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

Updated 3/13/2018

Clarification Items

Clarification items are proposed edits to clarify the meaning, application, and/or intent of a provision in the Uniform Standard. Clarification items would not change the meaning or effect of the provision or the current application and interpretation of the provision or Uniform Standard but would provide further or detailed explanation, description, or specification to the language in the Uniform Standard. The clarification items are compiled not only from suggestions or issues in the Comments but also from questions, issues, and circumstances that have arisen in the application and interpretation of the Uniform Standards by the IIPRC product and actuarial reviewers.

List of Clarification Items

1. Definition of Residual Disability – State Farm
2. Qualification Period and Elimination Period for Residual Disability – State Farm
3. Mental or Nervous Disorder Definition -- IAC
4. Grace Periods -- IAC
5. Change Term “Producer” to “Agent” -- IAC
6. Date Policy Ends -- IAC
7. Actively at Work and Full Time Status – IIPRC Office
8. Discounts for Multi-Life Plans – IIPRC Office
9. Minimum Loss Ratio for Multi-Life Discounts – IIPRC Office
10. Expenses and Contingency and Risk Margins – IIPRC Office

1. DEFINITION OF ***RESIDUAL DISABILITY***

APPLIES: §3 B.(26) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISION:

(26) "*Residual Disability*" shall be described in relation to a reasonable reduction in the insured's *Earnings* due to *Disability*. The definition or concept may also state that, due to *Disability*, 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) 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). The term *Residual Disability* shall be used (except as otherwise specified in this definition/concept) in reference to paying a benefit that is a percentage of the *Total Disability* periodic income benefit amounts. The percentage of the *Total Disability* periodic income benefit amounts paid for *Residual Disability* 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 *Residual Disability* benefit paid for a claim time period.

(i) 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.

(b) The reduction in *Earnings* of an insured for a claim time period (usually monthly) which shall trigger payment of a *Residual Disability* benefit shall be 20% (a company may lower this percentage but cannot raise it) of average *Prior Earnings* (calculated for a comparable time period). 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 shall be eligible for payment of the *Total Disability* benefits under the policy for the claim time period subject to satisfaction of all policy terms and conditions by the insured.

(c) The reduction in *Earnings* of an insured for a claim time period (usually monthly) less than 20% of average *Prior Earnings* (calculated for a comparable time period) may result in no *Residual Disability* benefits being paid.

(d) *Residual Disability* benefits may be predicated upon a qualification period during which the insured shall be *Totally Disabled* before *Residual Disability* benefits are paid. The qualification period may be in lieu of the *Elimination Period* or in addition to the *Elimination Period*. However, *Residual Disability* benefits cannot be denied for a time period in excess of 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*.

(e) Alternatively, standards as described in the *Partial Disability* definition or concept are acceptable, and, when this alternative is followed, the term *Residual Disability* may be used instead of the term *Partial Disability*.

COMMENTS:

Industry Comment: An Industry commenter suggested that the definition of Residual Disability be amended to clarify the Compact's intent. In the definition of *Residual Disability*, under (b) it states that if an insured suffers a reduction in *Earnings*, equals or exceed 80% of average *Prior Earnings* then the insured will be eligible for payment of the *Total Disability* benefits under the policy "subject to the satisfaction of all policy terms and conditions." The definition of *Total Disability* includes that the insured "is not in fact engaged in any job or *Occupation* for wage or profit." The standards also do not specifically address a minimum length of time that *Residual Disability* benefits should be made available after a period of *Total Disability*. The company states that they believe the intent of this provision is neither to deny benefits to an insured who is working but suffers a loss of *Earnings* equal to or greater than 80% of *Prior Earnings*, nor is it intended to prescribe a specific length of the *Residual Disability* benefit. The company suggests clarification of the language in (b) and suggests the following revision:

(b) The reduction in *Earnings* of an insured for a claim time period (usually monthly) which shall trigger payment of a *Residual Disability* benefit shall be 20% (a company may lower this percentage but cannot raise it) of average *Prior Earnings* (calculated for a comparable time period). 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 ~~eligible for payment of the Total Disability benefits under the policy~~ 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.

IIPRC Office Comments/Observations: The IIPRC Office agrees that the intent in (b) is not to deny benefits to an insured who is working but suffers a loss of *Earnings* equal to or greater than 80% of *Prior Earnings*, nor is it intended to prescribe a specific length of the *Residual Disability* benefit. The IIPRC Office also notes that Substantive Item #5 includes a suggestion to combine *Partial Disability* and *Residual Disability* as one definition.

IIPRC Office Recommendation: If the PSC decides to maintain separate definitions for *Partial Disability* and *Residual Disability*, the IIPRC Office suggests that the PSC consider the language offered by the commenter to add clarity to this provision.

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

While we do not object to the proposed changes, we prefer the combined definition for Partial and Residual Disability.

Insurance Compact Office update following the September 12, 2017 PSC Member Call: The PSC heard a summary of State Farm's request to amend (b) in the definition of *Residual Disability* to make it clear that the intent is not to deny benefits to an insured who is working but suffers a loss of *Earnings* equal to or greater than 80% of *Prior Earnings*, nor is it intended to prescribe a specific length of the *Residual Disability* benefit. The Committee agreed that regardless of the determination made for the previously discussed Substantive Change Item 5, a revision similar to the one suggested by State Farm should be made to any aspect of the definition(s) related to *Residual Disability* when they are drafted by the Compact Office.

