

Jennifer Wheatley
Senior Counsel
Regulatory and State Government Affairs



July 3, 2012

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Routing 584
8505 East Orchard Road
Greenwood Village, CO 80111
Telephone 303.729.8459
Fax 303.729.8433
Jennifer.Wheatley@Cigna.com

Dear Commissioner Jones:

Pursuant to California Insurance Code section 12938(b)(2), Life Insurance Company of North America ("the Company" or "we") hereby submits its response to the California Department of Insurance ("Department") published report of the targeted market conduct reexamination of its group long term disability claims closed during the period from January 1, 2009 through December 31, 2010 ("Exam Report"). This reexamination was made pursuant to an executed Stipulation and Waiver Agreement dated August 18, 2009 ("2009 Stipulation and Waiver") between the Department and the Company in resolution of the previous examination.

The Company has invested considerable time and resources into establishing a high-quality, efficient and robust claims experience for its insureds and vigorously objects to the allegations made in the Exam Report. As the Company demonstrated repeatedly throughout the reexamination process and prior to the issuance of the Final Report, its claims handling practices are in compliance with California law and with the standards agreed to by the Department in the 2009 Stipulation and Waiver that resolved the previous examination. In fact, in many instances, the Company's claim practices exceed those standards.

The Department now criticizes the Company for failing to meet standards that it had not articulated at the time of the 2009 Stipulation and Waiver and that exceed the requirements of California law. Moreover, as the Company sets forth below in more detail, these standards are, in some instances, contrary to California law and potentially detrimental to California claimants. Furthermore, the Department has taken a few isolated instances of claims handling error and is branding them general unfair business practices.

1. Investigation of a Claim

A. The Department's standards are not reflective of California law and exceed the standards articulated by the Department in 2009.

The Exam Report states that in a number of instances the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim. In making these allegations, the Department takes the position that the Company must obtain:

- The Workers' Compensation and Social Security Disability Income records of every claimant, regardless of their relevance to the claim determination and whether the same information has been gathered directly from other sources, including the claimant's providers.

- An Independent Medical Examination (IME) or Functional Capacity Examination (FCE) in every instance where it disagrees with the claimant's provider that the claimant is "Disabled," even though there may be no disagreement with respect to the claimant's diagnosis, condition or functional capacity and/or the IME or FCE may not provide insight into the claimant's condition during the time period relevant to the liability determination.
- The claimant's full medical records in every instance, regardless of whether such records would be relevant temporally or otherwise to the claimant's Disabling condition(s) or the liability decision.

The requirements now enunciated by the Department in the Exam Report are far beyond the mandates of California law and the agreement reached in the 2009 Stipulation and Waiver. Moreover, in some instances, these requirements would put the Company at risk of "seeking information not reasonably required for or material to the resolution of a claim" in violation of California insurance regulation section 2695.7(d). Seeking such information could possibly delay the determination of the claim. California law recognizes the balance between gathering information relevant to the claim determination without crossing into overly burdensome requests for information not reasonably relevant to determining liability. California insurance code section 790.03 holds insurers to a "reasonableness" and "relevance" standard with respect to the investigation of claims.

B. Consistent with California law, the Company reasonably, diligently and thoroughly conducts a fair and objective investigation of claims while simultaneously avoiding requesting information that is not reasonably required or relevant to the claim determination.

1. Workers' Compensation and Social Security Administration Records

Consistent with California's legal and regulatory requirements, the Company is committed to identifying and obtaining all records **relevant** to the claim determination and has internal policies and procedures that make it clear that information should be gathered from all relevant sources, including Worker's Compensation carriers, the Social Security Administration, and other applicable entities. The Department agreed that this practice was consistent with California law in the 2009 Stipulation and Waiver. However, the Department now insists that in every instance the Company must obtain records directly from the Workers' Compensation carrier and/or Social Security Administration, regardless of the relevance to the claim determination or whether the information has been gathered directly from the claimant or claimant's medical providers. This bright-line rule would require the Company to seek information not reasonably required for or material to the resolution of the claim and could possibly delay the determination of a claim where the Company already has all relevant information. Clearly, such a requirement is outside the letter and spirit of California law.

2. IME and FCE

The Company agrees that appropriate utilization of specialty medical resources supports evaluation of the claimant "as a whole." To this end, the Company encourages its claims staff to contact treating providers to resolve outstanding questions regarding a claimant's condition. In addition, the Company has extensively trained claims staff regarding when an IME or FCE should be requested and clarified expectations for the utilization of appropriate medical resources to aid in the evaluation of functional capacity. The parties' discussions during the previous exam recognized that this approach of applying the right resource at the right time to obtain relevant information and avoid unnecessary delay

was both reasonable and consistent with California law. However, the Department now insists that the Company obtain an IME or FCE in every instance where it disagrees with the claimant's provider that the claimant is "disabled," even though there may be no disagreement with respect to the claimant's functional capacity and/or the IME or FCE will not provide insight into the claimant's condition during the time period relevant to the liability determination. Again, the Department's position requires the Company to seek information not reasonably required or material to the claim determination and may unnecessarily delay determination of the claim.

