Impact of Disability Insurance Policy Mandates Proposed by the California Department of Insurance

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Attachment A. The Department's October 3, 2005 Notice A-1

Section I. Introduction

Milliman, Inc. has been engaged by America's Health Insurance Plans ("AHIP") on behalf of member companies who are licensed to sell disability income ("DI") insurance in California to prepare a report discussing the actuarial impact of the DI policy language changes that the California Department of Insurance ("the Department") has proposed. The policy language changes are discussed both qualitatively and quantitatively. This report does not assess the legal authority of the Department to impose such changes.

The authors are consulting actuaries employed by Milliman, Inc., who have extensive experience working with insurers and employers regarding disability insurance plans. In preparing this report, we were guided by the Actuarial Standards of Practice (ASOP's) that are promulgated by the Actuarial Standards Board of the American Academy of Actuaries. Specifically, we were guided by ASOP No. 5, "Incurred Health Claim Liabilities", ASOP No. 17, "Expert Testimony by Actuaries," and ASOP No. 41, "Actuarial Communications."

The cost estimates in this report are based on actuarial assumptions derived from historical data, premium rates currently charged by DI insurers in the competitive marketplace, and anticipated future experience. For items which could not be directly derived from historical data or current premium rates, we used actuarial judgment and professional experience to develop the estimates. As with any actuarial estimates, it is likely that future experience will vary from these assumptions. To the extent that such variation occurs, the actual cost impact may vary from our estimates.

To support our analysis, we surveyed a number of AHIP member companies who write group or individual DI insurance, regarding their DI product provisions, their claims experience and litigation costs, as well as consulted with a number of actuarial experts from these companies. Those survey data were aggregated and de-identified when summarized to encourage full responses and assure compliance with antitrust guidelines. The authors did not audit or independently verify the survey responses, except that they did review the responses for reasonableness and consistency. To the extent that any of the data or other information supplied was incorrect or inaccurate, the results of our analysis could be affected.

AHIP has Milliman's permission to submit this report to the Department. In doing so, we expect that the report will become a public document. Milliman does not intend to benefit any third party recipient of its work product. If distributed, we request that this report be distributed in its entirety.

Section II. Executive Summary

In its October 3, 2005, notice to insurers, the Department has proposed a number of significant changes to which DI insurance policies must conform in the state of California. (A copy of the October 3 notice is provided in Attachment A.) These changes would not only affect new product filings but also apply retroactively to policies that the Department has previously approved. The purchasers of group and individual DI insurance, both employers and individuals, will be the ones most affected by the Department's proposed policy language changes for DI policies.

Specifically, the proposed changes will:

- Significantly increase the cost of group and individual DI insurance;
- Limit the range of DI insurance products available to California consumers;
- Reduce the total amount of DI protection per life that Californians may access; and
- Discourage some DI claimants from returning to work.

More than most insurance products, the ultimate cost of DI insurance is affected by the personal motivation of insureds. Most insureds who become disabled want to return to a productive life as soon as medically possible, and DI insurance allows them to restore a portion of their lost income while they are recovering. However, past experience demonstrates that many personal or non-medical (e.g., economic) factors can adversely influence some claimants' motivation to return to work, even after they are medically able. As a result, the cost of DI insurance increases for all consumers.

DI insurers have introduced a number of contractual provisions to encourage consumers to return to productive work so as to provide valuable coverage at the lowest possible cost. The policy language changes proposed by the Department weaken many of these provisions. For example, under the Department's proposal:

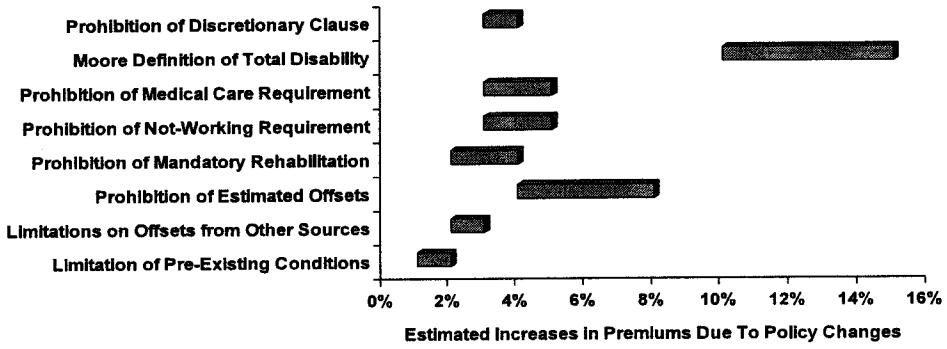
- Consumers of DI insurance, whether group or individual, will only be able to purchase a more expensive form of DI coverage known as "Pure Own Occupation" or the least expensive form known as "Any Occupation." Consumers will be unable to purchase other currently available options that fall between these two extremes and may better serve their needs.

- The requirement that claimants receive regular and appropriate medical care will be prohibited. This requirement was designed to reduce the average duration of claims, the cost of administering those claims, and the resulting cost of insurance.