Insurance Compact Office update following the October 10, 2017 PSC Member Call: Please see Substantive item #5 for the proposed language.

2. QUALIFICATION PERIOD AND *ELIMINATION PERIOD* FOR *RESIDUAL DISABILITY*

APPLIES: §3 B.(26)(d) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

(26) "***Residual Disability***" shall be described in relation to a reasonable reduction in the insured's *Earnings* due to *Disability*. The definition or concept may also state that, due to *Disability*, 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) 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). The term *Residual Disability* shall be used (except as otherwise specified in this definition/concept) in reference to paying a benefit that is a percentage of the *Total Disability* periodic income benefit amounts. The percentage of the *Total Disability* periodic income benefit amounts paid for *Residual Disability* 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 *Residual Disability* benefit paid for a claim time period.

(i) 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.

(b) The reduction in *Earnings* of an insured for a claim time period (usually monthly) which shall trigger payment of a *Residual Disability* benefit shall be 20%(a company may lower this percentage but cannot raise it) of average *Prior Earnings* (calculated for a comparable time period). 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 shall be eligible for payment of the *Total Disability* benefits under the policy for the claim time period subject to satisfaction of all policy terms and conditions by the insured.

(c) The reduction in *Earnings* of an insured for a claim time period (usually monthly) less than 20% of average *Prior Earnings* (calculated for a comparable time period) may result in no *Residual Disability* benefits being paid.

(d) *Residual Disability* benefits may be predicated upon a qualification period during which the insured shall be *Totally Disabled* before *Residual Disability* benefits are paid. The qualification period may be in lieu of the *Elimination Period* or in addition to the *Elimination Period*. However, *Residual Disability* benefits cannot be denied for a time period in excess of 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*.

(e) Alternatively, standards as described in the *Partial Disability* definition or concept are acceptable, and, when this alternative is followed, the term *Residual Disability* may be used instead of the term *Partial Disability*.

COMMENTS:

Industry Comment: An Industry commenter states that (d) in the definition of *Residual Disability* says that a period of *Residual Disability* can be required to follow a period of *Total Disability* and that "*Residual Disability* benefits cannot be denied for a time period in excess of six months due to a qualification period alone or in conjunction with an *Elimination Period.*" The company suggests a drafting note to explain what is meant by a qualification period in this context for clarity, or to require a certification for an insurer to verify it does not use an initial qualification period.

IIPRC Office Comments/Observations: The IIPRC Office notes the §3. B.(26)(d) states that "*Residual Disability* benefits cannot be denied for a time period in excess of six months due to use of a qualification period alone or in conjunction with an *Elimination*

Period." The definition of *Elimination Period* only provides a maximum period for policies issued with *Benefit Periods* of one year or less. It is not uncommon for other polices to have *Elimination Periods* in excess of six months. The IIPRC Office seeks clarification of whether the referenced sentence is intended to mean 1.) that the maximum combined *Elimination Period* and qualification period before an insured can receive *Residual Disability* benefits is six months or 2.) that the qualification period cannot extend the *Elimination Period* by an additional six months? The IIPRC Office has applied the former interpretation, but notes that this can result in situations where the insurer has an *Elimination Period* for *Total Disability* of a year or more, and an insured who never qualifies for Total Disability benefits is eligible to receive *Residual Disability* benefits.

IIPRC Office Recommendation: The IIPRC Office notes that under Substantive Item #5, one suggestion is to include a single definition for *Partial* or *Residual Disability*. The suggested language for that definition includes a provision that the specified period of time for which the covered person is required to be *Totally Disabled* before being eligible for *Partial* or *Residual Disability* may be less than, equal to or greater than the Elimination Period. The IIPRC Office suggests that the PSC first determine whether it wishes to combine the two definitions into one, and if not, that it clarify the intent of §3. B.(26)(d) in the definition of *Residual Disability*.

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

We support the combined definition for Partial and Residual Disability.

Insurance Compact Office update following the September 26, 2017 PSC Member Call: The PSC discussed the request to clarify whether (d) in the definition of Residual Disability means that the qualification period plus the Elimination Period cannot be more than six months before an individual qualifies for Residual Disability benefits or if it can be interpreted to mean that the qualification period cannot extend the Elimination Period by an additional six months. It was noted that the Compact Office reviews filings using the former interpretation and that the definition of Partial or Residual Disability in the group disability income uniform standards just states that the qualification period may be less than, equal to or greater than the Elimination Period. The definition of Disability in the group standards does say that "the certificate shall specify if such additional Disability benefit triggers may only apply after a specified period of Total Disability benefits have been paid under the certificate," making specific reference to total disability benefit payment, unlike the individual standards that just say the person may be required to be Totally Disabled. Based on this information, the PSC agreed that the Compact office's interpretation of the provision was correct and that the qualification period plus the

Elimination Period cannot be more than six months before the insured is eligible for Residual Disability benefits. The Compact office will provide the PSC with a drafting note for their review for the next call.

Insurance Compact Office update following the October 10, 2017 PSC Member Call: Please see Substantive item #5 for the proposed language of the drafting note.

