the *Disability* began while the insured was residing outside the specified area. For a suspension, the policy shall state that upon return to the specified area, a *Disabled* insured may re-apply for benefits under the policy.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: Pennsylvania asked about the language referencing exclusion, noting that the filings he reviewed indicated limiting coverage, not excluding. The companies agreed that the proposed provision did not need to reference exclusions, just limitation or suspension.

The IAC submitted the following written comments prior to the call:

We withdraw the request for the "working/travelling" language.

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The Compact Office went over the comments from Pennsylvania that were made during the Public call to eliminate excluding benefits from this provision. Tom Kilcoyne from Pennsylvania suggested further revisions to clarify the language and to indicate any limitation on benefits prior to suspension is for a period not less than 12 months. The PSC agreed that Pennsylvania would submit their suggested revisions in writing for review and consideration on the next member call.

Insurance Compact Office update following the Nov. 21, 2017 PSC Member Call: The PSC reviewed the suggested changes proposed by the Pennsylvania Department of Insurance and agreed that the revisions listed below provided clarity as well as reasonable standards for the limitation.

***DISABLED* INSURED RESIDING OUTSIDE THE UNITED STATES, TERRITORIES OR POSSESSIONS OF THE UNITED STATES OR CANADA, AS APPLICABLE (the "Specified Area")**

~~If~~ While a *Disabled* insured is ~~determined to be~~ residing outside the Specified Area, benefits for such *Disability* may be limited to a period of time not less than 12 months~~,~~ and subsequently suspended ~~or excluded~~. The limitation~~,~~ and suspension ~~or exclusion~~ may apply whether or not the *Disability* began while the insured was residing outside the specified area. ~~For a suspension~~ If benefits have been suspended, the policy shall state that upon return to the specified area, a *Disabled* insured may ~~re-apply~~ resubmit a notice of claim for benefits under the policy.

12. EXCLUSIONS AND LIMITATIONS FOR MENTAL HEALTH AND SUBSTANCE ABUSE RELATED DISABILITIES

APPLIES: §1. C.(1) and §3.F.(2), (9) and (10) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISIONS:

§1. C. VARIABILITY OF INFORMATION

(1) The company may identify items that will be considered variable. The items shall be bracketed or otherwise marked to denote variability. Variability shall be limited to benefit data applicable to the owner or insured, *Disability* benefits, amounts, durations, and premium information. The filing shall include a Statement of Variability that will discuss the conditions under which each variable item may change.

§ 3. F. PERMISSIBLE LIMITATIONS OR EXCLUSIONS

The Interstate Insurance Product Regulation Commission may approve the following limitations or exclusions if they meet the standards set forth below. The company may include in the policy one or more of these limitations or exclusions.

(2) Chemical Dependency. Loss that results from alcoholism or drug addiction may be limited or excluded.

(9) Intoxicants, Narcotics or Other Controlled Substances. Loss that results from the insured's legal intoxication defined by state law where the loss occurs, or loss that results from the use of narcotics or other controlled substances, unless administered on the advice of a physician, may be limited or excluded.

(10) Mental or Nervous Disorders. Loss that results from mental or nervous disorders may be limited or excluded. If coverage is to be limited, coverage shall be provided for at least 12 months.

COMMENTS:

Regulator Comments: The Vermont Insurance Division requested that the PSC recommend to the Management Committee that the provisions of the individual standards

relating to exclusions or limitations for mental health or substance abuse related disabilities be revised similar to the language in the group disability income insurance standards to be subject to applicable law in the state where the policy is issued or delivered for issuance. Vermont notes that the current IDI standards permit limitations or exclusions for mental health and substance abuse related disabilities and would violate the state's mental health parity laws. Conforming language similar to the group disability income insurance standards would apply consistent standards for group and individual products and prevent the Vermont Department from having to consider whether it would need to opt out of the IDI standards.

IIPRC Office Comments/Observations: The IIPRC office notes that the compromise language allowing limitations or exclusions for mental health and substance abuse related disabilities to be subject to applicable law in the state where the policy is issued or delivered for issuance was adopted by the Commission for the Group Disability Income Insurance Policy And Certificate Uniform Standards For Employer Groups in 2016.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC discuss consideration of the conforming language listed below to address Vermont's parity requirements and provide consistency between the individual and group standards:

§1. C. VARIABILITY OF INFORMATION

(1) The company may identify items that will be considered variable. The items shall be bracketed or otherwise marked to denote variability. Variability shall be limited to benefit data applicable to the owner or insured, *Disability* benefits, amounts, durations, and premium information. Variability may also include the limitations and exclusions that are required to comply with applicable law in the state where the policy is delivered or issued for delivery under Section 3.F. (2), (9) and (10). The filing shall include a Statement of Variability that will discuss the conditions under which each variable item may change.

§ 3. F. PERMISSIBLE LIMITATIONS OR EXCLUSIONS

The Interstate Insurance Product Regulation Commission may approve the following limitations or exclusions if they meet the standards set forth below. The company may include in the policy one or more of these limitations or exclusions.

(2) Chemical Dependency. Subject to the applicable law in the state where the policy is delivered or issued for delivery, ~~L~~loss that results from alcoholism or drug addiction may be limited or excluded.

(9) Intoxicants, Narcotics or Other Controlled Substances. Subject to the applicable law in the state where the policy is delivered or issued for delivery, ~~L~~loss that results from the insured's legal intoxication defined by state law where the loss occurs, or loss that results from the use of narcotics or other controlled substances, unless administered on the advice of a physician, may be limited or excluded.

(10) Mental or Nervous Disorders. Subject to the applicable law in the state where the policy is delivered or issued for delivery, ~~L~~loss that results from mental or nervous disorders may be limited or excluded. If coverage is to be limited, coverage shall be provided for at least 12 months.

Drafting Note: The Interstate Insurance Product Regulation Commission will maintain a comprehensive listing of state-specific requirements for those limitations and exclusions listed above that indicate "subject to applicable law in the state where the policy is delivered or issued for delivery," based on information reported by Member States.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

We note that, contrary to GDI where the cost is spread out, the IDI cost becomes a significant burden to individuals thereby making IDI less affordable. Because of the VT issue, some companies now include full mental/nervous/drug/alcohol coverage in their policies for all states and the policies are priced higher. A company typically offers a 10% reduction in premium if a proposed insured accepts a 2 year limitation. For consumers that have to buy the full coverage, they are paying higher premiums for coverage they may not have selected if given a choice.

Insurance Compact Office update following the September 12, 2017 PSC Member Call: Some members questioned consumers would be aware of state specific information and whether language in the policy is variable. The Compact Office noted that state information is included on the Insurer resources page of the Compact website and noted that some filers use variability by state while others note in the policy that it is subject to state law. Following discussion, the PSC agreed that this was a public policy decision for the Management Committee; however they would include a summary of the basis for the Management Committee decision on the Group

Disability Income Insurance Uniform Standards and note that in this situation, there does not appear to be a reason for group and individual standards to be different.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following written comments prior to the call:

We do not object to the proposed language.

13. INSURANCE WITH OTHER COMPANIES

APPLIES: §3. F. (8) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISION:

§ 3. F. PERMISSIBLE LIMITATIONS OR EXCLUSIONS

The Interstate Insurance Product Regulation Commission may approve the following limitations or exclusions if they meet the standards set forth below. The company may include in the policy one or more of these limitations or exclusions.

(8) Insurance with Other Companies

(a) If there is other valid coverage with other companies which provides benefits for the same losses as a policy with a provision that takes into account insurance with other companies, but the company with such a policy provision has not been given written notice of such other valid coverage prior to the occurrence or commencement of loss, the policy shall state that proportional benefits shall be paid, calculated as follows:

(i) Determining the benefits of the other valid coverage of which the company had notice (including the benefits of the policy with this type of provision);

(ii) Determining the benefits of all other valid coverage (including the benefits of the policy with this type of provision whether the company had notice or no notice; and

(iii) Placing (i) as the numerator over (ii) as the denominator to create a fraction. The fraction created shall be multiplied by the benefits that would otherwise be paid by the policy if the policy took no notice of the other valid coverage with other companies to arrive at the benefits paid by the policy. The company shall return that portion of the premium paid which exceeds the pro-rata portion of the premium for the reduced benefits paid by the policy.

(b) The term "other valid coverage" means individual disability coverage that must at a minimum include coverage provided by organizations subject to

regulation by the insurance law of any state or Canadian province. Benefits provided to the insured under compulsory benefit statutes, such as workers' compensation or employer liability, whether provided by a government agency or otherwise, shall be treated, for purposes of applying subsection (a) above, as "other valid coverage" of which the company had notice. The term "other valid coverage" shall not include group health or disability insurance, benefits provided by union welfare plans or employer or employee benefit organizations, or third party liability coverage.

(c) The use of the term "coordination of benefits" shall not be acceptable in describing this provision.