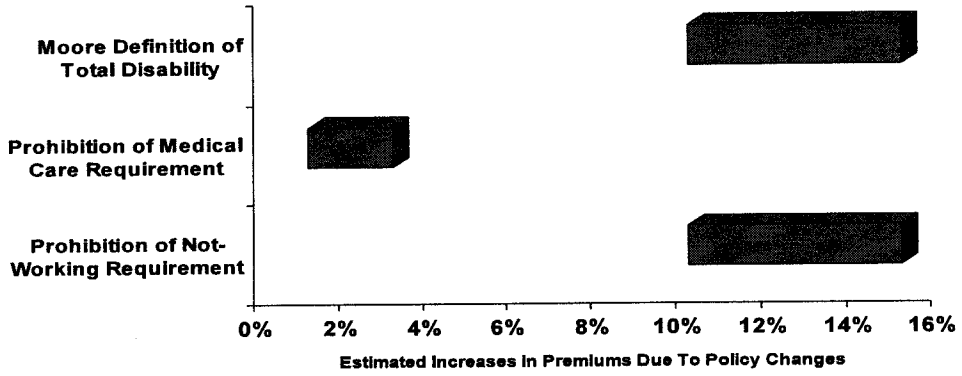
- Group DI benefits will no longer be reduced by estimated Social Security disability benefits. This prohibition reduces claimants' incentive to apply for Social Security benefits, which both the employer and employee have funded through their payroll taxes, and consequently further increases the cost of insurance.

We estimate that the Department's proposed policy language changes could increase the cost of insurance from 28% to 46% for group DI and 21% to 33% for individual DI, on polices that currently contain all of the prohibited provisions. The anticipated premium increases would be lower for DI policies that currently contain some but not all of the prohibited language. The following charts show the anticipated premium increases, separately for group DI and individual DI, for the specific proposed policy language changes contributing to the increases.

Impact of DI Policy Changes on Cost of Group DI Insurance



Impact of DI Policy Changes on Cost of Individual DI Insurance



These anticipated premium increases will be in addition to the significantly higher-than-average premiums currently paid by most California DI consumers. California consumers typically pay 20-70% more for individual DI and 10-15% more for group DI than do consumers in other states. These higher premiums are warranted by historically higher disability claims in California as evidenced by a recent industry study by the Society of Actuaries[1].

In addition to causing substantially higher costs for DI insurance, the Department's proposed policy changes will limit the DI insurance product choices available to California consumers. For example, the Department would prohibit the following types of DI benefits and policies, which are commonly available to consumers in other states:

- Loss of Income contracts, which reduce disability benefits for earned income during disabilities but which do not distinguish between Total and Residual or Partial disabilities;

- Additional benefits for insureds who are so severely disabled that they cannot perform certain activities of daily living;

[1] "Report of the Individual Disability Income Experience Committee – Analysis of Experience from 1990 to 1999," (IDEC Report), Society of Actuaries, January 2005, pp. 79-84.

- Additional benefits to claimants' 401(k) or pension plans while they are disabled;
- Individual DI buy-out policies, which facilitate the transfer of business ownership between partners resulting from the permanent disablement of one of the partners;
- Individual Key Person policies, which are designed to compensate businesses for the loss of key employees due to disabilities; and
- Survivor Income provisions, which typically pay three months of benefits to the spouse, children or estate of an insured following the death of the insured while disabled.

Should these proposals go into effect, DI insurers, in addition to raising premiums and restricting product options, will be likely to implement more restrictive underwriting rules and reduce the total amount of DI insurance per life that California consumers can purchase, since many of the proposed policy language changes serve to reduce claimants' motivation to return to work. Thus, insureds who are personally motivated to return to work, regardless of the policy provisions, may have lower portions of their incomes covered while disabled.

Although DI insurance provides valuable protection against loss of income due to a disability, relatively few people have this coverage. The U.S. Department of Labor reports in the 2005 National Compensation Survey that only 39% of workers are covered by short-term disability and 29% of workers are covered by long-term disability[2]. The portion of consumers who purchase individual DI insurance is lower. Employers today are facing the increasing cost of healthcare and are, in turn, sharing a greater portion of the cost burden with their employees. When group DI premiums increase, fewer employers may be willing to pay for this coverage. In these cases, some portion of employers will drop the coverage altogether or expect their employees to purchase it. Employees are likewise paying for the higher cost of health care, as well as incurring other financial demands on their disposable income, and consequently, they will be less willing or able to purchase DI coverage on their own.

The likely impact of the Department's imposed policy changes on the California DI consumer is significantly higher premiums, fewer product options, and more restrictive underwriting. The Department's proposal will likely result in fewer insured California residents, and, therefore, decreased financial security.

[2] "National Compensation Survey: Employee Benefits in Private Industry in the United States," U.S. Department of Labor, U.S. Bureau of Labor Statistics, August 2005, p. 9.

Section III. The Nature of the Disability Risk

If a person is unable to perform his or her occupation due to an accident or sickness, then that person will most likely suffer an income loss. The purpose of disability insurance is to restore a portion of that lost income while the person remains disabled.

