The American Council of Life Insurers

Written Statement for the Record

for

"Do Private Long-Term Disability Policies Provide the Protection They Promise?"

Before the

United States Senate Finance Committee

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American Council of Life Insurers (ACLI) Statement for the Record
"Do Private Long-Term Disability Policies Provide the Protection They Promise."
Senate Finance Committee
United States Congress
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The American Council of Life Insurers (ACLI) appreciates the opportunity to appear before this Committee to discuss the important issue of disability income insurance. We thank Committee Chairman Baucus (D-MT) and Ranking Member Grassley (R-IA) for giving us the chance to discuss the critical role private disability insurance plays in helping families manage what is very often a difficult time in their lives.

The ACLI represents more than 300 legal reserve life insurer and fraternal benefit society member companies operating in the United States. These member companies represent over 90% of the assets and premiums of the U.S life insurance and annuity industry. ACLI member companies provide the majority of disability income insurance coverage in the United States.

In order to provide the Senate Finance Committee with a better understanding of private disability insurance, our testimony is intended to provide a brief overview of the product as well as highlight the value this coverage offers to policyholders and certificate holders. In addition, we summarize the current federal and state regulatory framework that governs the claims handling process.

Overview of Disability Income Insurance

If an individual becomes disabled, disability income insurance provides money to help pay ongoing bills and avoid prematurely depleting household savings they may have accumulated for a child's education or retirement. Private disability insurance is a valuable option that provides income protection that complements the safety net provided by the Social Security Disability Income program.

Private disability insurance is generally sold in two forms: short-term disability coverage and long-term disability coverage. Additionally, the market consists of disability income coverage that is sold to employers for the benefit of its employees and that is sold to an individual consumer. Approximately 39 percent of U.S workers in the private industry are covered by short-term disability insurance and about 30 percent of the U.S work force is covered by long-term disability insurance.[1]

Private long-term disability insurers provide income protection coverage to approximately 43,600,000 individuals,[2] the vast majority of which are covered through their employer. The employer is the policyholder and decision maker in choosing the

[1] National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2007
[2] American Council of Life Insurers calculation based on NAIC data as of 12/31/2009

overall benefit design. Because employers can provide these benefits in a cost-effective way, millions of workers are able to enjoy coverage.

Short-term disability coverage makes benefits available when an individual is unable to work for a short period of time due to a covered illness or injury. These policies typically provide benefits for a maximum of 13 to 26 weeks.

When an individual is unable to work for longer periods of time, there is private long-term disability coverage. This coverage usually begins when sick leave and short-term disability coverage has been exhausted. Long-term disability insurance allows policyholders to sustain themselves financially should an illness or injury keeps them out of the workplace for an extended period of time. The duration of benefits available under this type of contract varies greatly, but generally ranges anywhere from a minimum of 2 years all the way to a maximum of the insured's retirement age.

Value to Consumers

In 2009 alone, insurers paid over $8.95 billion in long-term disability benefits.

In 2008 Harris Interactive conducted a survey to assess disability insurance claimants' satisfaction with their policy, as well as their experience filing a claim and receiving benefits. Key findings from that survey were as follows:

- Overall, four out of five claimants (82 percent) said that they are very satisfied or somewhat satisfied with their policy.

- Most claimants were satisfied with the process for filing a claim (81 percent), promptness of payment (79 percent), responsiveness of the insurer (75 percent), and overall communication from the insurer (71 percent).

- Two-thirds of claimants (66 percent) did not encounter any problems with the claims process, and among those that did, the vast majority (84 percent) had their problem resolved satisfactorily.

- The vast majority of claimants (96 percent) say it is at least somewhat likely they would have suffered financial hardship if they did not have disability income protection. Furthermore, two-thirds (67 percent) say it would have been very or extremely likely that they would have suffered financial hardship if they had not received private disability insurance payments.