COMMENTS:

Regulator Comment: The Idaho Department of Insurance commented that although the provision indicates that use of the term "coordination of benefits" shall not be used to describe the provision, in their view, it is basically a coordination of benefits provision. Under Idaho's coordination of benefits law IDAPA 18.01.74, a disability income insurance policy would not meet the definition of "plan" so the policy would pay regardless of any similar insurance with other companies. The Idaho Department requests consideration for an amendment to this provision to instead state that no benefits are offset and no return of premiums are paid if there is any "other valid coverage" (as defined in current § 3. F. (8)(b)) and the carrier would pay full benefits as if there was no other insurance in place.

IIPRC Office Comments/Observations: The IIPRC Office notes that the language in the standard was included from the time that the draft was initially developed by the National Standards (EX) Working Group and that there were no comments on this provision from the regulators or interested parties during the original rulemaking process. The provision applies to applicants who withhold information about existing coverage at time of application, potentially creating over insurance incentives. Similar language is found in several states. The calculation of payment of benefits and the requirement to refund the portion of the premium paid which exceeds the pro-rata portion of the premium for the reduced benefits paid by the policy is different from coordination of benefits requirements.

The Group Disability Income Insurance Policy and Certificate Uniform Standards For Employer Groups, adopted in 2016 contain provisions in §9.B. allowing for reduction in benefits for benefits payable under, among other things, other group or IDI policies. Those standards require that the certificate shall specify which reductions will be dollar for dollar

and which will be based on a formula specified in the certificate. The IIPRC Office has not received any questions or concerns regarding this provision.

IIPRC Office Recommendation: The IIPRC Office does not have a specific recommendation, but suggests that the PSC discuss whether their state laws or regulations include similar provisions and if circumstances or underlying assumptions have changed since the standards were adopted to necessitate revision to the provision.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC:

We have our own comments on this provision. In the last sentence of item (8)(iii), as we noted earlier in this commentary with regard to the definitions/concepts of Guaranteed Renewable and Noncancellable, there is a requirement to return premium. However, it is not clear if this is intended for a specific claim, or is the intent to require a permanent premium reduction in the policy for all future benefits? Both intentions are problematic for us since a policy is initially priced to fund the various benefits to be paid under the policy, and we further note that pricing is adjusted for "other valid coverage" not known or not in force at the time of application, as well as coverage which was in force but may end. Accordingly, the pricing takes into account potential proportionate benefit payments.

In the last sentence of item (8)(b), we believe that the term "other valid coverage" should be allowed to include group health or disability insurance, benefits provided by union welfare plans or employer or employer benefit organizations. A typical IDI policy will provide a monthly benefit equal to 40%-60-% of an insured's pre-disability earnings, not 100%. If an insured was to collect 100% or more of his or her pre-disability earnings from all other sources, this would be considered overinsurance. As the Report states at the bottom of page 31, Group DI allows reduction on account of IDI policies, so it makes perfect sense for IDI to allow reduction with group type plans.

Insurance Compact Office update following the September 12, 2017 PSC Member Call:. The PSC noted that unlike coordination of benefits laws, this provision was only applicable when the existence of other individual disability coverage is not disclosed in order to provide a method for determining benefits, and that the standard requires the company to return the portion of premium paid which exceeds the pro-rated portion of the premium for the reduced benefits. The Committee agreed that this standard provides protection to the consumer by returning premium while protecting the company when other disability income coverage is not disclosed. There was no evidence that circumstances or underlying assumptions have changed since the

standards were drafted and as a result the Committee determined that they would not recommend any change to this provision.

Insurance Compact Office update following the Oct. 24, 2017 PSC Public Call: The IAC submitted the following written comments:

In the comments we submitted on July 10, 2017, we alerted the PSC that in the last sentence of item (8)(iii) there is a requirement to return premium, and that it was not clear if this is intended for a specific claim, or is the intent to require a permanent premium reduction in the policy for all future benefits. We have not received a response to this, and we seek confirmation if this language would allow companies to permanently adjust benefits to account for unknown in-force coverage, and that doing so is not in conflict with the Definitions/Concepts of Guaranteed Renewable and Noncancellable in a policy.

Our other comment was regarding the request to have "other valid coverage" include group health or disability insurance, benefits provided by union welfare plans or employer or employer benefit organizations. The IIPRC office notes at the bottom of Page 38 of the Report that "this provision was only applicable when the existence of other individual disability income coverage is not disclosed.". If this is likely possibility for Individual DI sales, why is it ruled out that it is not a likely possibility that the existence of the Group DI coverage may also not be disclosed? If non-disclosure justifies inclusion in "other valid coverage" for Individual DI coverage, it should also be justifiable for Group DI coverage.

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The PSC discussed the IAC's question regarding whether return of premium was for a specific claim, or if the intent was to require a permanent premium reduction in the policy for all future benefits. The PSC noted that as mentioned in the report, the language in the standard was included from the time that the draft was initially developed by the National Standards (EX) Working Group and that there were no comments on this provision from the regulators or interested parties during the original rulemaking process. They also noted that the provision is an optional limitation, not a required provision so if a company is concerned with it, they can choose not to add such a provision to their policy. The Committee concluded that they were disinclined to make amendments to the provision to address specifically whether premium refunds were claim driven or would reform the contract and that such specific information is not generally included within the policy.

In reference to the IAC's request that the term "other valid coverage" should include group health or disability insurance benefits, the Committee determined that it would recommend no change. They questioned why group health insurance would have any impact on disability insurance benefits, and noted that group disability insurance can change frequently based on

employment as well as whether the employer continues to offer the coverage and how much the employee must contribute. The Committee noted that there can be a a significant difference in plan design and benefits between a group and individual policy and if an individual is purchasing individual coverage when he or she also has group coverage, it is usually to supplement the benefits and to potentially cover longer elimination periods, not to be reimbursed more than 100%. They discussed that group policies may be paid in whole or in part by the employer so allowing for reduction in benefits when there is valid individual disability insurance coverage makes more sense on the group side. The Committee noted that there has been no documentation of a problem in the marketplace that would require such a revision.

14. INCIDENTAL BENEFITS

APPLIES: §3.I. INCIDENTAL BENEFITS PROVISIONS of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

I. INCIDENTAL BENEFIT PROVISIONS

The policy may include the following benefits which shall satisfy the requirements included in the respective Interstate Insurance Product Regulation Commission standards as well as satisfy the requirements for a benefit to be deemed incidental, as specified below. Incidental benefits shall be in addition to any other benefits paid under the policy.

(1) **Accidental Death Benefits.** Benefits paid due to the death of the insured caused by an *Injury*. This benefit shall meet the requirements for accidental death benefits as contained in the Standards for Accidental Death Benefits and Accidental Death and Dismemberment Benefits as adopted by the Interstate Insurance Product Regulation Commission. The amount payable shall be a lump sum not to exceed the equivalent of 12 monthly *Disability* benefits payable under the policy.

(2) **Dismemberment Benefits.** Benefits to be paid to an owner due to loss resulting from an Injury or Sickness of the insured. The types of losses that may be covered are described in the Standards for Accidental Death and Dismemberment Benefits as adopted by the Interstate Insurance Product Regulation Commission. The benefit shall meet all the requirements specified in such standards. The amount payable shall be a lump sum not to exceed the equivalent of 12 monthly *Disability* benefits payable under the policy.

COMMENTS:

Industry Comment: The IAC suggests that Incidental Benefits be made a separate Section in the Standards, and that it include all incidental benefits listed in the Group Disability Income Insurance Policy and Certificate Uniform Standards with the exception of the Revenue Protection Benefit and the Worksite Modification Benefit.

IIPRC Office Comments/Observations: The IIPRC Office notes that it often receives requests for additional incidental benefits to be added to IDI policies and that based on the limited criteria in the standards, the requests cannot always be accommodated. The IIPRC Office also notes that although the IAC provided a lengthy list of Incidental Benefits for the Group Disability Income Insurance Policy and Certificate Uniform Standards, the Insurance Compact has received requests for benefits that do not fit squarely within this list.

IIPRC Office Recommendation: The IIPRC Office does not believe there is a need to reformat the standard to create a separate section exclusively for incidental benefits, rather the list can be expanded within the existing subsection. The IIPRC Office suggests that the PSC review the incidental benefits included in the Group Disability Income Insurance Policy and Certificate Uniform Standards to select those that should be included for IDI policies, as well as reviewing requests received by the Insurance Compact for benefits not currently listed in those standards. The PSC may also wish to consider the following revision to the standard to include the ability for the IIPRC Office to review incidental benefits not currently listed as long as no additional premium or fee is charged for the benefit:

> The policy may include the following benefits which shall satisfy the requirements included in the respective Interstate Insurance Product Regulation Commission standards as well as satisfy the requirements for a benefit to be deemed incidental, as specified below. Incidental benefits shall be in addition to any other benefits paid under the policy. In addition to the listed benefits, the Interstate Insurance Product Regulation Commission may approve other optional incidental insurance benefits that are secondary to or provided in connection with *Disability* benefits for which no additional premium, charge or fee is charged. The policy shall describe the benefit and any elimination period and shall specify the amount of benefit payable. The policy shall also specify when the benefit will end.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the Industry Advisory Committee (IAC):

We do not oppose how the IIPRC prefers to approach Incidental Benefits if the following can be answered/confirmed:

1. With regard to the last sentence in the preamble to this provision on page 33, we note that the Group DI preamble included exceptions for incidental benefits such as spouse ADL benefits, catastrophic disability benefits, contagious disease benefits, family member care benefits, which would not have to be paid in addition to any other disability benefit under the policy. We would also recommend that organ or bone marrow donor benefits and critical illness benefits also be added to this list. Will the IIPRC proposed language accommodate this?