This simple product concept is complicated by a number of factors:

- Difficulties in establishing the existence and extent of the medical condition and the causative relationship between the condition and the disability.
- The potential for adverse selection arising from "asymmetric information", where applicants or employees have material information concerning their personal circumstances that is not available to the insurer.
- The impact of personal motivation on an insured's ability or willingness to perform his or her occupation.
- The risk of overinsurance by which a claimant may receive more income while disabled than before.

Industry studies have shown that the level of benefits relative to pre-disability earnings, the richness of contractual provisions and economic factors can influence both the frequency that insureds become claimants and the duration of the resulting claims.

1. The Transactions of the Society of Actuaries Reports for 1982-84 show that group DI claim costs per dollar of benefit increase as the percentage of income insured increases[3].
2. The 2005 IDEC Report of the Society of Actuaries provides evidence of how certain contractual provisions and subjective factors affect both claim incidence and claim recovery[4].

[3] Transactions of the Society of Actuaries, Reports 1982 and 1984, p. 286 (1982), p. 254 (1984).
[4] IDEC Report, pp. 59-70.

The challenge for group and individual DI insurers is three-fold:

1. Offer DI insurance products that provide valuable protection against income loss due to disability.

   DI insurers must provide products that meet the critical needs of the insureds and administer their contractual obligations fairly.

2. Make the products available and affordable to as many people as possible.

   DI insurance, sold either on an individual or group basis, is a crucial part of the financial security for working Americans. By including appropriate risk management provisions within their policies, insurers who provide these coverages are able to offer protection to a larger number of customers at more affordable rates.

3. Maintain the financial soundness of the insurance plan.

   In order for DI insurance to remain a viable product, it must be profitable for the insurers who provide it. If the product cannot be written profitably, then most insurers will refuse to offer it, and those who remain in the market may face threats to their financial soundness and claim-paying ability.

The remainder of this report reviews in detail the changes to DI policy language that the Department is proposing. Specifically, the report discusses how the proposed changes will reduce the protection that DI products will be able to provide in California, and will substantially increase the cost of DI coverage.

Section IV. The Department's Proposed DI Policy Language Changes

This section covers each of the categories of policy language changes which the Department outlined in its October 3 notice to insurers.

1. Discretionary Clauses

The Department proposes prohibiting the use of the discretionary clause in DI contracts.

The discretionary clause, which is included in DI plans subject to the Employee Retirement Income Security Act (ERISA), vests in the insurer, in its role as plan fiduciary, the responsibility to review all the evidence and documentation submitted by the beneficiary seeking coverage from the plan. The fiduciary is **required by law** to use a level of discretion in interpreting the plan documents, a role formalized in the plan documents through the discretionary clause. This role was reiterated in two Supreme Court decisions, *Firestone v. Bruch (1989)* and *Aetna Health Inc. v. Davila (2004)*. Discretionary clauses do not allow the insurer "unfettered" discretion, but are consistent with federal law by which the interpretation of the plan's terms must be grounded on a "reasonable basis," and cannot be arbitrary, capricious or an abuse of discretion.

The presence or absence of the discretionary clause does not affect contractual entitlement for benefits or calculation of benefits. However, without the discretionary clause, the standard of review if a claim is contested will change. Under a discretionary clause, the administrator's claim decision can be overruled only if it is found to be "arbitrary and capricious." Without the discretionary clause, the standard of review is the same "de novo" standard applicable to individual DI plans where a jury can determine whether an insured qualifies for disability benefits.

We estimate that the removal of the discretionary clause would increase group DI premiums between 3% and 4%, based on the following three factors:

a. <u>Higher incidence of litigation</u>

   Based upon results from the survey of AHIP member DI carriers, the ratio of litigated claims relative to all active claims was 0.6% for group DI carriers and 0.9% for individual DI carriers. Although a number of factors could contribute to the different ratios, we believe the absence of a discretionary clause in individual DI policies is a significant consideration.

b. Higher cost per litigated claim

Based upon results from the survey of AHIP member DI carriers, the average cost to litigate individual DI claims is over 260% of the average cost to litigate group DI claims. We expect that in the absence of the discretionary clause, the cost to litigate group DI claims will be similar to the cost to litigate individual DI claims.

c. Lower claim recovery rates

A more litigious environment could result in DI insurers being more overly cautious in managing claims, allowing some insureds to remain on disability although the preponderance of evidence indicates that they are no longer disabled. We have assumed a 2-3% reduction in recovery rates as an estimate of this effect.

2. *Definition of Total Disability*

There is no definition of Total Disability contained in California insurance statutes or regulations that applies to individual and group DI contracts[5]. The Department's notice states that the definition of Total Disability must be "at least as advantageous to the insured" as the definition arising from *Moore v. American United Life Ins. Co. (1984) 150 CalApp3d 610, 632; 197 Cal.Rptr. 878, 892*, which was an interpretation of the definition of California case law from 1942. Under the *Moore* definition, Total Disability is a disability that "renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity." This is considered an "Any Occupation" definition of Total Disability, and insurers wishing to use an "Own Occupation" definition of disability must use the first part of the definition pertaining to "Usual Occupation."

Recent documents produced by the Department suggest that it is interpreting the material and substantial duties of an insured's Usual Occupation to mean the duties performed by the claimant in a specific employment setting prior to the disability rather than the duties based on a more standardized definition of the same occupation. In other words, the Department's interpretation of this definition of Total Disability incorporates the concept of "Own Job" versus Own Occupation.

