



**STATE OF NEW YORK
INSURANCE DEPARTMENT
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ALBANY, NEW YORK 12257**

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Governor**

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**Supplement No. 1 to Circular Letter No. 14
(2007)**

February 27, 2008

TO: All Insurers Licensed to Write Accident and Health Insurance in New York State

RE: Pre-existing condition provisions and elimination period provisions in group and blanket disability policies

STATUTORY REFERENCE: Section 3234 of the Insurance Law (as added by Chapter 650 of the Laws of 1993)

Subsequent to the Department's issuance of Circular Letter No. 14 (2007), which discussed the impact and application of the New York Court of Appeals' recent decision in *Benesowitz v. Metropolitan Life Insurance Company*, 8 NY3d 661 (2007), the Department received inquiries about the interplay between the statutory pre-existing condition waiting period set forth in Insurance Law Section 3234(a)(2) and the elimination period contained in many group and blanket disability policies. The issue arises in the very narrow set of circumstances where an insured who has no credit for prior disability coverages (as described in Insurance Law Section 3234(a)(1)) is healthy enough to be hired but has a pre-existing condition that leads to her total disability during the policy's pre-existing condition waiting period, and where the policy also includes an "elimination period." Although the term "elimination period" is not defined in either the New York Insurance Law or regulations promulgated thereunder, the Department recognizes that it and similar terms are nonetheless used in many disability policies. Elimination periods generally set forth a time period before disability benefits will be paid; they serve as a mechanism by which an insured can choose, for some specified period of time, to self-insure income losses from disability. Elimination periods also serve as mechanisms for premium affordability, since the longer the insured self-insures the income loss, the lower the premium that the disability income insurer needs to charge.

As noted on the Department's website with regard to group long term disability insurance, the Department views elimination periods of no longer than 180 days as reasonable. Elimination periods of any longer duration can work a hardship on a disabled insured. Accordingly, filings that provide for elimination periods longer than 180 days typically will be disapproved pursuant to Insurance Law Section 3201(c)(3). Nevertheless, the Department will consider approval of an elimination period greater than 180 days where the insurer adequately explains why it is necessary. For example, a longer elimination period may be appropriate where the insurer has issued both short and long term disability policies together, and the elimination period is designed to prevent payment of both long and short term disability benefits at the same time.

In the wake of *Benesowitz*, the Department will expect elimination periods and pre-existing condition waiting periods in group and blanket disability policies to run concurrently rather than consecutively. To treat them as running consecutively would create the possibility of extremely long periods of time during which a disabled insured would receive no benefits. All elimination periods should be construed to run from the first date of the disability, rather than upon expiration of the pre-existing condition waiting period. Payment of benefits therefore should begin upon

expiration of the elimination period, subject to the pre-existing condition waiting period. If the pre-existing condition waiting period has been satisfied, then payment of benefits should begin upon expiration of the elimination period. In cases where the elimination period has been satisfied and the pre-existing condition waiting period has not been satisfied, payment of benefits should begin on the first day of the month following the expiration of the pre-existing condition waiting period.

The following examples illustrate the application of elimination periods and pre-existing condition waiting periods in group and blanket disability policies:

Example A: John Doe is hired on 2/1/08. Mr. Doe's disability coverage effective date is 3/1/08. Mr. Doe becomes disabled 4/1/08. The disability policy has a 6-month elimination period. (Assume that Mr. Doe is "disabled" under the terms, limitations, and conditions of the policy and that he is disabled due to a pre-existing condition.) Mr. Doe's pre-existing condition waiting period and elimination period run concurrently. Mr. Doe's elimination period ends on 10/1/08. Mr. Doe's pre-existing condition waiting period ends on 3/1/09. Mr. Doe's disability benefits begin on 3/1/09.

Example B: Mary Jones is hired on 5/1/07. Ms. Jones' disability coverage effective date is 8/1/07. Ms. Jones becomes disabled 11/1/07. The disability policy has a 6-month elimination period. (Assume that Ms. Jones is "disabled" under the terms, limitations, and conditions of the policy and that she is disabled due to a pre-existing condition.) Ms. Jones' pre-existing condition waiting period and elimination period run concurrently. Ms. Jones' elimination period ends on 5/1/08. Ms. Jones' pre-existing condition waiting period ends on 8/1/08. Ms. Jones' disability benefits begin on 8/1/08.

Example C: Sue Smith is hired on 7/1/07. Ms. Smith's disability coverage effective date is 9/1/07. Ms. Smith becomes disabled 8/1/08. The disability policy has a 6-month elimination period. (Assume that Ms. Smith is "disabled" under the terms, limitations, and conditions of the policy and that she is disabled due to a pre-existing condition.) While Ms. Smith's pre-existing condition waiting period and elimination period run concurrently for a period of time, upon the expiration of the pre-existing condition waiting period there is an additional period of time before the elimination period expires and benefits under the policy become payable. Ms. Smith's elimination period ends on 2/1/09. Ms. Smith's pre-existing condition waiting period ends on 9/1/08. Ms. Smith's disability benefits begin on 2/1/09.

Insurers writing group or blanket disability income insurance should take all necessary steps to review their policy forms and determine if policy form submissions will be necessary to comply with this Circular Letter. If revisions are necessary, insurers should submit revised policy forms or policy form amendments to the Insurance Department's Health Bureau for review and approval as soon as possible.

Questions about this Circular Letter should be directed to:

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Very Truly Yours,

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