2. We note that the second paragraph of the current Group DI preamble to the Incidental Benefit Section addresses the issue of when the benefit the triggers for Disability (as defined) may also be included as incidental benefits. We believe that this is an important

clarification and guidance to IIPRC examiners and filers and it is needed to be included as a preamble standard. Can the IIPRC consider including this in its proposed language?

3. The current IDI Optional Provisions standards includes a provision entitled Supplemental Benefits for Injury, Sickness, or Injury and Sickness which companies inform us has been used by the IIPRC to also allow additional benefits for which there are no specific standards. Does the proposed language on page 34 of the Report obviate the need for this current standard? 4. The IIPRC notes that it has received filing requests for benefits that do not fit squarely within the Group DI list of incidental benefits. Will the IIPRC suggested approach for the IDI incidental benefits section allow the submission and approval of the following benefits:

ADL/Cognitive Impairment Benefits For Insureds
ADL/Cognitive Impairment Benefits for Spouses
Catastrophic Disability Benefits
Child(ren) Care Benefits
Child(ren) Education Benefits
COBRA Insurance Premium Benefit
Contagious Disease Benefit
Critical Illness Benefit
Death Benefit
Family Member Care Benefit
Hospital Confinement Benefit
Hospice Care Benefit
Medical Insurance Premium Benefit
Organ or Bone Marrow Donor Benefit
Retirement Plan Benefit
Right to Purchase Individual Life Insurance Policy Without Evidence of Medical Insurability
Terminal Illness Benefit

5. Note the red highlighted items above - if the IIPRC intends is to use the Group DI standards to review and approve IDI incidental benefits that are similar to the Group DI incidental benefits, will the IIPRC also allow the red highlighted benefits?

On July 24, 2017, the IAC submitted the following additional comments:

As a follow-up to the July 11 public call of the PSC, we are submitting the 4 Incidental Benefits that the companies wanted to include in IDI that are not currently found in the Group DI standards:

- Critical Illness Benefit

- Hospice Benefit
- Hospital Benefit
- Organ or Bone Marrow Donor Benefit

CRITICAL ILLNESS BENEFIT

(1) Benefit to be paid if an insured is diagnosed by a Physician to have a Critical Illness. The policy shall specify the amount of the benefit, such as $3,000, and if such benefit shall be a paid on a one time basis in one lump sum to the insured while living, or if such benefit may be paid on a periodic basis to the insured while living. The policy shall also specify if the benefit will only be paid for one Critical Illness, or if benefits may be paid for more than one Critical Illness.

(2) The policy shall specify when the benefit will end. The benefit may end on the date any of the following events occur:

(a) The date the insured no longer has a Critical Illness;

(b) The date the benefit is no longer payable under the policy because the maximum benefit has been exhausted;

(c) The date any other Disability benefit ends under the policy; or

(d) The date the insured dies.

"Critical Illness" means any one or more of the following:

(a) Major trauma or disease resulting in quadriplegia or paraplegia;

(b) End-stage kidney disease requiring dialysis;

(c) Major organ transplants. The policy shall specify the type of transplants that will be included in the policy, such as; heart, lung, liver, kidney, intestines, or pancreas;

(d) Heart attack, which shall be defined in a clear and precise way, such as: the death of a portion of the heart muscle as a result of blockage of one or more coronary arteries. The diagnosis shall be based on criteria, such as: history of acute chest pain concurrent with EKG changes consistent with new injury, elevation of cardiac enzymes, and in-patient admission to a hospital or acute care facility for evaluation or treatment for heart attack or complications.

(e) Stroke or brain attack, which shall be defined in a clear and precise way, such as: any acute cerebrovascular event caused by infarction of brain tissue, brain hemorrhage or embolism (clot) to the brain. Objective evidence of permanent neurological deficit shall be produced. Certain types of strokes or attacks may be specifically excluded in the policy, such as: transient ischemic attacks (TIAs);

(f) Cancer, which shall be defined in a clear and precise way, such as: a disease manifested by the presence of a malignancy characterized by uncontrolled growth and

spread of malignant cells. This may include, but is not limited to, leukemia, lymphoma, Hodgkin's Disease and invasive malignant melanomas. Certain types of cancer may be specifically excluded in the policy, such as:

(i) Stage 1 Hodgkin's disease;
(ii) Stage A prostate cancer;
(iii) Pre-malignant lesions, benign tumors or polyps;
(iv) Cancer-in-situ, including melanoma-in-situ; and
(v) All other skin cancers; or
(g) Any other illness or disease specified in the policy.

HOSPICE CARE BENEFIT

(1) In the event that an insured is Disabled and receiving Hospice Care under a plan prescribed by a Physician, the company will waive any unexpired portion of the Elimination Period and benefits will be paid for the Hospice Care for as long as the insured is Disabled, not to exceed the maximum Benefit Period specified in the policy.

The policy shall define the term “Hospice Care” in relation to the level of skill required, the nature of care and the setting in which care shall be given.

HOSPITAL CONFINEMENT BENEFIT

(1) In the event that an insured is Disabled and is confined in a Hospital during the Elimination Period, this benefit will pay an amount specified in a policy for each day of hospital confinement during the Elimination Period., such as 1/30 of the monthly Disability benefit payable under the policy.

(2) The policy shall specify when the benefit will end. The benefit may end on the date any of the following events occur:

(a) The date the insured is no longer confined in a Hospital;
(b) The date the insured is no longer insured for Disability benefits under the policy;
(c) The date the Elimination Period ends; or
(d) The date the insured dies.

ORGAN OR BONE MARROW DONOR BENEFIT

(1) Benefits will be paid to an insured who donates an organ or bone marrow for use as a transplant if, after a policy has been in force for a specified period of time, such as at least

six (6) months, an insured becomes Totally Disabled as a result of making such a donation. The Elimination Period requirement shall not apply. The benefits to be paid shall be equal to the benefits payable under the policy for Total Disability, for the period that the insured remains Totally Disabled.

Insurance Compact Office update following the Nov. 21, 2017 PSC Member Call: The Committee discussed whether there was a need to expand the incidental benefits contained in the IDI standards and agreed that in this case, there was no reason for IDI and GDI to be different. The Committee agreed to review the proposed preamble as well as the list of incidental benefits contained in the GDI Uniform Standards as well as the four new benefits proposed by the IAC and be prepared to discuss further on the next member call.

Insurance Compact Office update following the Dec. 12, 2017 PSC Member Call: The Insurance Compact staff provided the PSC with an overview of the suggested revisions to the preamble of the subsection of the Uniform Standards that outlines the Incidental Benefits. In response to questions, staff clarified that the requirement that there be no separate premium, charge or fee for the optional benefit was just for a proposed incidental benefit not specifically outlined in the list. For those included in the list, as indicated within the standards, the company would be required to identify any premium charge. It was suggested that the added language provide more specificity about when benefits end, similar to language used in each of the listed incidental benefits.

Pennsylvania stated that there are some incidental benefits listed that they believed were more appropriate for group rather than individual. He stated that Activities Of Daily Living (ADL) Deficiency or Cognitive Impairment Benefit for Spouses of Covered Persons and Child(Ren) Care Benefit and Child(Ren) Education Benefit were examples. He thought that rather than offering separate benefits specific to how the benefit is used, while marketing the product that the agent could make sure the insured had enough DI benefit to cover such instances. Illinois stated that they felt that these are optional benefits used to distinguish one company from another and as long as the consumer has choice, they were not opposed to these benefit offerings. Minnesota said they were concerned that it may be different when the employer is involved rather than as an individual plan and they thought it may create inequities for certain classes.

The members had no specific questions or comments on the four newly proposed incidental benefits and some members indicated that these are benefits that they are seeing filed in their states. The Committee agreed that the Insurance Compact staff would rework

the document and the PSC would seek public comment on the listed incidental benefits and whether they are currently offered in the individual market and if so, how they are priced.

Insurance Compact Office update following the Dec. 19, 2017 PSC Member Call: The Committee agreed to expose the list of requested incidental benefits for Public comment to obtain information on whether these benefits are currently offered in the individual market and if so, how they are priced.

Insurance Compact Office update following the Jan. 23, 2018 PSC Public Call:
Tom Kilcoyne. PA Insurance Department submitted the following comments:
Please accept the following comments on Incidental Benefit Provisions (Appendix B). Note that these are my own comments as an interested regulator and do not represent a position of the Pennsylvania Insurance Department.
Following are some characteristics of Employer Group coverage that may be relevant in determining how well a group insurance benefit will fit in an individual policy.