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

After discussion, the PSC agreed to the following revision to (c) in response to concerns regarding the potential for a lesser maximum qualification period for *Partial* or *Residual Disability*: (See Substantive Item #5)

(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.*

3. MENTAL OR NERVOUS DISORDER

APPLIES: §3 B.(14) of the Standards for Individual Disability Income Insurance Policies
CURRENT PROVISON:

CURRENT PROVISION:

B. DEFINITIONS AND CONCEPTS

(14) "***Mental or Nervous Disorder***" shall be no more restrictive than those classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), most current version as of the start of a *Disability*. If the DSM is replaced by the APA, these disorders will be those classified in the diagnostic manual then in use by the APA as of the start of a *Disability*. At the discretion of the company, the definition or concept may refer to: 1. disorders listed in the DSM, or 2. only certain disorders listed in the DSM. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, the company may substitute a comparable diagnostic manual subject to approval by the Interstate Insurance Product Regulation Commission before use of the comparable diagnostic manual.

Drafting Note: The company shall have the ability to exclude certain DSM disorders from the definition or concept. Inclusion or exclusion of DSM disorders may expand or restrict coverage for the insured. When inclusion or exclusion of DSM disorders restricts coverage, such restrictions shall be consistent with the Interstate Insurance Product Regulation Commission standards for the exclusions and limitations sections of the policy.

COMMENTS:

Industry Comment: The IAC requests an addition to the definition of "Mental or Nervous Disorder" to include a specific list of disorders which are at the time recognized in the psychiatric and psychology fields of medicine but may not yet be included in the DSM due to infrequent updating of the DSM. The IAC states that the DSM was updated in 1980, 1994 and 2013. The following language is suggested by the IAC.

Mental or Nervous Disorder" may be defined:

(a) to ~~shall~~ be no more restrictive than those classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric

Association (APA), most current version as of the start of a *Disability*. If the DSM is replaced by the APA, these disorders will be those classified in the diagnostic manual then in use by the APA as of the start of a *Disability*. At the discretion of the company, the definition or concept may refer to: 1. disorders listed in the DSM, or 2. only certain disorders listed in the DSM. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, the company may substitute a comparable diagnostic manual subject to approval by the Interstate Insurance Product Regulation Commission before use of the comparable diagnostic manual; or

(b) to mean an abnormality, disorder, disturbance, dysfunction or syndrome that is mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related, regardless of cause (which may include any biological or biochemical disorder or imbalance of the brain) and regardless of the presence of physical symptoms, for which an insured is under the regular care of a licensed psychiatrist or psychologist. The term includes, but is not limited to:

(i) bipolar affective disorder or organic brain syndrome;
(ii) schizophrenia or other psychotic or delusional disorders;
(iii) post-traumatic stress disorder;
(iv) depression and depressive disorders; or
(v) anxiety and anxiety disorders.

The term does not include Alzheimer's disease or similar forms of irreversible dementia, including dementia resulting from stroke, trauma or infectious diseases.

IIPRC Office Comment/Observation: The IIPRC Office is unaware of any questions or concerns from filers regarding the current definition and notes that the current definition of this term is the same definition that was initially proposed by the IAC for the group disability income insurance standards that were adopted in 2016. The NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) states "'Mental or nervous disorder' shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind."

IIPRC Office Recommendation: The IIPRC Office has no specific recommendation and suggests that the PSC discuss whether they wish to expand the definition in these standards as suggested by the IAC.

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

The company that suggested that we include this language had filed it and received approval in all IIPRC member jurisdictions in 2010, and the language was also approved by the IIPRC in 2016.

Insurance Compact Office update following the September 26, 2017 PSC Member Call: Noting that the preamble to the Definitions and Concepts section of the standards says that the definition shall be "consistent with the standards set forth below," not that the definition needs to be identical, and also noting that the IAC stated in their written comments that the individual company that suggested this language received approval of the language in its Compact filing, the PSC determined that there appeared to be no demonstrated need for expanding the definition and absent such a demonstration, they were not inclined to recommend change.

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

We accept the PSC's determination that no changes are needed to accommodate the language we had suggested since this can be filed with the IIPRC if needed.

4. GRACE PERIODS

APPLIES: §3. C.(6) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

C. REQUIRED PROVISIONS

Each policy shall contain all of the provisions as set forth below. The company may, at its option, substitute for one or more of the provisions below corresponding provisions of different wording approved by the Interstate Insurance Product Regulation Commission as not less favorable in any respect to the insured and/or owner.

(6) **Grace Period**.

(a) The policy shall include a provision that states that a grace period of a certain number of days shall be granted for the payment of each premium due after the first premium, and the policy shall remain in force during the grace period. For premiums paid on a weekly basis, a grace period of at least seven days shall be granted by the company. For premiums paid on a monthly basis, a grace period of at least ten days shall be granted by the company. For all other premium modes, a grace period of at least 31 days shall be granted by the company.

(b) In a policy which the company reserves the right to refuse renewal, the grace period provision shall state that the owner has a grace period unless, not less than 30 days prior to the renewal date, the company has delivered to the owner (or sent by first class mail to the owner) written notice of the company’s intent not to renew the policy beyond the period for which premium has been accepted by the company. The provision shall state that the company may refuse renewal of the policy, only as of the renewal date occurring on, or nearest the policy’s first anniversary, or as of an anniversary of such renewal date, or at the option of the company, as of the renewal date occurring on or nearest the anniversary of the policy’s date of last reinstatement.