[5] The only definition of Total Disability contained in California insurance statutes or regulations applies to the California State Disability Insurance (SDI), a state-mandated program funded through payroll deductions. For the purpose of qualifying for benefits under the California SDI: "An individual shall be deemed to be disabled on any day in which, because of his or her physical or mental condition, he or she is unable to perform his or her regular or customary work."

Although insurers typically take into account the duties of a claimant's job to some degree, the Own Job definition of disability is substantially more expansive than Own Occupation. For example, an engineer whose job requires frequent air travel to off-site locations and who suffers from an inner ear problem that makes flying extremely painful may be eligible for Own Job benefits although he or she may be able to perform all of the duties of an engineer at another firm in the same city that did not require air travel. Few group DI insurers and fewer individual DI insurers, if any, offer an explicit Own Job definition in their policies.

Of the group DI carriers who offer an Own Job definition, one charges between 8% and 15% more, although it limits the Own Job period to 18 months. Some group DI carriers will offer "Own Specialty" definitions of disability to attorney and physician groups with additional ranging between 15% and 20%. Based on what the group DI carriers are currently charging for similar definitions of disability, we estimate that the cost of insurance will increase between 10% and 15% on average as a result of requiring the Own Job definition of disability.

3. *Additional Benefit Criteria*

The Department proposes prohibiting additional criteria to those stated in the *Moore* definition of Total Disability and gives examples of the criteria that would no longer be permitted. Each example is discussed below.

Regular Medical Care and Appropriate Medical Care

The Department proposes requiring that definitions of Total Disability can no longer require the claimant to be receiving regular or appropriate medical care.

Requiring claimants to be receiving regular or appropriate medical care has been a common feature in disability contracts for many years[6]. Insurers will typically waive this requirement if they receive written proof that ongoing medical care would be of no benefit to the insured.

Although most claimants seek regular and appropriate medical care as a normal course of action, removal of this requirement makes it easier for those claimants who do not want to return to work or to seek appropriate care to remain disabled. In addition, not requiring regular and appropriate medical care makes adjudicating claims more difficult. For example, a claimant who is suffering from back pain or depression, which could be

[6] Black, Kenneth and Harold D. Skipper. Life and Health Insurance, 13th edition. Upper Saddle River, NJ: Prentice Hall, 2000, p. 153

easily treated with prescribed medications, but who is not receiving appropriate medical care, could possibly remain disabled indefinitely with little chance of improvement in his or her medical condition.

The Department's proposed restriction does not prohibit the insurer from requiring ongoing certification of the condition by a physician. However, in the absence of the medical care requirement, insurers will likely request more independent medical examinations (IME's) in order to monitor the claimant's medical condition.

The impact of removing a regular and appropriate medical care requirement from the definition of Total Disability is two-fold:

a. Higher volume of IME's

   We expect that additional IME's may be required at least every 6 months for the first 2 years and annually for the next 8 years. This higher volume of IME's will increase group DI costs by 2-3% and individual DI costs by 0.5-1%.

b. Lower recovery rates

   We anticipate that between 8-10% of claimants may not receive regular or appropriate medical care with the Department's proposed policy language change and, as a result, that both group and individual claim recovery rates will decrease 1-2%, with a corresponding increase in costs of 1-2%.

We estimate the combined effect will increase the cost of insurance by 3-5% for group DI insurance and 1-3% for individual DI insurance. In addition to increasing premiums due to higher costs from this prohibition, DI insurers may choose to limit the amount of coverage they will provide to individuals in order to provide a greater financial incentive for claimants to return to work in the absence of such benefits criteria as regular and appropriate medical care.

ADL's and Cognitive Impairments

The Department proposes prohibiting the use of activities of daily living (ADL's) and cognitive impairments as criteria for Total Disability. Some insurers have used such definitions of disability in contracts designed for people who do not have well-defined occupations, such as homemakers or those who are unemployed at the date of disability. Other insurers have developed optional riders which provide additional benefits to claimants who are receiving regular disability benefits but who are also so severely disabled as to be unable to perform two out of six ADL's or to be suffering from a cognitive impairment. It is assumed that claimants suffering from these more

catastrophic conditions may need the additional benefits to help in covering the extra costs that they incur as a result of these conditions.

By prohibiting these criteria, the Department will not add to the cost of DI coverage but rather will limit potentially valuable options and restrict access to coverage for California consumers.

Not-working Requirement

The Department proposes excluding the "Not-working" requirement in the definition of Total Disability.

The typical definition of disability for individual policies sold in the 1980s and early 1990s was labeled "Pure Own Occupation." It allowed an insured to work in another occupation while disabled from his or her Own Occupation and receiving benefits. The potential for overinsurance was significant. For example, a surgeon may be able to earn considerable income as an internist or teaching physician while unable to perform his or her normal surgical duties. Many insurers chose to include a "Not-working" requirement in their Own Occupation definition of disability, thus limiting their exposure to overinsurance and reducing the cost of insurance.