The employer is the policyholder rather than a disinterested third party.
The employer can subsidize benefits
Employee benefit packages can and do include non-insurance benefits.
The employer has direct access to family census data and to payroll/benefit data.

It would be beneficial to have some common ground as to the attributes of Incidental Benefits that are compatible with an individual disability policy. Please consider the following list for some insight into my opinion regarding various incidental benefits.

Trigger based on accident or sickness of the insured
Indemnity benefit, whether cash payment(s) or a shortened base benefit elimination period
Elimination period for the incidental benefit not to exceed 30 days
Benefit can be administered effectively without reliance on disinterested third parties(such as an employer or a financial institution)
Rates based on objective data or assumptions such that a substantive actuarial review is achievable
Premium/cost no more than X% of the base premium/cost
Benefit termination consistent with the trigger and with reasonable owner expectations
Following is a list of the specified incidental benefits that I would prefer to exclude with reference to the above list.

ADL for Spouses

Child Care Benefit
Child Education Benefit
COBRA Insurance Premium Benefit
Contagious Disease Benefit (may not be workable when the employer is a disinterested third party)
Eligible Survivor Benefit
Family Member Care Benefit
Medical Insurance Premium Benefit
Retirement Benefit
Right to Purchase Individual Life Insurance

With respect to specific language, there may be a need to rework variations on termination provisions such as "the date other Disability payments end", "the date other Disability benefits for the Covered Person end", and in particular "the date the Covered Person is no longer insured …" The most convenient place to offer specific suggestions is in the "Other Optional Incidental Insurance Benefits" portion of the document. A preliminary concern is that the use of "Optional" seems confusing and perhaps could be eliminated. Alternatively, "Other Optional" could be replaced with another expression that eliminates any unintended appearance of contradiction of redundancy. With respect to benefit termination, it isn't clear that "the date other Disability payments end under the policy" (item (3)(c)) is broadly applicable. Even if disability is a precondition for the incidental benefit, item (3)(a) already addresses both the disability precondition and the additional requirement(s) unique to the incidental benefit. If the (3)(c) is retained, perhaps it should be allowed only if the incidental benefit is preconditioned on disability. Alternatively, it could be qualified in some way such that it might be acceptable in nearly all cases. One possibility may be "the date other Disability payments end owing to a suspension or limitation applicable under the policy". If (3)(c) is eliminated or narrowed considerably, some may prefer that (3)(a) be clarified to remove any doubt that "the requirements" would include any disability precondition.
For the specific list of incidental benefits, "the date any other disability benefit ends" continues to be appropriate when the incidental benefit is preconditioned on disability, where absence of the specific trigger for the incidental benefit is treated separately in the termination provision. Following are some comments on other variations on termination conditions that currently appear in Appendix B. "The date the Covered Person is no longer insured for Disability benefits", if needed, perhaps should be "the date the policy terminates". The Critical Illness Benefit is not preconditioned on disability, so I don't believe "the date any other Disability payments end under the policy" is appropriate as a termination condition. The Hospital Confinement Benefit is preconditioned on disability,

but the nature of the benefit is such that no reference to "insured for Disability benefits" or "payment of Disability benefits" is needed in the benefit termination conditions.

The IAC submitted the following comments:

The companies are agreeable to delete items D, F. and G. (C was eliminated from the written comments since this was listed in error)

With regard to item H. COBRA Premium Benefit, companies currently offer this benefit in their IDI policies and it was approved in every state, except Connecticut. While monthly disability income benefits replace a certain portion of a person's income, it does not take into account additional monthly expenses that arise, solely from the disability, such as COBRA continuation premiums. These premiums can be rather excessive and are above and beyond expenses that are paid with a person's wages, prior to disability. So, not only is the disabled person taking in less than their net earnings prior to disability, but this person is incurring additional expenses that were not part of the equation before disability. At a point in time when a person needs health
insurance the most, he/she is in danger of not being able to afford the sudden additional cost for this insurance. This is most certainly a concern for people with individual insurance. Not all group policies offer this benefit and not all employers offer this benefit, so it is not a "group" only benefit.

With regard to item P. Retirement Benefit, many companies offer this benefit in IDI policies in some form or fashion and states have been approving it. Whether this is part of the base policy or, perhaps more appropriately, as a rider to a policy, the benefit is self-evident. Consider the effects of a long-term disability on a person's ability to save toward retirement. A disabled person is living on less income than prior to disability, especially those who do not have unearned income. Typically, medical and other expenses have increased, while static expenses have not been eliminated (house, food, clothing, etc.). For many people, just making ends meet is a struggle. Once disability benefits end, typically at age 65, if not before, this person needs some hope of a certain level of retirement income. If a disability has prevented this person's ability to save toward retirement and, due to loss of employment, has also caused loss of any employer contributions, what hope does this person have of being even reasonably self-sufficient, once disability benefits end? This benefit allows for a continuation of savings, strictly earmarked for retirement, in the event of a long-term disability, which is important concept in any type of disability policy.

Kristi Bohn, Minnesota Department of Commerce submitted the following comments:

I understand from Roger that a request for comment will be sent out on the incidental benefits issue. Here is some feedback from Minnesota.

1) Critical illness showed up twice on the previous attachment, but both sections are different.
2) This MN law creates problems for MN in terms of several of the incidental benefits suggested (critical illness, accidental death benefit, accidental dismemberment benefit):
60A.06 Subd. 3. Limitation on combination policies.
(a) Unless specifically authorized by subdivision 1, clause (4), it is unlawful to combine in one policy coverage permitted by subdivision 1, clauses (4) and (5)(a). This subdivision does not prohibit the simultaneous sale of these products, but the sale must involve two separate and distinct policies.
(b) This subdivision does not apply to group policies.
(c) This subdivision does not apply to policies permitted by subdivision 1, clause (4), that contain benefits providing acceleration of life, endowment, or annuity benefits in advance of the time they would otherwise be payable, or to long-term care policies as defined in section 62A.46, subdivision 2, or chapter 62S.
(d) This subdivision does not prohibit combining life coverage with one or more of the following coverages: (1) specified disease or illness coverage; (2) other limited benefit health coverage; (3) hospital indemnity coverage; (4) other fixed indemnity products, provided that the prescribed minimum standards applicable to those categories of coverage are met.
Where 60A.06 Subdivision 1
(4) To make contracts of life and endowment insurance, to grant, purchase, or dispose of annuities or endowments of any kind; and, in such contracts, or in contracts supplemental thereto to provide for additional benefits in event of death of the insured by accidental means, total permanent disability of the insured, or specific dismemberment or disablement suffered by the insured, or acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable;
(5)(a) To insure against loss or damage by the sickness, bodily injury or death by accident of the assured or dependents, or those for whom the assured has assumed a portion of the liability for the loss or damage, including liability for payment of medical care costs or for provision of medical care; (b) To insure against the legal liability, whether imposed by common law or by statute or assumed by contract, of employers for the death or disablement of, or injury to, employees;
3) Based on the attachment sent that described the benefits, many of them need to be edited in order to remove the concept that the policyholder as the employer: COBRA, Retirement Benefit, medical Insurance Premium Benefit.
4) Many benefits need to specifically address how and whether the benefit would be coordinated with other sources: critical illness benefit, family member care benefit.

5) Some are problematic in terms of pricing equity or adverse selection considerations (retirement benefit perhaps needs to be fixed dollar amounts and not based on savings elections, and pre-existing condition implications vary based on the actual condition such that I am not confident that what has been written thus far gives me guideposts within an individual disability policy perspective in terms of "price included"….some people have no preex conditions so how is that equitable?
6) One of the major concerns I had was that the benefits are not incidental…some of them are material in terms of a comparison with disability benefits. That said, many of them are incidental. The trouble comes in when we consider that a material benefit may have a higher loss ratio standard required, and thus disability could be a red herring used in order to accomplish lower loss ratios overall. This is particularly the case if the 45% loss ratio is offered for noncancelable disability….we have no loss ratio in our state with that low of a minimum loss ratio other than noncancelable disability.

Oral Comments during the call:
During the Public call, Miriam Krol, representing the ACLI noted that the IAC's written comments included a statement that the companies agreed not to include Activities of Daily Living Deficiency or Cognitive Impairment Benefit for Spouses of Covered Persons, Child(ren) Care Benefit, and Child(ren) Education Benefit as benefits for IDI, but they explained how Retirement Benefits and COBRA Premium Benefits would be relevant for IDI policies. Ms. Krol stated that the companies would have to review the other benefits on Mr. Kilcoyne's list since they were unaware previously that he questioned their applicability. The companies also noted that the written comments contained an error and they believe that Activities of Daily Living Deficiency or Cognitive Impairment Benefit for Insureds should be included with the list of IDI incidental benefits.
Ellen Owens of Ameritas stated that she believed the list of attributes was a good starting point and she thought the COBRA Premium Benefits and Retirement Benefits fit well within those attributes. She noted that disability income benefits are based on insured income not expenses, and many of the incidental benefits including COBRA Premium Benefits and Retirement Benefits provide added coverage for expenses that would not normally be incurred and/or included in the determination of disability benefits.