COMMENTS:

Industry Comments: The IAC suggested rewording the Grace Period provision to combine language in the individual and group Disability Income Insurance standards. The IAC did not provide an explanation for the request beyond 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:

(1) The policy shall include a grace period provision and describe the conditions of the provision.

(2) A grace period shall be provided for the payment of any *Premium* due except for the first, as follows:

(a) For *Premiums* paid on a weekly basis, at least seven (7) days;

(b) For *Premiums* paid on a monthly basis, at least ten (10) days; and

(c) For all other *Premium* modes, at least thirty-one (31) days.

(3) The coverage shall continue in force during the grace period. However, if *Premium* is not paid by the end of the grace period, coverage will automatically end on the date of the last period for which *Premium* was paid.

(4) The policy may state that if an insured dies during the grace period, the overdue *Premium* will be deducted from any *Disability* benefits payable under a policy.

(5) In a policy which the company reserves the right to refuse renewal, the grace period provision shall state that the owner has a grace period unless, not less than thirty (30) days prior to the renewal date, the company has delivered to the owner (or sent by first class mail to the owner) written notice of the company's intent not to renew the policy beyond the period for which *Premium* has been accepted by the company. The provision shall state that the company may refuse renewal of the policy, only as of the renewal date occurring on, or nearest the first *Policy Anniversary*, or as of an anniversary of such renewal date, or at the option of the company, as of the renewal date occurring on or nearest the anniversary of the policy's date of last reinstatement.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any questions or concerns from filers regarding the grace period provision, but notes that item (4) as suggested by the IAC is not currently specified in the individual standards, and such an addition, as well as rewording may add clarity.

IIPRC Office Recommendation: The IIPRC Office has no specific recommendation but suggests that the PSC discuss whether it wishes to revise the provision for clarity.

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

We wanted to make the IDI and Life Insurance provisions more consistent with each other to ease combination sales. We included the second sentence in item (3) which is not in the life standards because the companies have had significant issues collecting premiums for a grace period. While coverage may be continued during a grace period, at some point a premium for that period is still due and has to be paid. Some owners/insureds think that "grace period" means "free period". If premium is never paid, the policy ends on the date of the last period for which premium was paid.

Upon reconsideration, we agree to delete item (4). If one is receiving disability benefits under the policy, premiums are waived so there are no premiums due. If someone is not receiving disability benefits under the policy, upon their death the policy ends.

Insurance Compact Office update following the September 26, 2017 PSC Member Call: The PSC noted that the IAC has now requested deleting item (4) in their revised language since an insured receiving disability benefits is not paying premium. Noting that the suggested change is essentially to reformat existing language for clarity and to specifically state that if *Premium* is not paid by the end of the grace period, coverage will automatically end on the date of the last period for which *Premium* was paid, the PSC agreed to recommend this revision.

(6) Grace Period.

(a) The policy shall include a grace period provision ~~that states that a grace period of a certain number of days shall be granted for the payment of each premium due after the first premium, and the policy shall remain in force during the grace period.~~ and describe the conditions of the provision.

(b) A grace period shall be provided for the payment of any Premium due except for the first, as follows:

(i) For Premiums paid on a weekly basis, ~~a grace period of~~ at least seven (7) days ~~shall be granted by the company~~;

(ii) For Premiums paid on a monthly basis, ~~a grace period of~~ at least ten (10) days ~~shall be granted by the company~~; and

(iii) For all other Premium modes, ~~a grace period of~~ at least thirty-one (31) days ~~shall be granted by the company~~.

(c) The coverage shall continue in force during the grace period. However, if *Premium* is not paid by the end of the grace period, coverage will automatically end on the date of the last period for which *Premium* was paid.

(~~b~~d) In a policy which the company reserves the right to refuse renewal, the grace period provision shall state that the owner has a grace period unless, not less than 30 days prior to the renewal date, the company has delivered to the owner (or sent by first class mail to the owner) written notice of the company's intent not to renew the policy beyond the period for which premium has been accepted by the company. The provision shall state that the company may refuse renewal of the policy, only as of the renewal date occurring on, or nearest the policy's first anniversary, or as of an anniversary of such renewal date, or at the option of the company, as of the renewal date occurring on or nearest the anniversary of the policy's date of last reinstatement.

5. CHANGE TERM "PRODUCER" TO "AGENT"

APPLIES: §3. C.(17) and (18) of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

C. REQUIRED PROVISIONS

Each policy shall contain all of the provisions as set forth below. The company may, at its option, substitute for one or more of the provisions below corresponding provisions of different wording approved by the Interstate Insurance Product Regulation Commission as not less favorable in any respect to the insured and/or owner.

(17) **Right to Examine Policy**.

(a) The Right to Examine Policy provision appearing on the cover page or that is visible without opening the policy shall provide a minimum of 30 days for the owner to examine the policy, beginning on the date the policy is received by the owner.

(b) The provision shall include a requirement for the return of the policy to the company or a producer of the company, and state that the policy is considered void from the beginning and the parties shall be in the same position as if no policy had been issued. The provision shall state that if the policy is returned, a refund of any premium paid, including any policy fees or other charges shall be made.

(18) **Suspension of Coverage While in Military Service**.