In addition to replacing lost income for claimants in a timely manner, private disability insurers can play a key role in restoring disabled workers to financial self-sufficiency and maintaining productivity for America's businesses. The industry has been proactive by designing policies that facilitate claimants return to work. Additionally, by investing in rehabilitation and return-to-work programs, private disability insurers are actively engaged in assisting workers with disabilities return to the workforce.

Innovative rehabilitation and return-to-work programs include a wide range of strategies in recognition of the fact that persons with disabilities are highly diverse and face varying circumstances. Services offered include medical case management, vocational and employment assessment, worksite modification, purchase of adaptive equipment, business and financial planning, retraining for a new occupation, child or dependent care benefits during rehabilitation and education expenses. These innovative benefits reflect the industry's strong commitment to promoting employment and self-sufficiency among persons with disabilities.

Disability insurers also help consumers exercise their rights under the Social Security Disability Income (SSDI) program. The integration of disability income benefits with Social Security disability benefits has long been recognized by regulators, the insurance industry and employers as an important tool in reducing the cost of disability insurance coverage and keeping it affordable so that the maximum number of employees receive coverage. Disability income insurers carefully screen their long term disability claimants to determine if it is reasonable to expect them to receive Social Security benefits. For those who are expected to qualify, insurers dedicate significant resources to help with the application process.

Furthermore, helping qualified claimants apply for SSDI provides them with important benefits beyond a simple monthly income check. These benefits include cost of living adjustments, continuing credit toward Social Security retirement benefits, and, in time, eligibility for Medicare coverage. These SSDI benefits are in addition to what disability insurers pay to help cover living expenses while a person is unable to work and earn an income.

Basics of Disability Income Insurance

The principal purpose of disability income insurance is to provide replacement income to eligible individuals who become temporarily or permanently disabled and cannot work. The benefit is equal to some pre-designated percentage of the claimant's pre-disability income. In order to ensure that over-insurance does not exist, it is not intended that disabled employees receive an aggregate replacement income from all sources in excess of that predetermined amount.

Disability income insurance is not coverage for the diagnosis or treatment of medical conditions, nor does disability income insurance provide reimbursement of expenses incurred for medical conditions.

Disability versus Impairment

As part of understanding how an individual is determined to be disabled for disability income insurance, it is important to understand the distinction between disability and impairment.

Impairment is the degree to which an individual's ability to work is effected by a change in health status. The level of impairment is evaluated in the context of the medical and other relevant documentation gathered during the claim administration process. Impairment is an important contributing factor in determining disability; by itself, it is not sufficient to determine disability.

Disability is an administrative/legal determination. The definition(s) of disability in a contract describes the extent to which an insured must be unable to perform occupational duties as a result of impairment in order to be considered disabled.

Distinguishing between impairment and disability is imperative. One individual can be impaired significantly and have no disability, while another individual can be quite disabled with only limited impairment.

For example, a paraplegic who works full-time successfully as an actuary may have an impairment but is not disabled from employment. On the other extreme, someone could have a minor impairment and be disabled, such as a concert pianist with an injury to a digital nerve that severely limits her ability to perform her basic work activities, playing piano.

A medical diagnosis and resulting impairment are not the sole factors in determining disability benefits. The decision as to whether a person is disabled under a policy involves an integrated evaluation of multiple facets. In addition to a skilled judgment regarding an insured's impairment (medical diagnosis and any resulting mental or physical limitations or restriction), a disability assessment includes an appropriate and consistent interpretation and application of contract provisions and a vocational analysis of the insured's occupational experience, training and educational circumstances. Furthermore, many disability policies contain a financial loss component within the definition of disability that necessitates a comprehensive review and analysis of an insured's pre- and post-disability financial circumstances.

Eligibility determinations for disability benefits are not static; rather, they are often made on an ongoing basis in recognition of the fact that an insured's circumstances may improve, deteriorate or remain the same. Disability income contracts typically require an eligibility determination on an ongoing basis as the insured's circumstances evolve and a different definition of disability may become applicable. An eligibility determination, whether made by the insurance carrier or other fiduciary, is only valid based on the contractual requirements and information available at that point in time.