The IAC submitted the following comments on 2/5/2018:
Re: Kristi Bohn, Minnesota Department of Commerce Comments
Comment #2
While we understand that Minnesota would require issuance of two separate policies to provide IDI coverage and incidental benefits for critical illness, accidental death and accidental dismemberment, this would require such benefits to be provided on a stand-

alone basis. For critical illness and accidental dismemberment stand-alone policies, these would then make these policies subject to health requirements and accordingly out of the jurisdiction for the IIPRC.
Minnesota does not prohibit the sale of the combination products, just how they are issued. If a company has to issue separate policies for several benefits to be included in a plan of coverage selected by a consumer, policy fees would be added to the cost, and possibly separate premium notices would need to be generated during the life of the coverages - how is this a consumer benefit?
Many states today allow the inclusion of incidental benefits with IDI policies and we believe that the IIPRC standards should reflect the majority regulatory view.
Comment #3
We wish to advise that with regards to incidental benefits for COBRA and Retirement, the word "employer" was used to mean either a group policyholder or self-employment. With regard to the medical Insurance Premium Benefit, there are only references to "group medical insurance premium" and "group medical insurance plan". Accordingly, there is no "concept that the policyholder is the employer".
Comment #4
We believe the proposed standards for Insurance With Other Companies, Other Insurance With This Company, and the Disability Benefits Reduced on Account of Other Benefits or Income include all the benefits provided under a policy, including incidental benefits.
Comment #5
We did not understand the "pricing equity" se comments – not clear what are the underlying concerns.
The companies are not comfortable with a fixed dollar amount for certain expenses (ie, retirement savings) as the benefit to be provided needs to have some relationship with what is actually being saved at time of underwriting. We know from research that most consumers are unaware that their employer's contributions to their retirement plan end upon disability.
Comment #6
"Incidental" benefits are a way to balance the need for more coverage (the base IDI benefit is often a % of income) with an option to minimize the risk exposure to the companies. Some DOIs have asked companies to instead just issue more IDI coverage which, on its surface, seems logical. But the companies know from experience that insureds' behaviors change with more coverage. The companies believe that the approach of "stacking" coverage provides a more balanced way to provide more benefits overall.

Insurance Compact Office update following the Feb. 20, 2018 PSC Member Call:
Tom Kilcoyne suggested that instead of the list of Incidental Benefits proposed initially,

that the PSC consider a different approach and establish attributes of permissible incidental benefits. Several members expressed support of the concept, noting that some of the items in the Industry's list, such as COBRA benefits and Retirement benefits were not incidental in nature and could result in substantial additional payments. Following further discussion, the PSC agreed to expose the following change to §3.I. OPTIONAL PROVISIONS of the Standards for Individual Disability Income Insurance Policies for preliminary consideration. A small group of regulators from PA, MN, TX, UT and CO agreed to discuss the proposal in further detail to suggest any potential further changes and submit an update if there are changes for consideration prior to the March 6th Public Call:

I. INCIDENTAL BENEFIT PROVISIONS

(1) The policy may include the following benefits which shall satisfy the requirements included in the respective Interstate Insurance Product Regulation Commission standards as well as satisfy the requirements for a benefit to be deemed incidental, as specified below. Incidental benefits shall be in addition to any other benefits paid under the policy.

(~~1~~a) **Accidental Death Benefits.** Benefits paid due to the death of the insured caused by an *Injury*. This benefit shall meet the requirements for accidental death benefits as contained in the Standards for Accidental Death Benefits and Accidental Death and Dismemberment Benefits as adopted by the Interstate Insurance Product Regulation Commission. The amount payable shall be a lump sum not to exceed the equivalent of 12 monthly *Disability* benefits payable under the policy.

(~~2~~b) **Dismemberment Benefits.** Benefits to be paid to an owner due to loss resulting from an Injury or Sickness of the insured. The types of losses that may be covered are described in the Standards for Accidental Death and Dismemberment Benefits as adopted by the Interstate Insurance Product Regulation Commission. The benefit shall meet all the requirements specified in such standards. The amount payable shall be a lump sum not to exceed the equivalent of 12 monthly *Disability* benefits payable under the policy.

(2) In addition to the benefits listed above, the Interstate Insurance Product Regulation Commission may approve other incidental insurance benefits that are secondary to or provided in connection with Disability benefits provided:

(a) The benefit is designed to address a short-term need or to assist the insured in meeting an existing financial commitment;

(b) The elimination period for the incidental benefit does not exceed the policy elimination period;
(c) The benefit can be administered effectively, without reliance on disinterested third parties (such as an employer or a financial institution);
(d) The rates are based on objective data or assumptions such that a substantive actuarial review is achievable;
(e) Any death or dismemberment benefit shall be in the form of a lump sum not to exceed the equivalent of 12 monthly disability benefits payable under the policy;
(f) Any benefit other than a death or dismemberment benefit shall be payable for no longer than 18 months, or for the length of the base policy benefit if shorter; and
(g) The benefit termination shall be consistent with the trigger and with stated policy limitations and maximum benefit amounts.

Insurance Compact Office Update 2/27/2018: A subgroup of PSC members reviewed the draft language and suggested the following changes for public comment:

I. Incidental Benefit Provisions

The policy may include the following benefits which shall satisfy the requirements ~~included in the respective Interstate Insurance Product Regulation Commission standards as well as satisfy the requirements for a benefit to be deemed incidental,~~ as specified below. Incidental benefits shall be ~~in addition to any other benefits paid under the policy.~~ secondary to or offered in connection with *Disability* benefits.

(1) **Accidental Death Benefits.** Benefits paid due to the death of the insured caused by an *Injury*. This benefit shall meet the requirements for accidental death benefits as contained in the Standards for Accidental Death Benefits and Accidental Death and Dismemberment Benefits as adopted by the Interstate Insurance Product Regulation Commission. The amount payable shall be a lump sum not to exceed the equivalent of 12 monthly *Disability* benefits payable under the policy.

(2) **Dismemberment Benefits.** Benefits to be paid to an owner due to loss resulting from an Injury or Sickness of the insured. The types of losses that may be covered are described in the Standards for Accidental Death and Dismemberment Benefits as adopted by the Interstate Insurance Product Regulation Commission. The benefit shall meet all the requirements specified in such standards. The amount payable shall be a lump sum not to exceed the equivalent of 12 monthly *Disability* benefits payable under the policy.

(3) **Other Benefits.** In addition to the benefits listed above, the Interstate Insurance Product Regulation Commission may approve other incidental insurance benefits ~~that are secondary to or offered in connection with Disability benefits~~ provided:

(a) The benefit is designed to address a ~~short-term need or to assist the insured in meeting an existing financial commitment~~ specific financial need that arises as a consequence of the disability that is not ~~effectively~~ addressed by the base disability benefit;
(b) The elimination period for the incidental benefit does not exceed the policy elimination period;
(c) The benefit can be administered effectively, without reliance on disinterested third parties (such as an employer or a financial institution);
(d) The rates are based on objective data or assumptions such that a substantive actuarial review is achievable;
(e) With the exception of Accidental Death Benefits, any death or ~~dismemberment~~ terminal illness benefit shall be conditioned on prior disability and in the form of a lump sum not to exceed the equivalent of 12 monthly disability benefits payable under the policy;
(f) Any benefit other than a death or dismemberment benefit shall be payable for no longer than 18 months, or for the length of the base policy benefit if shorter; and
(g) The benefit termination shall be consistent with the trigger and with stated policy limitations and maximum benefit amounts.

Insurance Compact Office update following the March 6, 2018 PSC Public Call:

Minnesota submitted the following comments:

Minnesota supports the principle-based approach now proposed through the addition of the "other benefits" category. This approach is superior to the former list, because not only does the new approach allow for further innovation, but it also provides guardrails for the compact's review of these benefits. The former list may have caused Minnesota to exit the compact for disability benefits, because too many of our existing state laws would been violated in some of the listed items (despite industry's comments that stated otherwise or suggested that our state's laws should be ignored in favor of uniformity and speed to market concerns). Minnesota did not join the compact so that our laws could be circumvented. Minnesota recommends the following additional language (see **bold**) to the guardrails provided, in order to ensure pricing concerns are addressed, and in order to ensure the incidental nature of the proposed benefits in terms of the value to the traditional disability contract:

Other Benefits. In addition to the benefits listed above, the Interstate Insurance Product Regulation Commission may approve other incidental insurance benefits that are secondary to or offered in connection with Disability benefits provided:
(a) The benefit is designed to address a short-term need or to assist the insured in meeting an existing financial commitment specific financial need that arises as a consequence of the disability that is not effectively addressed by the base disability benefit;
(b) The elimination period for the incidental benefit does not exceed the policy elimination period;
(c) The benefit can be administered effectively, without reliance on disinterested third parties (such as an employer or a financial institution);
(d) The rates are based on objective data or assumptions such that a substantive actuarial review is achievable **and the expected loss ratio for each of the incidental benefits is provided and justified, and the expected loss ratio is no lower than the lesser of that which is traditionally required of the incidental benefit type(s) or that which is required of the base disability benefit**;
(e) With the exception of Accidental Death Benefits, any death or dismemberment terminal illness benefit shall be conditioned on prior disability and in the form of a lump sum not to exceed the equivalent of 12 monthly disability benefits payable under the policy;
(f) Any benefit other than a death or dismemberment benefit shall be payable for no longer than 18 months, or for the length of the base policy benefit if shorter; and
(g) The benefit termination shall be consistent with the trigger and with stated policy limitations and maximum benefit amounts**; and**
(h) Each incidental or secondary benefit is found to be financially incidental to the base disability benefit, in that its actuarial value is estimated to be no more than 25 percent of the actuarial value of the base disability benefit.