Without the Not-working requirement, the Own Occupation definition of Total Disability is equivalent to the Pure Own Occupation definition. (The Not Working requirement has no impact on an Any Occupation definition.) Some individual DI insurers will remove the Not Working requirement, increasing the premium for the more common long-term Own Occupation definition by 10% and 15%. Many companies will not allow occupations such as physicians (who have very precise manual duties) to purchase the Pure Own Occupation coverage. Although group DI carriers generally do not remove the Not Working requirement, we estimate that a corresponding increase in group premiums for removing this requirement would be 3-5%, reflecting the more typical two-year Own Occupation and Any Occupation thereafter definition for group DI.

In addition to increasing premiums due to the higher costs, DI insurers may choose to limit the amount of coverage to individuals and to offer only an Any Occupation definition to high risk occupations, which is not as beneficial to the insured as an Own Occupation but Not-working definition.

Loss of Income Standards

The Department proposes prohibiting any loss of income criterion (e.g., a minimum 20% loss of income due to the accident or sickness) in the definition of Total Disability. Our survey of DI insurers shows that most individual DI contracts that define Total Disability

do not include a loss of income criterion, while most group DI contracts that define Total Disability do include this criterion.

The Department's proposal would prevent "Loss of Income" DI contracts from being offered in California. A Loss of Income DI contract, which is favored by many group DI policies, defines a person as disabled if (1) unable to perform the material and substantial duties of his or her occupation due to an accident or sickness and (2) experiencing a loss of income as a result of the accident or sickness (often at least a 20% loss). The benefit formula, which adjusts the benefit for the presence of earned income, is applied to all claimants regardless of the extent that the insured cannot perform the duties.

Loss of Income contracts do not distinguish between Total Disability and Partial or Residual Disability since the same loss of income benefit formula applies to all disabilities. Because the benefits are reduced due to income earned while the insured is disabled, these contracts have the advantage of controlling the risk of over-insurance more effectively than Pure Own Occupation contracts. Conceptually, these contracts are more consistent with the fundamental purpose of DI insurance, which is to pay disability benefits when the insured incurs an economic loss due to an accident or sickness. There is less opportunity for overinsurance to occur under Loss of Income contracts, which reduces the cost of insurance.

Under the Department's proposal, the Loss of Income contract would be prohibited in California because its provisions would require a claimant, who might satisfy the *Moore* definition of Total Disability, to satisfy a loss of income criterion as well. In lieu of offering Loss of Income, insurers would be compelled to offer only DI contracts that distinguish between Total Disability and Partial or Residual Disability and to apply a loss of income trigger only when the insured is Partially or Residually Disabled. The effect is to force insurers to offer the more expensive Pure Own Occupation coverage and prohibit the access of the California consumer to lower cost forms of disability coverage.

For this cost analysis, the higher costs arising from the Department's proposed prohibition of the loss of income criteria in Total Disabilities are reflected in the cost of prohibiting the Not-working requirement during a Total Disability. Thus, they are not treated as additional costs beyond what has already been considered in our analysis.

Mandatory Vocational Rehabilitation

The Department proposes eliminating mandatory vocational rehabilitation requirements from DI contracts. Many group DI contracts currently require a claimant to participate in a vocational rehabilitation plan if approved by the insurer as a condition for receiving disability benefits. The vocational rehabilitation plan is designed to enable the employee to return to work, if possible, even if on a part-time basis. If the employee refuses

participate in the plan without a just cause, then disability benefits will terminate. Such programs are expected to shorten the duration of disabilities by encouraging disabled workers to return to productive employment. Mandatory vocational rehabilitation is not typically found in individual DI policies.

Currently, insurers will typically increase premiums by 2% to 4% when a mandatory vocational rehabilitation program is removed from the group DI plan. Thus, we estimate that cost of group DI plans that currently have mandatory vocational rehabilitation requirements would increase by comparable amounts if those programs are prohibited as the Department is proposing.

National Economy Standard

The Department proposes prohibiting the use of a National Economy standard to define one's usual occupation within the context of Total Disability. Currently some carriers use this language to clarify that they are providing Own Occupation coverage rather than the more costly and specific Own Job coverage.

It is unclear whether the Department might permit the use of a definition of disability that refers to occupational duties in the Local Economy. However, as discussed earlier, we believe that the Department interprets Usual Occupation in the definition of Total Disability as Own Job, and the prohibition on using a National Economy standard reinforces this position. Thus, the additional cost of insurance associated with this prohibition is reflected in the additional cost of insurance arising from interpreting Usual Occupation as Own Job, which is discussed in the section on Total Disability.

4. *Offsets in Group Disability Income Insurance*

Group DI benefits are typically reduced by applying offsets for income received by the claimant from a variety of sources. This is done to prevent overinsurance. The Department proposes imposing limits on the types of other income that are deductible.

No Deductions for Estimated Income

The Department proposes prohibiting insurers from deducting estimated amounts of income. This applies primarily to Social Security disability benefits where a common practice amount group DI carriers is to deduct an estimated Social Security disability benefit until the claimant's application for Social Security disability benefits is denied or approved. Ultimately, disability benefits and offsets are trued up so only the actual Social Security benefits will have reduced the disability benefits.