Policy Features – Some Key Terms

When considering a disability income policy or receiving coverage as part of an individual's employment package, there are key policy features and definitions to consider.

Definition of disability: Some policies pay benefits if an individual is unable to perform the major duties of their *own* occupation. Other policies pay benefits if an individual is unable to perform the duties of *any* occupation for which they are reasonably qualified by education, training, and experience.

Many policies, primarily employer-sponsored group policies, combine these features, providing "own occupation" coverage for one or two years and "any occupation" coverage after that time frame. Employers are the decision makers in deciding the terms and provisions in the disability policies offered to their employees. Many employers choose policies with a change in definition provision because this provision makes the policy affordable. Some of the benefits of a two-year *own* occupation provision are that for the first two years, the own occupation provision is a more generous standard than SSDI's standard. After two years, many group policies then require a determination of whether an insured can perform "any *gainful* occupation." When this change in definition occurs, private insurance will continue to pay even if the person can work and yet is unable to earn a gainful wage. Thus, private insurers do not require people who have work capacity to work at a job that would pay below gainful wages.

Extent of disability: Some policies require total disability before beginning payments while other policies cover partial disability. Others may cover partial disability for a limited time, but only when it follows a period of total disability for the same cause.

Benefit level: The benefit amount an individual would receive if disabled varies by policy. The most common policy benefit pays between 60-66⅔ percent of monthly salary. Policies purchased by individual consumers generally afford the opportunity to protect a higher percentage of earned income, either as stand alone coverage or as a supplement to employer sponsored plans.

Benefit period: How long an individual receive benefits varies by policy. Some individual policies pay benefits for a specified period, such as two or five years, while others may pay benefits until age 65 or your retirement age under Social Security.

Elimination period: Policies have different waiting periods (elimination periods) before benefits begin. Typically the elimination period can be 90 days to 180 days for a long-term disability policy. The length of the insured's disability must exceed the elimination period in order to qualify for any benefits. In a group setting, the elimination period of the long-term disability benefit is often equal to the duration of the short-term disability benefit.

These are just some of the major policy features that would be in a state-approved disability policy. These features are also outlined in the certificate of coverage provided to employees covered under employer sponsored plans.

Current Federal and State Regulatory Framework for Disability Claims

In an ERISA plan, the insurer that is acting as administrator has fiduciary responsibility. As previously mentioned, eligibility determinations may be complex and require a multitude of professional opinions for benefit decisions. In addition, these benefit eligibility determinations are not static: they are often made on an ongoing basis in recognition of the fact that an insured's circumstances may change over time. Disability income contracts typically require an eligibility determination on an ongoing basis as the insured's circumstances evolve and different contractual provisions may apply over time.

It should be noted that, unfortunately, disability income insurance can be susceptible to fraud and abuse. Many states have passed regulations that require short-term and long-term disability companies to be alert to and report claims on when fraud is suspected. While fulfilling their contractual and regulatory responsibilities, insurers need to remain attentive to potentially fraudulent claims. Therefore, an eligibility determination, whether made by the insurance carrier or other fiduciary, is only valid for the information at that point in time and must be periodically re-evaluated to account for changes in the claimant's condition.

A 2008 industry study representing the majority of group disability carriers indicated that 78.8% of submitted claims were approved.[3] Of those claims not approved, over 25% were not paid because the claimant had never met the elimination period; that is they apparently recovered before the typical 90 or 180 day elimination period expired.

Most private sector disability income coverage is provided by employer-sponsored plans. These group disability policies, like all private employer-sponsored health and welfare benefits, are governed by federal law under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA regulations specify that a plan fiduciary (generally the insurance carrier in this instance) is required to act in the best interest of the plan participants and beneficiaries.

For the protection of consumers, ERISA additionally sets out detailed and specific requirements for the fair, transparent and timely handling of disability claims. These requirements address timeframes for claim decisions; requirements for keeping claimants informed and apprised of claim actions and the reasons for them; and the appeal rights afforded claimants whose claims are denied.