The IAC submitted the following comments:

We have the following comments on the proposed draft:
Item (a):
We suggest changing the end of the item to say "and that is not addressed by the *Disability* benefits otherwise payable under the policy." Other reference to "disability" needs to say "*Disability*."
Item (b):
We suggest changing the item to say:
"The *Elimination Period* for the incidental benefit shall not exceed the *Elimination Period* for the basic *Disability* benefit under the policy."
Item (c):

We don't believe that the word "disinterested" is needed.

Item (d):

We have some concerns about what the expectation would be for "objective data or assumptions". If a benefit is innovative in the marketplace, where would the data/assumptions come from?

Item (e):

We suggest changing to say "shall be conditioned on a prior *Disability* and paid in a lump sum not to exceed the equivalent of 12 monthly *Disability* benefits payable under the policy."

Item (f):

We suggest changing the end to say "or for the length of the *Disability* benefit period under the policy, if shorter."

We may need the flexibility to express the benefit as not exceeding a multiple of the *Disability* benefit otherwise payable under the policy, vs. a specified length of time – would this be acceptable?

Oral comments during the call:

For item (c), Tom Kilcoyne of Pennsylvania stated that he agreed "disinterested" was not needed. He also noted that in situations where a newer benefit was offered without "objective data or assumptions," there should be some data perhaps for a different product or market. Standard Life suggested deleted the word "objective and perhaps changing substantive to sufficient, so the sentence would read (d) The rates are based on ~~objective~~ data or assumptions such that a ~~substantive~~ sufficient actuarial review is achievable.

In reference to the comments from Minnesota, the IAC stated that they were unclear about the meaning of the phrase "the expected loss ratio is no lower than the lesser of that which is traditionally required of the incidental benefit type(s) or that which is required of the base disability benefit, " specifically how one determines what is traditionally required. Utah suggested deleting the word "traditionally" would be a sufficient fix and the IAC agreed. The IAC also questioned reference to the word "basic" in several spots in the proposal, indicating that using the defined term *Disability* benefit would suffice.

In reference to the IAC comments on (f), Standard Life explained that sometimes there are payments that may be lump sum, rather than for a duration, so having an option to describe both in terms of length of benefit or amount would be helpful.

Insurance Compact Office update following the March 13, 2018 PSC Member Call:

Insurance Compact staff summarized the request from the IAC to clarify subsection (a) and (b) to add the terms Disability and Elimination Periods as these terms are specifically defined in the *Standards for Disability Income Insurance Policies*.

(a) The benefit is designed to address a specific financial need that arises as a consequence of the ***Disability*** that is not ~~effectively~~ addressed by the ~~base~~ ***Disability*** **benefits otherwise payable under the policy;**

(b) The ***Elimination Period*** for the incidental benefit does not exceed the ~~policy~~ ***Elimination Period*** **for the basic *Disability* benefit under the policy;**

The Committee agreed to the suggested language outlined above.

Compact staff presented recommended language submitted by Tom Kilcoyne of Pennsylvania to address comments raised by the IAC on the March 6th Public Call, related to use of the terms "objective" and "substantive." Compact staff also suggested the word "verifiable" instead of "relevant" to allow review of verifiable information through the actuarial review. The Committee agreed to the recommended language pertaining to rates:

(d) The rates are based on ~~objective~~ **verifiable** data ~~or~~ **and reasonable** assumptions such that a ~~substantive~~ **thorough** actuarial review is achievable;

The Compact staff presented two suggestions received from Pennsylvania and the IAC in response to Standard Life's oral comments made during the March 6th Public call. On that call Standard Life explained that sometimes there are payments that may be lump sum, rather than for a specific duration, and having an option to describe the benefit in terms of length of benefit or amount would be helpful. Staff noted that the proposed provisions were similar; however the IAC proposal did not provide a monetary cap for the multiple of the monthly Disability benefit payable under the policy and the Pennsylvania proposal did. The Compact staff suggested that the language submitted by Pennsylvania would address the issue raised by the IAC and also establish limits to assure that the benefit is incidental in nature.

The Committee approved Pennsylvania's recommended language as follows:

(f) Any benefit other than a death or terminal illness benefit shall be payable either

(i) for no longer than 18 months, or for the length of the *Disability* benefit period under the policy if shorter; or

(ii) in amounts that in total do not exceed the equivalent of 6 monthly *Disability* benefits payable under the policy;

The Compact staff reviewed language suggested by Minnesota to limit incidental benefit actuarial value to no more than 25 percent of the actuarial value of the base *Disability* benefit.

Staff suggested that the previously approved Pennsylvania language for (f) establishes limits to assure that the benefit is incidental. The Committee agreed that Pennsylvania's recommended language limits the value of incidental benefit payments and there is no need to add subsection (h).

15. LOOK BACK PERIOD FOR UNDERWRITING QUESTIONS

APPLIES: §4. ADDITIONAL STANDARDS FOR UNDERWRITING QUESTIONS of the Individual Disability Income Insurance Application Standards

CURRENT PROVISONS:

B. GENERAL BACKGROUND QUESTIONS

The application may include the following questions to be answered by each proposed insured:

(2) ***Felony or Misdemeanor.*** Whether the proposed insured has in the past 10 years plead guilty to or been convicted of a felony or misdemeanor. For a "yes" response, details may be requested such as: the nature of the plea or conviction, the date and state where the plea or conviction occurred, and whether time was served in prison.

F. MEDICAL QUESTIONS

(1) The application may include the following questions to be answered by the proposed insured:

(d) ***Drug and Alcohol Use*.** Whether a proposed insured has within the past 10 years:

(i) Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician;

(ii) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs; or

(i) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.

For a "yes" response, details may be requested such as: type of drug or alcohol used, contact information for the medical professional or facility providing treatment, advice or counseling, type and dates of treatment or

counseling, and self-help membership periods. As an alternative to requesting details in the application, the application may require the completion of a Drug and Alcohol Use supplement which shall request details such as those described above.

(f) Disorders and Diseases. Whether a proposed insured has within the past 10 years been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:

(i) Any disorder or disease of the brain or nervous system;

(ii) Any disorder or disease of the heart, blood vessels or circulatory system;

(iii) Any disorder or disease of the respiratory system;

(iv) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas or abdominal organs;

(v) Any disorder or disease of the genito-urinary organs;

(vi) Any disorder or disease of the skeletal system;

(vii) Any disorder or disease of eyes, ears, nose or throat;

(viii) Any disorder or disease of the blood, skin, thyroid, lymph or other glands;

(ix) Any psychiatric or mental health disorder or disease;

(x) Any gynecological disorders or diseases;

(xi) Any cancer, tumor, cyst or nodule;

(xii) Any sexually transmitted disorders or diseases; or

(xiii) Any disorders or diseases of the immune system except those related to the Human Immunodeficiency Virus (AIDS virus).

For any category of disorder or disease included, the application shall include specific disorders and diseases that the company determines it needs for underwriting purposes.

For any "yes" answer, details may be requested such as: name, address and telephone number of the medical professional or facility providing treatment, diagnosis, dates of diagnoses, consultations, tests and treatments.

(g) ***Immune Deficiency.*** Whether a proposed insured has within the past 10 years been:

(i) Diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia;

(ii) Diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS).

For any "yes" answer, details may be requested such as: name, address and telephone number of the medical professional or facility providing diagnosis or treatment, diagnosis, dates of diagnoses, tests, and treatments

COMMENTS:

Industry Comment: The IAC commented that the look back restrictions in the IDI application standards are a significant concern for the companies from an underwriting perspective. While it is understandable that a person may not remember every little health issue or injury that happened over years, the IAC believes individuals would remember significant health conditions such as cancer and major surgeries. From an underwriting perspective, there are health issues that cause concern, regardless of when they happened. Longtime, serious injuries or illnesses can affect that person's ability to work in his

occupation, but insurers aren't privy to this information if it happened more than 10 years ago.

The IAC requests reconsideration of the use of "ever had" on the same basis as is allowed in the Individual Life Application for the following reasons:

1. The IDI and Individual Life products are sometimes sold in combination, so the ability to be able to ask the same questions would save time for the applicant and reduce a company's application processing expenses.

2. The consideration of amount at risk for IDI is not that different from Individual Life. IDI policies can provide monthly benefits well in excess of $10,000. At $10,000 a month ($120,000 annually), the exposure is much more significant, over time, than a $120,000 life insurance policy. The amount at risk on an IDI policy can easily reach into the millions of dollars over the life of a claim.