(a) The policy shall include a provision that entitles persons in military service to have their coverage suspended during a period of military service. To be entitled to coverage suspension an insured shall:

(i) Be in the military service (land, sea or air) of any nation or international authority or in a reserve component of the armed forces of the United States, including the National Guard; and

(ii) Have entered voluntarily or involuntarily upon active duty or had active duty voluntarily or involuntarily extended (other than for the purpose of determining physical fitness and other than for training). The policy may state that there shall be no entitlement to coverage suspension for a period of active military training lasting three months or less.

(b) The company may restrict the period of suspension of coverage to five years beyond the date of suspension but not to exceed the period of active duty. The policy shall state that in the implementation of the coverage suspension:

(i) The owner shall make a written request to the company or its producer for coverage suspension providing information that the insured is eligible for the coverage suspension; and

(ii) The company shall suspend the coverage for eligible insureds from the date of receipt of the owner's written request for coverage suspension (or a later date if requested by the owner) and refund any unearned premiums for the period of suspension.

COMMENTS:

Industry Comment: The IAC suggests that reference to producer be changed to agent for consistency with other standards, and that the phrase "as applicable" be added since not all companies have agents. In addition the IAC suggests that the provision in (18) regarding when the suspension is in effect should be the earlier of the date the company receives the owner's written request or the date military service begins.

IIPRC Office Comments/Observations: The IIPRC Office is not aware of any questions or confusion from filers regarding this provision, but notes that the term "agent" instead of "producer" is used in the life, annuity and long-term care insurance uniform standards. The words "as applicable" are not included in other standards and the IIPRC Office is not aware of any concerns related to the lack of this language.

IIPRC Office Recommendation: The IIPRC Office recommends that the PSC consider substituting "agent" for "producer" and also consider if the following revision to clarify that the date of change is the earlier of the date of the written request or the date the military service begins would be appropriate:

(17) **Right to Examine Policy**.

(b) The provision shall include a requirement for the return of the policy to the company or ~~a producer~~ an agent of the company, and state that the policy is considered void from the beginning and the parties shall be in the same position as if no policy had been issued. The provision shall state that if the policy is returned, a refund of any premium paid, including any policy fees or other charges shall be made.

(18) **Suspension of Coverage While in Military Service**.

(b) The company may restrict the period of suspension of coverage to five years beyond the date of suspension but not to exceed the period of active duty. The policy shall state that in the implementation of the coverage suspension:

(i) The owner shall make a written request to the company or its ~~producer~~ agent for coverage suspension providing information that the insured is eligible for the coverage suspension; and

(ii) The company shall suspend the coverage for eligible insureds from the earlier of the date of receipt of the owner's written request for coverage suspension or the date military service begins (or a later date if requested by the owner) and refund any unearned premiums for the period of suspension.

Insurance Compact Office update following the September 26, 2017 PSC Member Call: The PSC agreed that one term should be used consistently in the uniform standards and that it appeared in most standards the reference was to agent or agent of the company. The PSC agreed to recommend use of the word agent rather than producer. Compact staff noted that in addition to the two areas noted by the IAC, the term producer was used in other sections of this standard, so she would review and make the needed proposed revisions. The PSC agreed to the other recommendations for clarity under the Suspension of Coverage While in Military Service provision of the standards.

6. DATE POLICY ENDS

APPLIES: §3.H. BENEFIT PROVISIONS of the Standards for Individual Disability Income Insurance Policies

CURRENT PROVISON:

There is no specific current standard for the Date Policy Ends

COMMENTS:

Industry Comment: The IAC requested adding a Date Policy Ends standard to the Benefit Provisions, since not all disability benefits ending result in the policy ending. The following is the language suggested by the IAC:

(1) A policy will end, as applicable, at the earliest of:

(a) The expiry date shown in the policy, unless an insured renews the policy as provided in the renewal provisions of the policy;

(b) The end of the period for which *Premium* has been paid, if *Premium* is not paid by the end of the grace period;

(c) The date the company receives the owner's written request to end the policy;

(d) The date the policy ends under the Suspension of Coverage While in Military Service and the insured does not request that suspension end before the five (5) year suspension period would otherwise expire;

(e) The date the policy ends under the Suspension of Coverage While Unemployed if the insured does not resume *Premium* payment when the suspension benefit ends; [Note: this is based on the request in Substantive Item #12] or

(f) The date the insured dies.

IIPRC Office Comments/Observations: The IIPRC Office notes that filed IDI policies usually contain a provision regarding when the policy ends that is specific to the type of policy. The IIPRC Office does not object to the inclusion of termination provisions within the policy and reviews these provisions as they relate to type of policy (noncancellable, guaranteed renewable or conditionally renewable) and the Payment of Premium and Reinstatement provisions within the standards.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider whether the suggested addition to the standards referencing when the policy ends will provide further clarity.

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

We think the title of the provision should be "Date Disability Policy Ends". We also suggest adding the following provision since the date the policy ends and the date the disability benefit ends are each subject to their own triggers:

DATE DISABILITY BENEFITS END

(1) The policy shall state that *Disability* benefits shall end at the earliest of:

(a) The date an insured ceases to be *Disabled*;

(b) The date an insured dies;

(c) The end of any specified *Benefit Periods* shown in the policy;

(d) The end of any maximum period of payment specified in the policy. "Maximum period of payment" means the longest period of time that a company will make payments to an insured for any one period of *Disability*;

(e) For any condition specified in the policy with limited benefits, the end of any lifetime maximum *Benefit Period* specified in the policy for that condition. "Lifetime maximum *Benefit Period*" means the aggregate number of months of benefits which will be paid to an insured during his/her lifetime for any combination of *Disabilities* caused or contributed to by the specified condition, even if the *Disabilities* are not continuous; and

(f) The date an insured fails to submit satisfactory *Proof of Loss* as required in the policy.