For initial consideration of a disability claim, ERISA:

- Requires that the insurers reach a claim decision within a "reasonable time," but at the latest 45 days from initial notice.

- Provides for up to two 30-day extensions, but only if the insurer can show reason for the extension is "beyond the control of the plan."

[3] JHA's 2008 U.S. Group Disability Rate and Risk Management Survey

- Requires the insurer to send notice of the extension to the claimant before the prior deadline passes.

- Requires the insurer to explain circumstances requiring extension.

- Requires the insurer to provide date by which a claim decision is expected (if required information is provided).

For a decision on an appeal of a claim denial, ERISA:

- Requires the insurer to reach a decision within "reasonable time," but at the latest 45 days from receipt of request for appeal.

- Allows one 45-day extension, but only if the insurer can show "special circumstances" require such extension.

- Requires notice to the claimant of the extension that explains the "special circumstances" requiring the extension and the date by which a decision is expected.

ERISA requires that, for an appeal of a claim denial:

- The review must be conducted with "no deference" to the initial claim decision.

- The insurer personnel reviewing the appeal did not make the initial claim decision and is not a subordinate of the initial decision-maker.

- If the appeal is based in part on medical judgment, the reviewer must consult health care professionals with appropriate training and experience. This consultation cannot be with health care professionals consulted for the initial decision – or a subordinate thereof.

- If claimants disagree with claim decisions, and exhaust their appeal rights as enumerated above, they also have the right to appeal denials to the federal courts.

Additional State Consumer Protections for Disability Claimants

States have also established requirements to ensure that claims are handled promptly and properly. In 1990, the National Association of Insurance Commissioners (NAIC) adopted the Unfair Claims Settlement Practices Act, which has since been adopted in various forms in 48 jurisdictions. Specifically, the Unfair Claims Settlement Practices Act outlines protections including, but not limited, to the following:

- An insurance company may not knowingly misrepresent material facts or relevant policy provisions in connection with a claim;

- An insurance company should adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

- An insurance company should affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claims;

- An insurance company must provide claim forms, and process claims, within certain outlined time periods;

- An insurance company shall provide reference to the policy provision, condition or exclusion upon which the denial is based;

- An insurance company shall notify the claimant in writing of his or her right to have the matter reviewed by the Department of Insurance if the claimant opposes a rejected claim; and

- An insurance company shall maintain adequate files for review and examination by the commissioner of insurance.

These are just a few provisions of the NAIC Unfair Claims Settlement Practices Act and the NAIC Unfair Trade Practices Act that disability income insurers are required to follow to ensure claims are paid promptly and properly. In addition, these models set out enforcement procedures that Commissioners can use to sanction companies failing to follow the law. It should be noted that the U.S. Supreme Court has upheld state laws that regulate the substance of insurance coverage as well as state insurance laws that are aimed at the insurance claims review process.

As mentioned, the consumer is made aware that he or she may file a complaint with the insurance departments, which have resources allocated to handle complaints. In addition, insurance departments also conduct periodic market conduct exams where the overall review of the insurer is performed, including the claims review department. Any pattern of abuse discovered, either through market conduct exams and other regulatory means, can and have led to corrective actions.

Conclusion

In summary, employers want to attract and retain the best employees. Employees recognize that long-term disability coverage, as a part of their benefit package, provides a valuable measure of protection in the event of a disabling injury or illness. While most people are able to return to work following a short period of recovery, some people find themselves unable to return to work within six months, and need long-term disability insurance to assist them and their families during this difficult time. A combination of public and private coverage can provide critical financial support.

The private disability income insurance industry has for many decades played an integral role in providing for the financial well-being of and peace of mind for American workers and their families. The current framework of federal and state consumer protections affords the all important balance of providing a reasonable cost of coverage and appropriate handling of claims.

Once again, the ACLI appreciates this opportunity to appear before this Committee to discuss the importance of private disability income insurance.