3. If one set of questions could be asked for IDI and Individual Life insurance, this could also potentially eliminate unintentional errors made by the applicant who is applying for both products at the same time.

4. If one set of questions could be asked for IDI and individual Life insurance, this would allow for consistency in underwriting between the two product lines.

5. Requiring each application to have different look-back time frames may require an applicant to change the response for each application. Conceivably, this person could answer one question in the affirmative on the Individual Life application and in the negative on the IDI application, just based on the timing of the event. Follow-up personal interviews would also have to be adjusted, adding to complexity and inconsistency.

IIPRC Office Comments/Observations: The IIPRC Office notes that the look back period was discussed in detail at the time the IDI standards were initially adopted as well as during the development of the group disability insurance standards, which also include the ten year look back period. The PSC at that time weighed the challenges of an application for a combination product with different look back periods against the consumer protection issue of limiting a look back period for a disability product, and noted that consumer complaints in this area are related to disputes about forgotten minor health matters going back many years that were not disclosed on an application. The PSC decided that the 10

year look back would address the consumer protection issue and was more reasonable for a disability product than the unlimited look back period found in the life products.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC discuss whether the arguments presented by the IAC represent a change in circumstance or underlying assumptions that would justify amending the look back period.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the Industry Advisory Committee (IAC):

One company reported that applications filed in 2010-2013 received approval in 39 IIPRC member jurisdictions. The two questions that used "ever" addressed drug and alcohol use, counselling and treatment, and addressed whether a proposed insured has ever had been diagnosed, treated, or been given medical advice by a member of the medical profession for specified diseases and disorders – a list included disorders and diseases similar to those shown in item (f) [shows up as (k)] on page 15 of the current IIPRC standards for the IDI application.

Another company reported that in 2013 it filed its application with "ever had" questions and 10 jurisdictions required limited look back periods.

We are again requesting that the PSC consider allowing "ever had" to be for the following questions on page 15 of the current IIPRC standards for the IDI application:

(d) Drug and Alcohol Use

(f) Disorders and Diseases.

The majority of IIPRC member jurisdictions have approved such questions in the realization that the average applicant would recall whether or not they have ever had certain diseases or disorders or have had drug/alcohol use issues.

If an applicant is expected to reply to an "ever" question in a Life Insurance application, why would we also not expect an applicant to be able to respond to an "ever" question in a Disability Income application?

Insurance Compact Office update following the Nov. 21, 2017 PSC Member Call: The Committee discussed the request for an unlimited look back period for certain application questions, similar to those on life applications. They noted that the IAC has presented no new information or data to support the arguments that they made when both IDI and GDI Uniform Standards were drafted and as a result the Committee was disinclined to consider

the same debate under the Five Year Review. The Chair requested that members look at what they are doing on applications filed with their respective states.

Insurance Compact Office update following the Dec. 12, 2017 PSC Member Call: A member noted that his state questions look back periods beyond 10 years because of the Insurance Compact Uniform Standards, and Pennsylvania indicated that they have a 5 year look back requirement. It was also noted that if Industry was concerned that combination products had different look back periods, they could alter life questions to a 10 year period. The PSC concluded that the IAC has presented no new information or data to support the arguments that they made when both IDI and GDI Uniform Standards were drafted and there was no evidence that a 10 year look back period is detrimental to insurers or consumers. The PSC concluded that they will not recommend any change.

Insurance Compact Office update following the Jan. 23, 2018 PSC Public Call:

The IAC submitted the following comments:

Only 20% of all states, including non-compacting states, limit the look-back periods to something other than "ever" for health-related questions. This is an important risk concern for DI companies. It is one of the driving concerns making companies reluctant to use the IIPRC for filing DI products.

In classifying health risks, companies use detailed underwriting manuals from reinsurance companies, which have been developed over time using a significant amount of data. The manuals allow for consistent and concise underwriting, based on the facts disclosed for a proposed insured, starting with the application. These manuals give clear distinctions of risk, how to categorize them, what specific parameters to use, including length of time from diagnosis of health conditions.

According to these manuals, there are specific health issues that warrant an "ever" look-back. These types of conditions can lie dormant for years or can progress at such a rate as to be missed, if underwriting with a limited look-back period, and yet are known to manifest into long-term disabilities. Based on these manuals, many of these conditions require the action of either declining an offer, or modifying the offer, for example, with a rating or limiting coverage, regardless of when the condition manifested, due to the probability of a future disability. In many cases, like cancer for example, the treatment itself is cause for concern. Radiation, chemotherapy and other forms of treatment can leave the patient with other serious health issues, which may not manifest into a condition or disability for an extended period of time. All of these considerations come into play when determining the correct course of action at underwriting.

We propose that the PSC consider a reasonable compromise to parse out the health issues of greatest concern to the companies, as listed below, allowing for an unlimited look-back for those conditions. Doing so would go a long way toward alleviating companies' underwriting concerns. These types of health conditions include:

- AIDS/HIV
- Aneurysm
- Arthritis
- Cancer
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Dementia
- Emphysema
- Heart attack
- Heart valve disease
- Hepatitis
- Multiple sclerosis
- Stroke
- Transient ischemic attack.

These conditions are certainly not ones that a person would be in danger of forgetting, nor are they inconsequential when it comes to appropriately determining the risk profile of a proposed insured.

Allowing this compromise would alleviate a big concern for companies when considering using the IIPRC for their IDI filings.

The CAC submitted the following comments:

5). We support the item 15 recommendation of a ten-year limit on look back for underwriting questions. We question the IAC's unsupported assertion that the "average" consumer doesn't need this protection.

Oral comment during the call:

Fred Nepple of the CAC noted that it has been his experience that consumers do not always recall even significant health conditions for an extended period of time and ten years seems adequate. Utah asked if the companies have specific data that verifies that people with certain health conditions that are untreated for a period of more than ten years are more of a risk than those without such conditions. The companies responded that they did not know and would research.

Insurance Compact Office update following the Feb. 6, 2018 PSC Member Call: Compact staff summarized the IAC's comments to limit the unlimited look-back on the application to a set of specific health conditions/health issues of greatest concern to the companies. The Industry initially asked for the same unlimited look back as is contained in the life insurance standards. The IAC submitted comments indicating only 20% of all states (including non-compacting states) have a look-back period that is shorter than unlimited. Compact staff noted that the companies emphasized that this has become a significant issue for companies in determining whether to file with individual states or with the Compact. It was suggested that if concern over consumer protection prevents members from approving such a change at the Compact level, but requirements at the state level do not meet the same expectation in regard to look-back periods, then a meaningful difference is created between the states and the Compact.

The Committee discussed and raised concern that applicants may not understand some of the conditions presented on the application that are on the industry's list and could unintentionally fail to disclose. The Committee will take more time to consider the proposed change and revisit on the next call.

Insurance Compact Office update following the Feb. 20, 2018 PSC Member Call: Following further discussion of this request, the PSC concluded that there was no documented evidence that people who experienced the health conditions listed many years earlier and are untreated for a period of more than ten years prior to application are more of a risk than those without such conditions. They also observed that a change to the existing standards would result in taking away what could be considered an existing consumer protection, and that some of the items listed could be difficult for consumers to understand (such as transient ischemic attack).or in some cases, such as mild arthritis, may not remember prior treatment if there was no need for further treatment later. For these reasons and since the 10 year look back period is in place for both the current group and individual disability income insurance uniform standards, the PSC concluded that they were not recommending further change.

Insurance Compact Office update following the March 6, 2018 PSC Public Call:

The IAC submitted the following comments:

It is very disappointing that the PSC is not interested in even considering a compromise to the 10-year look-back periods for the application. Instead of focusing on the serious medical conditions, such as cancer, heart disorders, or degenerative diseases that are of grave concern to underwriting, the PSC chose to pull out one term from the list that may not be "understood" or focus on a situation that is not an expected reality: ***arthritis is not***

curable, and even ***osteoarthritis is degenerative in nature***. It is not uncommon for a person to have cancer, become cancer free for 12, 15, even 20 years, and then develop cancer again. Cancer treatments are severe and leave their mark on the future health of a person. While medical technology is becoming better at treating cancer, it is unknown what long-term effects the new treatments will have on a person.

With 80% of states allowing an "ever" look-back, it is disappointing that the PSC could not agree to a compromise on this standard.

Oral Comments during the call:

Utah asked if the 80% figure actually indicated states that had an unlimited look back, or if it including states that had a reasonableness standard. Industry responded that they could not specifically answer since the data was based on states approving the application questions with an unlimited look back.

An industry commenter noted that policies usually have a two year contestability provision and it is infrequent that a company would learn of a condition from more than ten years ago if the insured had no claim during that two year period.

Oregon and the CAC spoke in support of maintaining the current standard.

Insurance Compact Office update following the March 13, 2018 PSC Member Call: The Chair summarized the IAC's request for an unlimited look back period for certain medical conditions, also noting that no credible data or information was submitted to verify that people with certain health conditions that are untreated for a period of more than ten years are more of a risk than those without such conditions. The comments presented by the IAC on the March 6th call did not provide any new information for consideration. The Committee did not wish to pursue changes to the look back period based on the comments received from the IAC.