(2) The policy may also include these additional dates that *Disability* benefits may end:

(a) The date an insured fails to participate in a Rehabilitation plan, without good cause, as stated in section §__. REHABILITATION PROVISIONS of the policy;

(b) The date an insured elects not to return to limited work while *Disabled* when the insured is functionally capable of performing such work; and

(c) The date an insured retires.

Insurance Compact Office update following the September 26, 2017 PSC Member Call: The Compact staff noted that most filings received for disability income insurance products do contain a Termination provision, and that the Compact does not object to these provisions as long as they are consistent with the uniform standards. Staff noted that most other uniform standards do have Termination standards. The Compact staff suggested that a termination provision consistent with other standards and with approved filings would add clarity. Compact staff noted that most disability income insurance policy filings do not contain a separate section in the policy specific to when disability benefits end as requested in the IAC's additional comments, since many benefits are interwoven and the whole policy must be considered. When benefits end is addressed in various ways throughout the standards. The PSC agreed that in concept, pending the Compact office draft revisions to the IAC suggestions to create less prescriptive requirements, with the idea of adding a Termination provision consistent with other uniform standards. They concluded that the addition of another provision for when benefits end would cause confusion and was unnecessary given the ability to address benefit limitations and termination of benefits within the existing individual disability income insurance uniform standards.

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

The PSC agreed to expose the following Termination provision for comment:

Termination of Insurance Under the Policy

(1) The policy shall include a provision stating how and when insurance under the policy may end. The provision may include termination,.~~A policy will end,~~ as applicable, at the earliest of:

(a) The expiry date shown in the policy, unless an insured renews the policy as provided in the renewal provisions of the policy;

(b) The end of the period for which *Premium* has been paid, if *Premium* is not paid by the end of the grace period;

(c) The date the company receives the owner's written request to end the policy;

(d) The ~~date the policy ends under the~~ expiration of applicable Suspension of Coverage ~~While in Military Service and~~ period(s) specified in the policy if the insured does not request that suspension end before ~~the five (5) year suspension period would otherwise expire~~ such expiration; or

(e) ~~The date the policy ends under the Suspension of Coverage While Unemployed if the insured does not resume *Premium* payment when the suspension benefit ends; or~~

~~(f)~~ The date the insured dies.

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

The term "termination" is used in the proposed new title but the term "end" is used within the provision. For readability reasons industry has abandoned "termination" in favor of "end". In either case, terms should be consistent.

We withdraw our request for a "Date Disability Benefits Ends" provision.

In follow up communication, the IAC requested that the comments regarding termination and end be disregarded since other standards use the same language included in this proposal.

Insurance Compact Office update following the Nov. 14, 2017 PSC Member Call: The Compact staff advised the PSC that the IAC asked that their comments regarding use of "termination" and "end" be withdrawn since other Uniform Standards use both and policies can use either term.

7. ACTIVELY AT WORK AND FULL TIME STATUS

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

CURRENT PROVISON

§ 4. ADDITIONAL STANDARDS FOR UNDERWRITING QUESTIONS

E. ACTIVELY AT WORK

(1) The application may include a question regarding if the proposed insured, within a specified period of time (not to exceed 180 days prior to the date of application) has not been continuously at work on a full-time basis (minimum of 30 hours per week) performing the duties of their occupation due to an injury or sickness. For any "yes" answer, details may be requested such as: number of days missed due to the injury or sickness, specification of the injury or sickness, explanation of inability to work; name, address and telephone number of medical professional or facility consulted; diagnosis; treatment prescribed; medications prescribed; date of onset and recovery.

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office has received questions related to this provision and whether it means that only IDI policy forms covering full time workers may be filed through the Insurance Compact. The IIPRC Office currently applies the minimum 30 hours parenthetical only to situations where the insurer is asking the question related to applicants who work full-time. Since there is limitation expressed in the Individual Disability Income Insurance Application Standards or the Standards for Individual Disability Income Insurance Policies for part-time workers, the IIPRC Office does not limit this question to only full-time employees.

IIPRC Office Recommendation: The IIPRC Office suggests that the PSC consider the following revision to make it clear that the question can apply to both full-time and part-time employment as applicable and to provide further clarity:

(1) The application may include a question regarding if the proposed insured, within a specified period of time (not to exceed 180 days prior to the date of application) has not been continuously at work <u>for the prescribed hours</u> ~~on a full-time basis (minimum of 30 hours per week)~~ performing the duties of their occupation due to an injury or sickness. For any "yes" answer, details may be requested such as: number of days missed due to the injury or sickness, specification of the injury or sickness, explanation of inability to work;

name, address and telephone number of medical professional or facility consulted; diagnosis; treatment prescribed; medications prescribed; date of onset and recovery.

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 agree with the Report suggestion as long as companies can use whatever hourly requirement that is appropriate.

Insurance Compact Office update following the August 29, 2017 PSC Member Call: The PSC noted that the purpose of the clarification is to make it clear that the question is not just applicable when the applicant works full time hours and can be phrased to address the applicable prescribed hours. The PSC agreed with the language recommended by the Compact office.