Some group DI insurers allow the claimant to forego the reduction of DI benefits from estimated Social Security amounts if the claimant (1) provides proof of application for Social Security disability benefits, and (2) signs a reimbursement agreement promising repayment of any group DI overpayments to the insurer. Other group DI insurers deduct the estimated Social Security disability benefit only if the claimant refuses to cooperate with or participate in the insurer's Social Security assistance program designed to help claimants apply for and receive Social Security disability benefits.

In general, 70% to 80% of group long-term disability claimants, who remain disabled for at least five years, ultimately qualify for Social Security disability benefits and the resulting benefit offsets lower the cost of insurance by 40% to 45%. Removing the insurer's ability to offset estimated Social Security benefits increases the cost of insurance in two ways:

a. Fewer claimants will be approved for Social Security benefits because, if their group DI benefits are not reduced for estimated Social Security amounts, they will have less incentive to apply for Social Security and pursue appeals, if necessary. We estimate approval rates could decrease by 5-10%.

b. There will be more overpayments of group DI benefits when companies are unable to reduce disability benefits by the estimated offsets during the Social Security approval process. Companies can only recover these past over-payments by reducing ongoing group DI benefits, which are already reduced by the regular Social Security offset. We estimate that 15-25% of the overpayments may not be recovered.

We estimate that the resulting increase in the cost of insurance from lower Social Security approval rates and higher unrecoverable Social Security payments will be 4% to 8%. Lower Social Security approval rates result in a shifting of some disability benefit payments from the Social Security program to group DI insurers. The total amount of benefits received by claimants (from Social Security and private insurance combined) would be unchanged. Because insurers would need to increase premium rates to cover their higher benefit payments, however, and because it is highly unlikely that Social Security payroll taxes would decrease due to lower approval rates for Social Security disability claims, the combined cost of public and private disability protection would increase for consumers.

Income Offsets from Other Sources

The Department proposes prohibiting other income offsets to disability benefits unless they arise from the same loss for which the disability benefits are being paid. This prohibition mainly affects three types of offsets:

1. Non-disability Related Retirement Income

   Under this prohibition, claimants who elect early retirement from their employers while receiving disability benefits may potentially receive more income while disabled than they earned prior to the disability.

2. Worker's Compensation Permanent Disability Benefits

   The Department would permit the offset from Worker's Compensation temporary disability benefits. Apparently, the Department bases its rationale on *Russell v Bankers Life Co.*, where the judge ruled that Worker's Compensation permanent disability benefits from the same loss may not be offset, although such benefits are paid when the employee is considered permanently disabled and unable to work in gainful employment. Although the Department would prohibit offsets for Worker's Compensation Permanent Disability Benefit for DI contracts, eligibility or receipt of permanent Worker's Compensation permanent disability benefits does, however, disqualify claimants receiving benefits under California's SDI program.

3. Insurance Proceeds

   The Department reminds group DI insurers that disability benefits cannot be offset by insurance proceeds from other DI policies, according to 10 Cal. Code Regs. Section 2232.34. Group DI contracts typically offset for disability benefit proceeds from other group contracts, but do not usually offset for proceeds from individual DI contracts.

In general, benefit offsets from sources other than Social Security come from Worker's Compensation awards and, to a lesser extent, retirement income plans. Whereas Social Security offsets reduce the cost of insurance by 40% to 45%, these other types of benefit offsets reduce the cost by 4% to 5%. If offsets from permanent Worker's Compensation awards and retirement income plans are prohibited, we estimate that the cost of insurance will increase between 2% and 3%.

Beyond just the impact of higher costs, this prohibition, along with the prohibition on a loss of income standard while totally disabled, serves to increase the total income that individuals can receive during a disability, raising the risk of overinsurance. In other words, the combined effect of these three prohibitions can reduce return-to-work rates, not just the amount of benefits paid to claimants.

5. *Definition of Pre-existing Condition*

The Department proposes to prohibit DI contracts from defining pre-existing conditions that use terms such as "consultation" and "diagnostic measures" or other similar terms, "unless the definition makes it clear that a condition or disease was diagnosed or actually pre-existed the effective date of the contract."

This prohibition would have a greater effect on group DI coverage than individual DI, because group DI plans must rely more on pre-existing conditions for protection against adverse selection, in the absence of medical underwriting. The Department's proposal limits the protective value of pre-existing condition exclusions by prohibiting exclusions of any medical condition for which a person may have sought consultation and diagnostic measures but never received any treatment, care, services, or prescribed medicines.

The cost impact of this requirement varies by the size of the group. The protective value of the pre-existing condition limitation is greater for smaller size groups. Based on premiums that group DI insurers charge for different pre-existing condition options, we estimate the cost of this prohibition to be approximately 0.5% of the total cost of insurance for cases of 100 lives or more, but possibly 3% for smaller cases. For the purpose of deriving an average estimate covering all group DI policies, we anticipate that this proposed limitation on the definition of pre-existing conditions will increase the cost of group DI insurance by 1-2%. Individual insurers, who have the option of expanding their applications to cover pre-existing situations such as those prohibited by the Department, should incur no significant additional cost.