16. MINIMUM LOSS RATIO

APPLIES: §2.B.(1)(g) of the Standards for Initial Rate Filings for Individual Disability Income Insurance

CURRENT PROVISONS:

B. ACTUARIAL SUBMISSION REQUIREMENTS

(1) An actuarial memorandum prepared, dated, and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

(g) A description of the determination of the MLR applicable to the policy form. The MLR shall be determined as follows:

(i) The Initial MLR shall be based on the guidelines below using the Renewal Provision for the policy:

Renewal Provision	Initial MLR %
Conditionally Renewable	55
Guaranteed Renewable	55
Noncancellable	50

(ii) Adjustments to Initial MLR to determine MLR. The adjustment below should be made only if the expected average annual premium for the policy form, considering the distribution of business assumptions in § 2B(1)(e)(v) above, is less than $2,500:

The initial MLR shown in the table above shall be adjusted according to the formula below, where:

MLR = (Initial MLR)* (A-25*I)/A and

I = [CPI-U, Year (N-1)] / 103.9 where

(I) The value for A is the average annual policy premium.

The average annual policy premium shall be estimated by the insurer based on an anticipated distribution of business by all significant criteria having a price difference, such as age, gender, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies;

(II) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted to the Interstate Insurance Product regulation Commission; and

(III) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Labor Statistics. The CPI-U for any year is the value as of September;

(iii) Limitation on Adjustments to Initial MLR

In no event shall the adjustment to the initial MLR be more than 5%; and

(iv) The discount rate, average annual policy premium (A), and MLR shall be shown as part of the information in Appendix A attached to these standards.

COMMENTS:

Industry Comment: An Industry commenter requested that the Insurance Compact adopt minimum loss ratios (MLR) which mirror the MLR for Loss of Income insurance in the NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms as follows:

Optionally Renewable (60%),

Conditionally Renewable (55%),

Guaranteed Renewable (50%), and

Non-Cancellable (45%).

The commenter notes that the NAIC guidelines also include possible adjustments to these MLR's for both Low Average Premium Forms and High Average Premium Forms. Using the NAIC guidelines will allow for consistency between policies filed with the Compact and those that are not. They state that a lower MLR standard allows for a higher contingency and risk margin, which can give companies more freedom to explore and provide new, innovative benefits to customers.

IIPRC Office Comments/Observations: The IIPRC Office notes that the MLRs listed in the current adopted standards were in the initial draft of the rate standards as submitted to the PSC by the National Standards (EX) Working Group and were not the subject of discussion by the PSC before or after the initial proposal was exposed for comment. The Office also notes that at this time, the standards do not contain a definition or reference to *Optionally Renewable.* It is noted that the comments submitted by the IAC include a suggestion, without specific rationale, to include the definition of *Optionally Renewable* that is listed in the Group Disability Income Insurance uniform standards. The group rate standards contain the following MLR's:

Renewal Provision	**Initial MLR %**
Conditionally Renewable	55
Guaranteed Renewable	55
Optionally Renewable	55
Noncancellable	50

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC refer this matter to the Actuarial Working Group for its input and recommendation regarding both whether the MLR percentages should be the same as those in the Model and whether *Optionally Renewable* should be added to the standards.

Insurance Compact Office update following the July 11, 2017 PSC Public Call: The following written comments were received from the IAC*:

We included "Optionally Renewable" as another way to diversify and offer a plan that may be more affordable for the average consumer who may not be able to afford a higher end plan. This type of plan is not likely to be introduced in the IDI market anytime soon, so we are withdrawing this comment from consideration.

***Note**: This comment was not received by the company that submitted the request for this change.

Insurance Compact Office update following the September 12, 2017 PSC Member Call: The PSC received an overview of the request that the Insurance Compact adopt minimum loss ratios (MLRs) which mirror the MLR for Loss of Income insurance in the NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms and agreed to refer this matter to the Actuarial Working Group for their review and recommendations.

Insurance Compact Office update following the Dec. 19, 2017 PSC Member Call: The Insurance Compact staff provided an overview of the Actuarial Working Group (AWG) feedback and noted that the AWG members agreed that the MLR's should be consistent with the NAIC Guidance #134, but they were less certain about adding a requirement for adjustment of the MLR for High Average Premium policies. They believed that the High Average Premium MLR adjustment listed in the proposal, although consistent with the NAIC Guidance, was different since the Compact's adjustment for Low Average Premium set a considerably higher premium than in the NAIC Guidance #134. The AWG questioned whether many states followed a similar process. They suggested that the PSC consider exposing the draft with a requirement to adjust the MLR for High Average Premium plans to obtain feedback and that the Committee check to see if their states require an adjustment to the MLR for High Average Premium plans and if so, what the details of the adjustment/threshold are.

The PSC agreed with the AWG feedback and seeks comment regarding the proposed revisions:

(g) A description of the determination of the MLR applicable to the policy form. The MLR shall be determined as follows:

The Initial MLR shall be based on the guidelines below using the Renewal Provision for the policy:

Renewal Provision	Initial MLR %
Conditionally Renewable	55
Guaranteed Renewable	~~55~~ 50
Noncancellable	~~50~~ 45

~~Adjustments to Initial MLR to determine MLR.~~ Companies may make adjustments to the Initial MLR for low average premium plans to determine the MLR. The adjustment below should be made only if the expected average annual premium for the policy form, considering the distribution of business assumptions in § 2B(1)(e)(v) above, is less than $2,500:

The initial MLR shown in the table above shall be adjusted according to the formula below, where:

MLR = (Initial MLR)* (A-25*I)/A and

I = [CPI-U, Year (N-1)] / 103.9 where

(I) The value for A is the average annual policy premium.

The average annual policy premium shall be estimated by the insurer based on an anticipated distribution of business by all significant criteria having a price difference, such as age, gender, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies;

(II) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted to the Interstate Insurance Product regulation Commission; and

(III) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Labor Statistics. The CPI-U for any year is the value as of September;

(iii) Companies shall make adjustments to the Initial MLR for high average premium plans to determine the MLR. The adjustment below should be made if the expected average annual premium for the policy form, considering the distribution of business assumptions in § 2B(1)(e)(v) above, is greater than $15,000:

The initial MLR shown in the table above shall be adjusted according to the formula below, where:

MLR = (Initial MLR)* (A+150*I)/A and

I = [CPI-U, Year (N-1)] / 103.9 where

(I) The value for A is the average annual policy premium.

The average annual policy premium shall be estimated by the insurer based on an anticipated distribution of business by all significant criteria having a price difference, such as age, gender, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies;

(II) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted to the Interstate Insurance Product regulation Commission; and

(III) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Labor Statistics. The CPI-U for any year is the value as of September;

~~(iii)~~(iv)Limitation on Adjustments to Initial MLR

In no event shall the adjustment to the initial MLR be more than 5%; up or down; and

~~(iv~~v) The discount rate, average annual policy premium (A), and MLR shall be shown as part of the information in Appendix A attached to these standards.

17. PROCEDURES FOR REVIEW OF A DENIAL OF A CLAIM

APPLIES: §3 POLICY PROVISIONS of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

There currently is no provision outlining procedures for review of a denial of a claim.

COMMENTS:

Regulator Comments: The Minnesota Department of Commerce called to the attention of the PSC a U.S. Department of Labor rule effective April 1, 2018 that requires employer-sponsored disability income insurance plans to provide disability claimants with explanations of claim denials and information on how to appeal such a denial. The new rule could have impact on some policies subject to the individual disability income insurance uniform standards.

Industry Comment: The Industry Advisory Committee noted that they had suggested including a standard for Procedures for Review of a Denial of a Claim similar to that found in the GDI uniform standards which reflects the ERISA requirements, and noted that companies were already including this type of language for their individual IDI guaranteed issue cases that are employer sponsored.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the addition of a provision for Review of a Denial of Claim and determine if they would like it considered under Required Provisions or Optional Provisions.

Insurance Compact Office update following the Feb. 20, 2018 PSC Member Call: The Committee reviewed draft language prepared by the Compact office and agreed to recommend adding the following provision to §3. Policy Provisions D. Optional Provisions:

(6) Procedures for Review of a Denial of a Claim

(a) The policy may include a provision for review of denial of a claim. If included, the provision shall state that the insured must request, in writing, a review of the denial of claim within a specified number of days after the insured receives notice of the denial.

(b) The policy shall include a provision that an insured has the right to review, upon request and free of charge, copies of all documents, records, and other information relevant

to the insured's claim for benefits, and the insured may submit written comments, documents, records and other information relating to the claim for benefits.

(c) The policy shall include a provision that the insurance company will review an insured's claim after receiving the insured's request and send the insured a notice of its decision within a specified number of days after the insurance company receives the request, or within another specified period of days if special circumstances require an extension. The number of days shall be specified in the policy. The insurance company will state the reasons for its decision and refer the insured to the relevant provisions of the policy. The insurance company will also advise the insured of the insured further appeal rights, if any.