3. Medical Records

The Company agrees that medical records are an integral part of the Disability claim investigation. In recognition of the challenge of obtaining medical records from California providers, the Company agreed in the 2009 Stipulation and Waive to expand methods for requesting medical documentation. For example, several of the larger California providers refuse to release records in response to any authorization form other than their own and also require pre-payment for records and use of a third-party copy service to physically copy and/or transmit the records. The Company created a Medical Records Clerk position dedicated to focusing on making medical requests, expanded use of copy services to obtain records (at the Company's expense), implemented a Verbal Authorization system that allows claimants to provide a verbal authorization that can be documented and reproduced in hard-copy format, and began to maintain and utilize medical authorizations specific to California major medical providers such as Kaiser Permanente and Cedars-Sinai Medical Center. However, the relevance of medical records to the Disability claims investigation, generally, does not and should not mean that all of a claimant's medical records are relevant to the claim determination in every instance. For example, records reflecting treatment of a condition unrelated to the disabling condition or that are so old as to be irrelevant to the claimant's current condition would not be relevant to the liability determination and should not be required under California insurance regulation section 2695.7(d). The Department's current insistence that the claimant's complete medical records be obtained in every instance, regardless of whether the particular records are relevant temporally or otherwise, again forces the Company to seek immaterial and irrelevant information, in contravention of section 2695.7(d), and impedes its ability to complete a reasonable and prompt investigation.

2. The Definition of "Total Disability"

A. **The Department's interpretation of own-occupation coverage is contrary to California law.**

The Exam Report also criticizes the Company for its interpretation of "total disability." Like many other insurers, the Company's group long term disability policies provide benefits to claimants who become disabled from their "own occupation" for a period of time after which the claimant will continue to receive benefits if they are disabled from "any occupation." California law provides that a claimant is disabled from his own occupation when he is "unable to perform with reasonable continuity the substantial and material acts necessary to pursue his [the claimant's] usual occupation in the usual or customary way." See *Erreca v. Western States Life Ins. Co.*, 19 Cal.2d 388 (1942), *Moore v. American United Life Ins. Co.*, 150 Cal.App.3d 610 (1984). A claimant is disabled from any occupation under California law when he/she is unable to "engage with reasonable continuity in another occupation in which he or she could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity. *Moore*, 150 Cal. App. 3d at 632.

The Company's process in evaluating whether a claimant is disabled from their own occupation is to first seek job description information from the claimant, the employer and, where applicable, refer to the catalogue of job descriptions provided by the employer. While the Company may refer to the occupational description from the Dictionary of Occupational Titles ("DOT") as a reference point, in every instance the Company analyzes the substantial and material acts of the claimant's usual occupation, including considering whether the claimant's usual occupation may differ from the corresponding description in the DOT. The Company's practices in this regard are in compliance with California law.

The Department refers to the Company's failure to obtain information "of jobs that actually exist in the job market" including "the geographical location of the occupation." In doing so, the Department attempts to re-write California's existing legal standard by requiring the Company to determine whether the claimant can return to work at his *same job for the same employer*. The policies at issue provided group disability "own occupation" coverage, not "own job" coverage. "Own job" disability insurance coverage is available in the marketplace, but typically at a far greater cost than "own occupation" coverage because of the greater coverage it offers. The employer/policyholders here chose "own occupation" coverage making a determination that that type of coverage was right for themselves and their employees. Nevertheless, the Department continues to insist that a claimant is disabled from their own occupation if s/he can not return to work at the same job for the same employer. The Department's interpretation of "own occupation" coverage would transform that coverage into "own job" coverage in every instance, rendering the decisions of policyholders about their own coverage moot and driving the price of coverage beyond most purchasers ability. Furthermore, this interpretation was not articulated by the Department in 2009 and is contrary to California case law.

B. The Department's interpretation of "station in life" exceeds California law.

With respect to the evaluation of whether a claimant is disabled from "any occupation," the Company must identify alternative occupations which are in line with the claimant's station in life, training, education, and employment history. If the claimant can not engage with reasonable continuity in the alternative occupations identified, California law provides that s/he is determined to be disabled from any occupation.

In identifying appropriate alternative occupations, the Company considers whether the alternative occupation provides earnings commensurate with the claimant's pre-disability earnings. To do so, the Company first relies on any wage replacement threshold chosen by the policyholder as set forth in the policy. For example, the policy may dictate that the Company may only consider alternative occupations as aligned with the claimant's "station in life" if they provide wages of at least sixty to eighty percent (60-80%) of the claimant's pre-disability earnings. Where the policy is silent, the Company uses an eighty percent (80%) wage replacement standard, which the Department previously agreed was an acceptable standard in 2009. This analysis, in conjunction with an analysis of the claimants' education, training and experience, appropriately considers the claimant's "station in life" when determining alternative occupations in compliance with California law.

However, the Department now insists that the Company only consider alternative occupations that provide wages "approximately the same" as the claimant's pre-disability earnings, which would equate to a wage replacement threshold of at or near one hundred percent (100%). This far exceeds the standard previously articulated by the Department and in all cases exceeds the threshold chosen (and paid for) by the policyholder. The Department's position disregards the fact that the Company was obligated to handle claims in accordance with its policy language. Moreover, its position is an interpretation of "station in life" that is beyond the requirements of California law.

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Thank you for this opportunity to provide comments to the Exam Report. For the reasons herein, the Company disputes the accuracy of the findings and maintains that it has acted in compliance with California law.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Wheatley". The signature is fluid and cursive, with the first name being the most prominent.

Jennifer Wheatley, Esq.

Senior Counsel

Regulatory and State Government Affairs

cc: Towanda David
Pam O'Connell
Kara Baysinger
Stephanie Duchene