(1) The application may include a question regarding if the proposed insured, within a specified period of time (not to exceed 180 days prior to the date of application) has not been continuously at work for the prescribed hours ~~on a full-time basis (minimum of 30 hours per week)~~ performing the duties of their occupation due to an injury or sickness. For any "yes" answer, details may be requested such as: number of days missed due to the injury or sickness, specification of the injury or sickness, explanation of inability to work; name, address and telephone number of medical professional or facility consulted; diagnosis; treatment prescribed; medications prescribed; date of onset and recovery.

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

We agree with the Report suggestion since there is consensus that companies can use whatever hourly requirement that is appropriate.

8. DISCOUNTS FOR MULTI-LIFE PLANS

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

CURRENT PROVISON:

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:

(b) For multi-life plans, the company may use “premium class” to establish discounts based on case characteristics, documented in the Actuarial Memorandum, such as, for example, number of lives, who pays the premium, and/or premium mode. The criteria for the discount should be applied consistently between groups. In addition, the company shall submit adequate experience data to support the use of the same Minimum Loss Ratio (MLR) requirement for multi-life plans utilizing a discount as for those where a discount is not applicable. Such experience data should indicate that any expense savings occurring as a result of the discount are accompanied by a commensurate reduction in expected claims costs for multi-life plans where the discounts are applied.

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office actuaries question whether the sentence “In addition, the company shall submit adequate experience data to support the use of the same Minimum Loss Ratio (MLR) requirement for multi-life plans utilizing a discount as for those where a discount is not applicable” should be referencing the Anticipated Loss Ratio (ALR) rather than the MLR. Since the experience data should indicate that “any expense savings occurring as a result of the discount are accompanied by a commensurate reduction in expected claims costs,” it seems to imply ALR rather than MLR.

IIPRC Office Recommendation: The IIPRC Office suggests that if the PSC is uncertain if this is a typographical error or not, that they refer the matter to the Actuarial Working Group for their recommendation.

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 think the reference is to the ALR. The MLR is a minimum loss ratio that is set in the standards. This minimum may vary based on whether the policy is Noncancellable, Guaranteed Renewable, etc., but it does not vary by whether the product is multi-life or not. The standard seems to be looking for a comparison of the expected multi-life loss ratio with the expected non-multi-life loss ratio which would be through the ALR.

Insurance Compact Office update following the August 29, 2017 PSC Member Call: The PSC agreed to refer this item to the Actuarial Working Group for their review and input.

Insurance Compact Office update following the Dec. 19, 2017 PSC Member Call: The AWG reported that they agreed that in the sentence in the standards "In addition, the company shall submit adequate experience data to support the use of the same Minimum Loss Ratio (MLR) requirement for multi-life plans utilizing a discount as for those where a discount is not applicable," the reference should be to the Anticipated Loss Ratio (ALR) rather than the MLR. The members concluded that they had no actuarial concerns with the proposed revision. The PSC agreed with the AWG recommendation.

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

As proposed [on page 106] the standard would require companies to affirm that the ALR is the same for all multi-life discount levels. This presumes that all multi-life discounts are funded exclusively by reduced claim costs. However, there are other reasons why a company might offer a multi-life discount. A discount might be partially funded by reduced operating expenses – for example, by using list bills rather than traditional billing practices. In such a case, the multi-life plan would have a different ALR than policies where no discount is available.

Additionally, the proposed language implies that the only permissible discounts are multi-life discounts. Several IDI companies offer discounts on traditional individual sales as well. In previous filings, the companies have been required to report ALRs for all of their discounts.

We suggest that the PSC consider:

1. Eliminating the requirement to use the same ALR for all levels, but retain the requirement that the company report an ALR for each discount level.

2. Eliminating all references to multi-life, thus clarifying that the requirement applies to all discounts regardless of when they apply.

Based on these comments, the Compact staff believes the IAC is suggesting the following changes to the proposal:

In addition, the company shall submit adequate experience data to support the use of the ~~same~~ Anticipated Loss Ratio (ALR) requirement for ~~multi-life~~ plans utilizing a discount as for those where a discount is not applicable. Such experience data should indicate that any expense savings occurring as a result of the discount are accompanied by a commensurate reduction in expected claims costs for ~~multi-life~~ plans where the discounts are applied.

Insurance Compact Office update following the Feb. 20, 2018 PSC Member Call: The Committee agreed to the suggested revisions from the IAC.

9. MINIMUM LOSS RATIO FOR MULTI-LIFE DISCOUNT LEVELS

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

CURRENT PROVISON:

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;

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office actuaries request that filers document the MLR for each of the different multi-life discount levels. This is not always included in the initial actuarial memorandum, resulting in additional delays and review time.

IIPRC Office Recommendation: The IIPRC Office suggests that the standards be clarified as follows so filers know to submit the MLR documentation for each different multi-life discount level:

(g) A description of the determination of the MLR applicable to the policy form, including, when applicable, each multi-life discount level. The MLR shall be determined as follows:

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 suggested change is contradictory to what is proposed in Clarification #8 above. The MLR is what it is based on whether the policy is Noncancellable, Guaranteed Renewable, or Conditionally Renewable. The ALR may vary by the size of the discount, but the ALR has to be equal to or greater than the prescribed MLR.