6. *Compulsory Uniform Provisions*

The Department requires every disability contract to contain the Compulsory Uniform provisions contained in California regulations and prohibits any provisions that are less favorable in any respect to the insured than the statutory provisions. Since these statutory provisions are not new, there should be no issues from the insurers' or consumers' perspective.

7. *All Benefits Must Be Paid to the Insured*

The Department intends to require that all benefits be paid directly to the insured. As a result of this provision, the Workplace Modification Benefit and Pension Contribution Benefit are not permitted.

This restriction prohibits several valuable benefits available in many DI contracts:

- The Workplace Modification Benefit pays for certain modifications to a disabled employee's work location that would facilitate their return to work. Employers are required to make reasonable accommodations for employees' disabilities under the ADA. Thus, the Workplace Modification Benefit is valuable for both employees and employers who may not have the resources to make the necessary modifications.

- The Pension Contribution Benefit pays benefits to a 401(k) plan or annuity while the insured is disabled in addition to the regular disability benefits that are paid directly to the insured. These additional benefits help insureds to continue funding a portion of their retirement when disabled and less able to make such contributions on their own. In the absence of this benefit, disabled employees may have no means of saving for retirement.

Although they are not specifically mentioned in the Department's October 3 notice, the following benefits or coverages would also be prohibited because benefits are paid to parties other than the insureds:

- Disability Buy-out policies, which are designed to provide funds to the business partner of a disabled insured to allow a buy out of the insured's share of business;

- Key Person policies, which are designed to protect a business against losses resulting from the disability of a key employee;

- Voluntary Rehabilitation Programs, which many individual DI policies offer, could be prohibited because the insurer would be paying for expenses incurred by someone (e.g., physical or vocational therapists) other than the insured; and

- Survivor Income provisions, which typically pay three months of benefits to the spouse, children or estate of an insured following the death of the insured while disabled.

There are no direct financial costs incurred due to a prohibition of benefits that are not paid directly to the insured. However, this prohibition may be seen as harming California consumers by preventing their access to a wide range of valuable benefits that are available to residents of other states.

8. *Summary of the Impact of DI Policy Changes on the Cost of Insurance*

The following table summarizes the various DI policy changes that were discussed above. Some of the proposed policy changes (not included in the table) limit the availability of certain benefits to California consumers but do not appear to add to the overall cost of insurance. Since some of the policy changes listed in the table apply only to group DI insurance, the cost impacts shown below were split between group and individual DI policies.

Impact of DI Policy Changes on Cost of Insurance				
	Group DI Policies		Individual DI Policies	
DI Policy Language Changes:	Low	High	Low	High
Prohibition of Discretionary Clause	3.0%	4.0%		
CA Definition of Total Disability	10.0%	15.0%	10.0%	15.0%
Prohibition of Medical Care Requirement	3.0%	5.0%	1.0%	3.0%
Prohibition of Not-working Requirement	3.0%	5.0%	10.0%	15.0%
Prohibition of Mandatory Rehabilitation	2.0%	4.0%		
Prohibition of Estimated Offsets	4.0%	8.0%		
Offsets from Other Sources	2.0%	3.0%		
Limitation of Pre-existing Conditions	1.0%	2.0%		

The combined increase from all of the proposed DI policy language changes is estimated to be between 28% and 46% for group insurance and 21% to 33% for individual insurance, for policies that currently contain all of the prohibited language. The expected combined increase would be lower for DI policies that currently contain some but not all of the prohibited language.

In addition to creating higher costs of insurance and limited product availability, most of the Department's proposed changes will exacerbate one or more of the factors discussed earlier in this report that complicate DI insurance: difficulties associated with the medical determination of disabilities, adverse selection, overinsurance and the insured's motivation. These changes will disproportionately benefit the small number of claimants who do not wish to return to work or who elect not to receive appropriate medical care for their disabilities. The costs, however, will be significant, and they will be borne by all insurance consumers in California.

Attachment A

The Department's October 3, 2005 Notice

STATE OF CALIFORNIA

JOHN GARAMENDI, *Insurance Commissioner*

DEPARTMENT OF INSURANCE

Legal Division, Office of the Commissioner
45 Fremont Street, 23rd Floor
San Francisco, CA 94105

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October 3, 2005

SUBJECT: Disability Income Insurance Policy Language

The Department is concerned that there are provisions of disability income insurance products which would not be approved if they were submitted to us today, and in many cases have not been approved for many years, but which nevertheless are contained in policy forms that the Department approved in the past, and are therefore being sold in policies to individuals and employers in California.

This letter is the beginning of the process of determining how we are going to address these concerns and of providing an opportunity for the recipients of this letter to provide input into that process. Our goal is that at the end of the process, provisions that are determined to be lawful and appropriate to be in existing policies that are being offered for sale in California will henceforth be approved in new policy forms filed with the Department, and provisions that are determined not to be lawful and appropriate will no longer be offered for sale in California. One course of action that the Department is considering is to withdraw approval, pursuant to Insurance Code §§ 10291.5(f) and 12957 of all previously-approved policy forms that contain provisions that are determined not to be lawful and appropriate.