Insurance Compact Office update following the August 29, 2017 PSC Member Call: The Insurance Compact office stated that they believe that the IAC may have misunderstood the intent of this clarification item. The reference to MLR in this provision is to the adjusted MLR. Although the Initial MLR is determined by renewability category, the reference in this item is to the MLR following the adjustments as outlined in B.(1)(g)(ii). The PSC agreed to refer this item to the Actuarial Working Group for their review and input.

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

Our July 10, 2017 comments were presumed to be a "misunderstanding of the intent of this clarification item." We understand that the clarification was referring to the adjusted MLR and that the ALR has to be greater than the adjusted MLR. However, just because there is a multi-life discount does not necessarily mean that the MLR will have to be adjusted. The guidelines say that the adjustment takes place if the average expected premium is less than $2,500. This $2,500applies whether there is a discount or not. It is not the discount that is the trigger – the trigger is the average expected premium. Basically, the guidelines for determining what the MLR is have to be followed whether there is a multi-life discount or not.

Insurance Compact Office update following the Dec. 19, 2017 PSC Member Call: The AWG reported that the Compact staff explained that multi-life discounts that the Compact has seen are more related to worksite marketed products, not partnership coverage or insured with spouse coverage. The adjusted MLR might be different by discount level if a Company is adjusting the MLR due to the average annual premium being less than $2,500. The Compact asks companies to provide additional documentation in the filing to include a comparison of the ALR to the adjusted MLR separately for each available multi-level discount. Following the explanation, the AWG concluded that they had no actuarial concerns with the proposed revision. The PSC agreed with the AWG recommendation.

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

As proposed on page 106, the standard would require companies to affirm that the ALR is the same for all multi-life discount levels. This presumes that all multi-life discounts are funded exclusively by reduced claim costs. However, there are other reasons why a company might offer a multi-life discount. A discount might be partially funded by reduced operating expenses – for example, by using list bills rather than traditional billing practices. In such a case, the multi-life plan would have a different ALR than policies where no discount is available.

Additionally, the proposed language implies that the only permissible discounts are multi-life discounts. Several IDI companies offer discounts on traditional individual sales as well. In previous filings, the companies have been required to report ALRs for all of their discounts.

We suggest that the PSC consider:

1. Eliminating the requirement to use the same ALR for all levels, but retain the requirement that the company report an ALR for each discount level.

2. Eliminating all references to multi-life, thus clarifying that the requirement applies to all discounts regardless of when they apply. On page 106, we suggest removing the term "multi-life," and "level" so that it reads:

"A description of the determination of the MLR applicable to the policy form, including, when applicable, each ~~multi-life~~ discount ~~level~~."

Insurance Compact Office update following the Feb. 20, 2018 PSC Member Call: The Committee agreed to the suggested revisions from the IAC.

10. EXPENSES AND CONTINGENCY AND RISK MARGINS

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

CURRENT PROVISON:

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:

(f) A brief description of how rates were determined for each marketing methodology, including the complete description and source of each assumption used in pricing the product including, but not limited to:

(i) Mortality;

(ii) Voluntary termination (if separate from mortality);

(iii) Morbidity (including any trend assumption);

(iv) Investment return;

(v) Distribution of business (by mode, premium class, sex, issue age, etc.); and

(vi) Expenses, including contingency/risk margins (for expenses, pricing variations that reflect percent of premium, dollars per policy and/or dollars per unit of benefit shall be included as well as overall expenses plus contingency and risk margins as a percent of premium on a present value basis);

COMMENTS:

IIPRC Office Comments/Observations: The IIPRC Office actuaries note that filers often fail to provide overall expenses plus contingency and risk margins as a percent of premium on a present value basis as required in (2)(f)(vi), resulting in objections being issued which delays form review.

IIPRC Office Recommendation: The IIPRC Office suggests that (2)(f)(vi) be reformatted as follows to draw attention to the complete requirements:

(vi) Expenses, including contingency/risk margins shall include:

A. ~~(f~~For expenses, pricing variations that reflect percent of premium, dollars per policy and/or dollars per unit of benefit; and ~~shall be included~~

B. ~~Include as well as o~~Overall expenses plus contingency and risk margins as a percent of premium on a present value basis~~)~~.

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 have no issues or concerns with this clarification.

Insurance Compact Office update following the August 29, 2017 PSC Member Call: At the request of a member, the PSC agreed to ask the AWG to review this item prior to making a recommendation to make sure the language is as clear as possible.

Insurance Compact Office update following the Dec. 19, 2017 PSC Member Call: The AWG reported that they had no actuarial concerns with this proposal. The PSC agreed.

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

The Utah Insurance department submitted the following comments:

On behalf of the State of Utah, I'd like to offer the following comments regarding Standards for Initial Rate Filings for Individual Disability Income Insurance.

The paragraph describing information to be submitted in regard to expenses, 2.B.(1)(f), is not very clear. We would suggest rewriting it along the following lines:

(vi) Expenses, including contingency/risk margins, expressed in two different ways:

A. as pricing variations that reflect percent of premiums, dollars per policy and/or dollars per unit of benefit; and

B. as a percent of lifetime premium on a present value basis.

Regardless of the language used to describe the requirement it would also be useful to provide an example.

Insurance Compact Office update following the Feb. 20, 2018 PSC Member Call: The Committee discussed the comment and determined that the Compact actuaries understood the requirements and the proposed revisions and Industry had no objections to the initial proposed revision, so they concluded no further change was needed.