The process will work as follows. We will direct all insurers holding a Class 6 license from the Department to provide us with an electronic copy of each of its individual and group disability income policy forms, riders and insert pages as well as any later revised forms that have been approved by the Department and approval of which has not been withdrawn.

Attached to this letter is a description of those policy provisions that the Department does not currently approve, but which are contained in policy forms previously approved by the Department. Interested parties are invited to submit written comments up to 20 pages concerning the legality and appropriateness of these policy provisions, and/or concerning the steps the Department should take to address the concerns described herein.

In addition, the recipients of this letter are invited to attend a meeting with me and other Department staff to discuss these issues on November 17, 2005 in the Administrative Hearing Room at the Department's offices, 45 Fremont Street, San Francisco, 22nd floor. In order to

assure sufficient seating, please register to attend this meeting by November 10, 2005 by contacting Jean Hipon at hiponj@insurance.ca.gov or 415-538-4088.

Questions about this letter may be addressed to:

Alice Gates, Senior Staff Counsel
45 Fremont Street, 21st Floor
San Francisco, CA 94105

Email – gatesa@insurance.ca.gov

Sincerely,

Gary M. Cohen
General Counsel

Addendum

1. Discretionary Clauses may not be used These are contract provisions purporting to confer on the insurer discretionary authority to determine eligibility for benefits and to interpret the terms and provisions of the policy. The use of discretionary clauses render the contract "fraudulent or unsound insurance" within the meaning of Insurance Code §10291.5. Discretionary clauses were the subject of a previous Notice to Withdraw Approval of 8 contracts in February, 2004. The Commissioner's decision following hearing on that notice can be found at http://www.insurance.ca.gov/docs/FS-Legal.htm, File No. AHB-PF-04-01.
In addition, language such as "satisfactory to the insurer" which may create an illusory provision is also precluded under Cal. Ins. Code §10291.5(b).

2. The definition of Total Disability used as a benefit trigger in disability income coverage must be at least as advantageous to the insured as the following: "The term 'total disability' is defined as a disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity." *Moore v. American United Life Ins. Co. (1984) 150 CalApp3d 610, 632; 197 Cal.Rptr. 878, 892.* This is an "any occupation" definition. Insurers wishing to use an "own occupation" standard must use the first portion of the above definition.

3. Additional benefit triggers may not be used: The contract may require no additional criteria to those stated in the California definition of Total Disability cited above. For example, conditions such as regular medical care, appropriate medical care, impairments in Activities of Daily Living (ADL's), cognitive impairments, no-working requirements, loss of income standards or vocational rehabilitation may not be required as benefit triggers or pre-conditions to receiving the benefit. Likewise, benefits may not be discontinued or coverage terminated for such reasons. A "national economy" or other similar standard may not be used to evaluate the insured's occupation under the California definition of Total Disability cited above.

4. Offsets in Group Disability Income Insurance: We interpret 10 Cal. Code Regs §2232.4 to mean that the insured is entitled to receive all periodic payments promised in the contract. Moreover, the amount of the benefit payment may not be stated in a way that is uncertain or ambiguous. CIC §10291.5(b)(1). Therefore, so long as benefit reductions by offset remain lawful, reductions of the promised benefit for "other income" are permissible only: (1) when the insured has received other income (For example, insurers may not reduce benefits by "estimated" amounts or amounts for which an insured "may be eligible"); and (2) when the "other income" is paid in compensation for the same loss as the benefits under the contract. (For example, under *Russell v Bankers Life Co. (1975) 46 Cal.App.3d 405,* "temporary disability benefits are the only workers compensation benefits that may be offset." Unrelated vacation or sick pay, retirement,

inheritance, lottery winnings, etc... may not be used to offset); and (3) if it can be demonstrated that the resulting amount will be specific and unambiguous.
Insurance proceeds may not be used to offset in group insurance. 10 Cal. Code Regs. §2232.34. Offsets for monies paid to spouse or children are appropriate only when the spouse or children are dependents of the insured.
In individual insurance, benefit offsets are not permissible at all. Cal. Ins. Code §10401.

5. Definition of pre-existing condition: Contracts containing limitations for pre-existing conditions may not define "pre-existing condition" using terms such as "consultation" and "diagnostic measures" or other similar terms unless the definition makes it clear that a condition or disease was diagnosed or actually pre-existed the effective date of the contract.

6. Compulsory Uniform Provisions: Every disability contract must contain the Compulsory Uniform provisions. For group products, the compulsory provisions are set forth in 10 Cal. Code Regs. §2232.16 et seq. An exception is that the Incontestability period is 2 years as required in 10350.2. For individual policies, see Cal. Ins. Code § 10350 et seq. Further, contracts may not contain other provisions that "...make a policy or any portion thereof less favorable in any respect to the insured...than the [statutory] provisions..." *Galanty v. Paul Revere Life Ins. Co. (2000),* 23 Cal. 4th 368,387; 97 Cal. Reptr. 2nd 67.

7. All benefits must be paid to the insured: Under 10 CCR 2232.24, all benefits are paid directly to the insured. Therefore, provisions such as Workplace Modification Benefit or Pension Contribution are not permissible unless the benefit is paid directly to the insured.